



Psychiatric comorbidity in women and men with eating disorders results from a large clinical database

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ABSTRACT

Psychiatric comorbidity is common in patients with eating disorders (ED), but prevalence estimates are heterogeneous, probably due to methodological differences between studies (population, diagnostic method, sampling procedure etc.) and a few studies include men. The aim of this study is to investigate psychiatric DSM-IV Axis I comorbidity in a large sample of adult patients, both males and females, with the whole spectrum of DSM-IV ED diagnoses. Initial presentation assessment data on 11,588 adult men and women presenting to specialist ED clinics in Sweden between 2008 and 2012 were extracted from a large clinical database. Diagnostics were based on semi-structured interviews (SCID-I) and the Structured Eating Disorder Interview (SEDI). Seventy-one percent of the patients with ED had at least one other Axis I disorder. The most common type of diagnosis was anxiety disorders (53%), where generalized anxiety disorder was the most common diagnosis. The highest levels of comorbidity were found for women with Binge Eating Disorder (BED) and men with Bulimia Nervosa (BN). Findings are consistent with previous research showing a high prevalence of psychiatric comorbidity in both men and women with ED. The small gender differences observed seem negligible compared to the general similarity in comorbidity.

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1. Background

Psychiatric comorbidity is common in patients with eating disorders (ED), and previous studies have reported a prevalence of 20–95% (Blinder et al., 2006; Buhren et al., 2014; Grilo et al., 2013; Herzog et al., 1992; Hudson et al., 2007; Kaye et al., 2004; Milos et al., 2004; Spindler and Milos, 2004; Zaidler et al., 2000). Differences in estimates are most likely due to methodological differences between studies concerning, e.g., ED population, choice of diagnostic methodology (interviews, retrospective chart reviews, different screening and/or diagnostic instruments), type of sample (e.g. in- or outpatients, population-based samples), whether both men and women were included, etc. Psychiatric comorbidity may increase ED severity, chronicity and treatment resistance (Blinder et al., 2006), although some studies do not find any prognostic impact of Axis I comorbidity (Zerwas et al., 2013). Also, comorbidity has been shown to contribute to diagnostic instability in the ED itself (Milos et al., 2013). Milos (Milos et al., 2013) suggest that psychiatric Axis I comorbidity, mainly affective disorders,

affects diagnostic transition between ED diagnoses. In ED patients the most common comorbidities are mood disorders (with estimates between 20% and 98%), anxiety disorders (7–65%, with obsessive-compulsive disorder, OCD, and social phobia being most common), and substance use disorders (SUD, 6–55%) (Blinder et al., 2006; Herzog et al., 1992; Kaye et al., 2004; Milos et al., 2004; Spindler and Milos, 2004; Zaidler et al., 2000). Some studies also suggest shared genetic pathways among ED and other psychiatric disorders (e.g. OCD) (Mas et al., 2013), making a broad overview of comorbidity in ED an important field of study. However, the evidence concerning ED and comorbidity rests on relatively few studies, most containing only a few hundred patients (Blinder et al., 2006; Buhren et al., 2014; Grilo et al., 2013; Herzog et al., 1992; Hudson et al., 2007; Kaye et al., 2004; Milos et al., 2004; Spindler and Milos, 2004; Zaidler et al., 2000) and most research comprises only female patients. However, male patients with ED have shown higher levels of general psychopathology and comorbidity than female patients with ED in some studies (Bean et al., 2005) but this is a small study including just 27 men. Comparison studies have shown that depression and substance abuse and obsessive compulsive behaviors are more common in male compared to female ED patients. However, other studies have shown gender similarities on comorbidity (Braun et al., 1999; Weltzin et al., 2007; Woodside et al., 2001). Also, many studies are

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based on one ED diagnosis in relation to one type of comorbidity, making it difficult to generalize to the entire group of patients with ED. A few studies do include all ED diagnoses and comorbidities for example Hudson et al. (Hudson et al., 2007) made a large population-based study including 2980 respondents. 56.2% of the respondents with anorexia nervosa, 94.5% with bulimia nervosa, 78.9% with Binge Eating Disorder, 63.6% with subthreshold Binge Eating Disorder, and 76.5% with any binge eating met criteria for at least 1 DSM-IV disorder. Blinder et al. (2006) performed a retrospective chart review of 2436 female ED inpatients, and found one or more comorbid Axis I diagnosis in 97% of the cases, with virtually no differences across ED diagnosis. The most common comorbidities involved mood-, anxiety-, and SUD. Anorexia nervosa (AN) patients were twice as likely to have OCD compared with bulimia nervosa (BN) and eating disorder not otherwise specified (EDNOS), while SUD were more common in BN compared with AN.

The aim of this study was to study psychiatric Axis I comorbidity in a large sample of adult patients of both genders with the entire spectrum of ED.

