



Predictors of change in psychosocial impairment secondary to an eating disorder



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ABSTRACT

Eating disorders (ED) can significantly impair psychosocial health in patients. However, no published studies have so far used a standardized and specific instrument to evaluate predictive factors in ED-related psychosocial impairment. This prospective cohort study involved 177 patients receiving outpatient treatment for an ED at baseline and 115 patients at the 1-year follow-up. Patients completed three self-administered questionnaires: the Clinical Impairment Assessment (CIA), the Eating Attitudes Test-12 (EAT-12), and the Health-Related Quality of Life in ED-short form (HeRQoLED-s). Descriptive statistics, ANOVA, chi-square, and Fisher's exact test were applied to examine intervariable relationships. Multivariate linear regression was used to determine predictors of change in CIA scores. An improvement was reported by patients with restrictive anorexia nervosa (AN) compared to those with purgative AN. In the multivariate analysis, employment status, subtype of ED, and the bulimia and food preoccupation factor of the EAT-12 were significant predictors of change in the CIA scores.

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1. Introduction

Eating disorders (ED) are serious psychiatric illnesses. They impair health-related quality of life (Hay and Mond, 2005; Stice et al., 2009) and have other profoundly negative effects on patient lives (Bohn et al., 2008). The severity of the disorder combined with the risk of chronicity can substantially affect patient physical health (Diaz-Marsa et al., 2000; Jagielska et al., 2001), mental health, and social adjustment (Padierna et al., 2000). While the physical effects of EDs are well characterized, their psychosocial impact is less well understood. Data have shown that individuals with EDs who receive specialist treatment have high levels of impairment in certain aspects of quality of life, particularly those relating to psychosocial functioning (Hay and Mond, 2005; Jenkins et al., 2011; González et al., 2012). The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) recognizes that clinical impairment is an important criterion for identifying individuals in need of treatment because mental health symptoms may not always be associated with subjective emotional distress (Stein et al., 2010). Because an ED tends to have a risk of chronicity

(Steinhausen, 1999), and it is often the psychosocial component of the illness that leads patients to seek help, it is important to better understand the psychosocial impact secondary to ED (Fairburn, 2008).

The Clinical Impairment Assessment (CIA) was developed as a brief self-report questionnaire to assess the extent to which an individual's eating habits, exercising, or feelings about his or her shape, weight, or eating impact daily functioning in various domains, including social, emotional, and cognitive aspects (Bohn and Fairburn, 2008). The CIA is distinguished from other eating disorder-related quality-of-life measures in that it clearly emphasizes the severity of impairment across important domains of functioning that occurs as a direct consequence of an individual's ED psychopathology (Vannucci et al., 2012). Cross-sectional studies of psychosocial impairment secondary to ED using the disease-specific CIA measure found that mean CIA global scores ranged between 30 and 34 in clinical samples from the United Kingdom and Spain (Bohn et al., 2008; Jenkins, 2013; Martín et al., 2015) (global CIA score ranges from 0 to 48). In addition, the instrument has been used in nonclinical samples (White and Warren, 2013; White and Warren, 2014). No published studies, however, have used a standardized and specific instrument to evaluate predictive factors in ED-related psychosocial impairment. Such information could provide important insights into the clinical outcome of these processes and their impact on general wellbeing,

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and may also help assess the effectiveness of different therapeutic options.

The objectives of our study were to assess changes over time in psychosocial impairment of ED patients and to identify factors that influence those changes, taking into account patient status at baseline.

2. Methods

2.1. Participants

We conducted a prospective study of all patients diagnosed with and treated for an ED in the Eating Disorders Outpatient Clinic, which is part of psychiatric services at Hospital Galdakao-Usansolo in Spain. This hospital, which serves a population of 300,000 inhabitants, is part of the Basque Health Care Service, which provides free, unrestricted care to nearly 100% of the population. Outpatients recruited between January 2010 and January 2011 were eligible for the study if they had been diagnosed with AN, bulimia nervosa (BN), or an eating disorder not otherwise specified (EDNOS) by a psychiatrist based on criteria established in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (American Psychiatric Association, 1994). In order to participate, patients were required to provide written informed consent. Patients were excluded from participating if they had a malignant, severe organic disease, could not complete the questionnaires because of language barriers, or did not give written informed consent to participate in the study. Patients were classified as disabled if they were unable to work because of their ED. There were different treatments used for different diagnoses in our study: Cognitive behavior therapy has been established as the treatment of choice for BN and EDNOS (Agras et al., 2000); family-based interventions have been established as the treatment for adolescents with AN (Eisler et al., 1997; Robin et al., 1994); and nonspecific supportive clinical management has been established as the treatment for adults with AN; this treatment provided education and nutritional advice and used supportive psychotherapy principles in responding to the patient (McIntosh et al., 2005). Throughout the 2-year study period, each patient received a psychopharmacologic and psychotherapeutic treatment program consisting of cognitive-behavioral treatment; nutritional orientation and counseling; psychoeducation; motivational therapy; social skills training; and therapy to modify distorted perception of body image. These interventions were adjusted to each patient's needs by a multidisciplinary team. A total of 244 ED patients were invited to participate in the study. Of these, 177 completed the questionnaires at baseline (72.54%) and 115 completed them at the 1-year follow-up (64.97%). Dropouts at the beginning of the study were due mainly to patients not consenting to participate. During the follow-up, some patients could not be contacted due to changes in their addresses or telephones, and some did not want to continue participating in the study.

