



Less symptomatic, but equally impaired: Clinical impairment in restricting versus binge-eating/purging subtype of anorexia nervosa

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ARTICLE INFO

Keywords:

Anorexia nervosa
Impairment
Subtype
Quality of life

ABSTRACT

Objective: This study investigated subtype differences in eating disorder-specific impairment in a treatment-seeking sample of individuals with anorexia nervosa (AN).

Method: The Clinical Impairment Assessment (CIA) and the Eating Disorder Examination-Questionnaire (EDE-Q) were administered to 142 patients. Of these, 54.9% were classified as restricting type (AN-R) and 45.1% were classified as binge-eating/purging type (AN-B/P) based on an average weekly occurrence of binge eating and/or purging episodes (≥ 4 episodes/28 days).

Results: Individuals with AN-B/P exhibited higher levels of core ED psychopathology (dietary restraint, eating concern, shape/weight concerns) in addition to the expected higher frequency of binge/purge episodes. No significant differences existed between AN subtypes in the severity of ED-related impairment. Weight/shape concerns and binge eating frequency significantly predicted level of impairment. Differential associations were observed between the type of ED pathology that significantly contributed to impairment according to AN subtype.

Discussion: Although those with AN-B/P displayed higher levels of core attitudinal and behavioral ED pathology than AN-R, no significant differences in ED-specific impairment were found between AN subtypes. Eating disorder-related impairment in AN was not related to the severity of underweight or purging behaviors, but was uniquely and positively associated with weight/shape concerns and binge eating frequency.

1. Introduction

Anorexia nervosa (AN) is characterized by a relentless restriction of energy intake despite potentially life-threatening medical consequences and premature mortality (Fichter & Quadflieg, 2016; Keshaviah et al., 2014). Anorexia nervosa is associated with a range of functional impairment, including social isolation and/or a failure to achieve academic or employment potential (Klump, Bulik, Kaye, Treasure, & Tyson, 2009; Schmidt et al., 2016). Despite these sequelae, individuals with AN are often steadfast in failing to recognize or acknowledge the seriousness of low body weight, rarely complaining about severe underweight per se. Rather, the drastic reduction in food intake and weight loss is valued as an extraordinary achievement or sign of self-discipline (APA, 2013) and experienced as highly reinforcing (Walsh, 2013) at least initially, with potentially anxiolytic effects for some individuals (Kaye, Wierenga, Bailer, Simmons, & Bischoff-Grethe, 2013).

This paradox is reflected in studies of quality of life (QOL) and impairment, which have often yielded inconsistent findings pertaining

to AN. Some studies have demonstrated no differences in impairment between AN and other eating disorders (ED) (Dahlgren, Stedal, & Ro, 2017; DeJong et al., 2013), less impairment (Bamford & Sly, 2010; Doll, Petersen, & Stewart-Brown, 2005; Padierna, Quintana, Arostegui, Gonzalez, & Horcajo, 2000; Welch, Birgegard, Parling, & Ghaderi, 2011), and on some domains, even comparable health-related QOL to healthy controls (Mond, Hay, Rodgers, Owen, & Beumont, 2005), whereas other studies report poorer functioning in AN (Abraham, Brown, Boyd, Luscombe, & Russell, 2006). Discrepant findings may intrinsically reflect the “egosyntonic” nature of the illness, associated dysfunctional cognitions of AN linked to the undue influence of shape and weight control on self-evaluation, or limited insight or minimization of the detrimental aspects of the illness (Attia, 2014; Halmi, 2013). Inconsistencies in findings may also reflect methodological differences such as precision in measurement (i.e., illness-specific versus generic measures), as generic measures are less nuanced and demonstrate less sensitivity in detecting diagnostic differences than illness-specific measures (Ackard, Cronmeyer, Richter, & Egan, 2015; Mitchison et al.,

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2013). The majority of studies, however, have utilized generic measures, such as the SF-36, to assess quality of life in AN (see Agh et al., 2016; Baiano et al., 2014; Jenkins, Hoste, Meyer, & Blissett, 2011 for reviews).

Additionally, inconsistencies in prior research may relate to symptom heterogeneity within the AN diagnostic category itself. Anorexia nervosa has two diagnostic subtypes in the DSM-5, including restricting type (AN-R) and binge-eating/purging type (AN-B/P) (APA, 2013). The restricting type of AN is characterized by weight loss primarily accomplished via fasting or excessive exercise, while AN-B/P characterizes individuals who regularly engage in binge eating and/or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas) during the past 3 months. Several studies have linked AN-B/P to negative correlates such as impulsivity, substance use, self-harm and suicidality (Buhren et al., 2014; Peat, Mitchell, Hoek, & Wonderlich, 2009; Peterson et al., 2016), as well as the incidence of medical complications upon hospital admission (Rylander, Brinton, Sabel, Mehler, & Gaudiani, 2017) and neurobiological correlates such as inferior inhibitory control or greater punishment sensitivity (Lock, Garrett, Beenhakker, & Reiss, 2011; Murao et al., 2017). These findings suggest it may be similarly important to delineate AN subtypes to disentangle the degree and type of functional impairment observed in AN.