2. Methods

Data in this study came from the Stepwise quality control database, a large-scale Internet based data collection system for specialized ED care. Criteria for inclusion in the database are medical or self-referral to one of the 35 participating treatment units, a diagnosed ED according to DSM-IV (American Psychiatric Association, 1994) and an intention to treat the patient at the unit in question (Birgegård et al., 2010). The database includes data from patients of all ages and both genders. In the present study, however, only adult patients (18 years or older) were included. Stepwise contains structured diagnostic interviews for ED- and other DSM-IV Axis I diagnostics; for a full description of Stepwise, see Birgegård et al. (2010).

2.1. Procedure

Patients were assessed by ED specialists with special training in the Stepwise system. The training is a 2 day course focusing on the measurement methods in the Stepwise system. The assessment was made prior to treatment, usually within the first three visits to the unit, following, if necessary, medical assessment by a physician. For inpatient cases with severe physical complications, assessments were performed within the first week of care. After a brief orienting interview lasting a few minutes, diagnostic Axis I interviews were conducted, followed by clinical ratings (including Global Assessment of Functioning (GAF)- a scale used to rate the social, occupational, and psychological functioning (American Psychiatric Association, 1994).), collection of demographic and psychiatric history, including BMI, and weighing the patient if necessary. Interviewers were seated at a computer and recorded answers on the screen. Patients subsequently completed the questionnaires while sitting at a computer. Assessment took on average slightly less than 1.5 h. Informed consent for research purposes was obtained from each patient.

2.2. Participants

Data for the present study was registered between March 2005 and May 2014, resulting in 11,588 patients from 35 treatment units (in- and out patients) from all over Sweden. Of these, 832 patients who did not meet the criteria for an ED diagnosis were excluded (Stepwise is used for assessment purposes, and patients are sometimes retained in the database even though inclusion criteria

are not fulfilled). 486 patients who declined research participation were excluded, as were 2906 patients under 18 years of age. Thus, data from 7156 patients over 18 years of age were analyzed in this study. Of these, 235 patients were male and 6921 female.

2.3. ED diagnoses

The patients were classified as AN restricting type (ANR), AN binge eating/purging type (ANBP), BN (BN/purging type and BN/non purging type), ED not otherwise specified (EDNOS; including EDNOS2; AN criteria except that weight is normal despite weight loss, EDNOS3; BN criteria except that frequency and/or duration of bingeing/compensation are too low, EDNOS4; purging without binge eating, and EDNOS5; chewing and spitting food) and Binge Eating Disorder (BED). Patients with EDNOS type 1 (AN criteria except amenorrhea) were reclassified into the most suitable AN category, since amenorrhea is widely regarded as lacking diagnostic validity, and has been removed in DSM-5. The diagnoses in this study were all established through clinical interviews and are based on the DSM-IV system.

2.4. Psychiatric comorbidities

Comorbid disorders were assessed using semi-structured interview (see below), and categorized for group difference analyses as Any mood disorder (Major depressive disorder, depressive disorder not otherwise specified, dysthymic disorder, other mood disorders, bipolar disorders), Any anxiety disorder (Obsessive-compulsive disorder, Post-Traumatic Stress Disorder, Generalized Anxiety disorder, Panic disorders, Specific Phobia, Social Phobia, other anxiety disorders) and Any addictive disorder (Alcohol abuse, Alcohol dependence, Substance abuse, Substance dependence).

2.5. Instruments

2.5.1. Structured Clinical Interview for DSM-IV Axis I (SCID-I) (First et al., 2002)

The Stepwise system includes the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) Axis-I Disorder, Research Version (SCID-I/NP). The SCID-I has repeatedly been shown to have good psychometric properties (Lobbstaël et al., 2011; Steiner et al., 1995). SCID-I is a semi-structured assessment instrument for clinical disorders. The aim with SCID-I is to systematically collect clinical relevant information connected to the DSM-IV criteria (First et al., 2002).

2.5.2. The Structured Eating Disorder Interview (SEDI)

The SEDI assesses ED symptoms and establishes a preliminary ED diagnosis. The interview comprises 20–25 questions and is loosely based on SCID-I and Mini-International Neuropsychiatric Interview for children (M.I.N.I.-KID. M.I.N.I.-KID is a short structured diagnostic interview for DSM-IV and ICD-10 psychiatric disorders in children and adolescents" The M.I.N.I.-KID is a structured clinical diagnostic interview designed to assess the presence of current DSM-IV and ICD-10 psychiatric disorders in children and adolescents aged 6–17 years in a way that is comprehensive and concise. The interview is administered to the child/adolescent together with the parent(s), although it can be administered to adolescents without a parent being present (Sheehan et al., 2010)), but is able to differentiate between all DSM-IV ED subtypes, including research criteria for BED, and five remaining EDNOS examples. Preliminary validation against the Eating Disorder Examination interview has shown a concordance of 81% for specific ED diagnosis (including EDNOS and BED) and Kendall's Tau-b of 0.69 ($p < .0001$) (de Man Lapidoth and Birgegård, 2010). Age- and

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