The study was approved by the institutional review board of Hospital Galdakao-Usansolo.

2.2. Measures

2.2.1. Clinical Impairment Assessment

The CIA (v. 3.0) (Bohn et al., 2008; Bohn and Fairburn, 2008) is a 16-item self-report instrument specifically designed to assess psychosocial impairment secondary to features of an ED. Items are rated on a four-point Likert scale, ranging from 0 = "Not at all" to 3 = "A lot". A global CIA score ranging from 0 to 48 is calculated to provide a global index of the severity of psychosocial impairment due to ED pathology during the past 28 days. A higher score

indicates greater impairment. Subscale scores can be calculated to determine the three domains of impairment—personal, social, and cognitive—attributable to eating habits, exercising, or feelings about eating, shape, or weight over the previous 28 days. The original report of the CIA's psychometric properties supported adequate reliability and validity of the measure within a clinical sample of ED patients (Bohn et al., 2008). A version of the CIA has been translated into, and validated in, Spanish (Martín et al., 2015). The CIA is distinguished from other ED-related quality-of-life measures in that it emphasizes the severity of impairment across important domains of functioning that occur as a direct consequence of an individual's ED (Vannucci et al., 2012).

2.2.2. Eating Attitudes Test-12

Eating problems were measured by the Eating Attitudes Test-12 (EAT-12) (Lavik et al., 1991). This 12-item instrument uses a 4-point scale that ranges from *never* (score 0) to *always* (score 2). The EAT-12 yields three factors: dieting, bulimia and food pre-occupation, and oral control. Higher scores indicate more disordered eating. Previous studies have supported its validity as a measure of disordered eating (Wichstrøm et al., 1994; Wichstrøm, 1995). The internal consistency was a 0.71.

2.2.3. Health-Related Quality of Life in ED-short form (HeRQoLED-s)

The equality of life of ED patients was evaluated using the Health-Related Quality of Life in ED-short form (HeRQoLED-s) (Las Hayas et al., 2007; Las Hayas et al., 2010). This questionnaire consists of 20 items distributed into two domains: social mal-adjustment ($\alpha=0.91$) and mental health and functionality ($\alpha=0.90$). The higher the score, the lower the quality of life. This measure has been used successfully with Spanish-speaking populations (Engel et al., 2009; Muñoz et al., 2009; Martín et al., 2011; Padierna et al., 2012).

2.3. Procedure

Data collection started in 2010; 1-year follow-ups were conducted during 2011 and 2012. Psychiatrists collaborating in the study informed their patients about the objectives of the study and recorded sociodemographic information including age, gender, marital status, level of education, and employment status. Patients who agreed to take part in the study were sent the questionnaires and the informed consent form by mail. They were asked to return these by mail using an enclosed, pre-stamped envelope.

Two reminders were sent at intervals of 15 days to those who did not respond to the first mailing. A year later, the same study instruments were mailed, with the same follow-up for nonresponders.

2.3.1. Statistical analysis

Patient sociodemographic and clinical variables were analyzed by ED subtype. Descriptive statistics included frequencies and percentages for categorical variables, and means and standard deviations (SD) for continuous variables. Chi-square and Fisher's exact tests were used to evaluate associations between ED subtype and categorical variables, and nonparametric Wilcoxon tests were applied for continuous variables.

The main outcome of interest was the change in CIA score between baseline and the 1-year follow-up. Thus, only patients with both measurements were considered in the following analyses. To analyze the change between baseline and 1-year follow-up, these measurements were plotted, stratified by diagnosis. In addition, descriptive statistics were computed for baseline, follow-up, and change. In order to identify potential predictors of change in the CIA scale and subscales, bivariate linear regression analyses adjusted by

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