Only a few studies have investigated ED-specific quality of life or functional impairment in AN by subtype and the results are mixed. A few studies have demonstrated poorer global functioning (De Young et al., 2013) or higher ED-related impairment (DeJong et al., 2013; Martin et al., 2016) in AN-B/P compared to AN-R, whereas others have found no significant subtype differences (Bamford & Sly, 2010; Ekeroth, Clinton, Norring, & Birgegard, 2013). For instance, a study by Bamford and Sly (2010) found that although those with AN-R and AN-B/P had lower scores on the illness-specific ED-QOL (and hence better quality of life) than those with eating disorder not otherwise specified (EDNOS), there were no significant differences between AN subtypes. Similarly, Ekeroth et al. (2013) found no significant subtype differences in patients receiving specialized ED treatment in Sweden, although individuals with AN-B/P had higher levels of impairment than atypical AN, purging disorder, and unspecified feeding or eating disorder (USFED). The relatively few studies yielding mixed findings warrants additional research to improve our understanding of potential subtype differences in impairment associated with AN. Furthermore, little is known about potential subtype differences across the various life domains in which impairment may occur.

The main purpose of this study was to investigate AN subtype differences across key domains of ED-related impairment (global, personal, social, cognitive) in a clinical sample of AN patients. From a clinical standpoint, addressing perceived impairment as an outright treatment goal may help facilitate therapeutic alliance and strengthen adherence, constituting an important patient-reported outcome beyond symptom-centric outcome measures. This seems particularly relevant in light of some evidence of a bidirectional, or reciprocal relationship between improvement in quality of life and ED symptoms, with improvement in one domain leading to improvement in the other (Mitchison, Morin, Mond, Slewa-Younan, & Hay, 2015). As a secondary aim, we investigated the unique associations between ED-related impairment and core cognitive and behavioral features of ED, including severity of BMI. This is an understudied issue in low-weight clinical samples of AN, as prior investigations of the unique contributions of individual eating disorder features to ED-related impairment have either utilized community (Hovrud & De Young, 2015; Jenkins, Rienecke, Conley, Meyer, & Blissett, 2015) or mixed diagnostic samples (Dahlgren et al., 2017), or have more broadly investigated correlates of health-related QOL rather than illness-specific impairment (Abbate-Daga et al., 2014; Weigel, Konig, Gumz, Lowe, & Brettschneider, 2016). Understanding the unique associations between low weight, core ED pathology, and psychosocial impairment may help inform treatment planning, and shed light on treatment ambivalence and the outwardly

paradoxical behaviors observed in AN, such as engaging in extreme dietary restriction despite ensuing malnutrition and starvation. To summarize, the purpose of this study was to 1) investigate AN subtype differences in ED-specific impairment across life domains, and to 2) investigate the unique associations between ED-related impairment and core ED pathology in a low-weight, treatment-seeking sample of AN.

2. Method

2.1. Participants

The total sample consisted of 146 (140 women, 6 men) adult in-patients or outpatients recruited from seven specialist eating disorder centres in Norway (Reas & Rø, 2017). All patients met the International Classification of Diseases-10th Revision (ICD-10) criteria for F50.0 (WHO, 1992), which corresponds to the DSM-5 code for AN (307.1; APA, 2013). Any case (N = 4) with missing frequency data required to classify into AN subtype were excluded, leaving a total of 142 cases (136 females, 6 males). Due to unsystematic recording of AN subtypes in the dataset, we operationally defined the AN subtypes based on endorsement of average weekly (1 × per week) occurrence of binge eating (≥ 4 OBEs) or purging behaviour (≥ 4 total episodes of self-induced vomiting or laxative use) on the Eating Disorders Examination-Questionnaire during past 28 days. Although the DSM-5 lacks specification on frequency counts to operationally define regular engagement (“recurrent episodes”), we applied a once per week threshold, which is in line with prior research (De Young et al., 2013) as well as the binge-purge frequency criteria for other DSM-5 ED (APA, 2013). A composite purging variable was created by summing the total frequency of self-induced vomiting and laxative use.

2.2. Assessment measures

The *Eating Disorder Examination-Questionnaire* (EDE-Q) (Fairburn & Beglin, 1994, 2008) consists of 28-items that assess the core attitudinal and behavioral symptoms of eating disorders. The EDE-Q is comprised of four clinically-derived subscales (dietary restraint, eating concerns, shape concerns, weight concerns) of 5–8 items per scale, each of which is scored using a forced-choice format (0–6). The Norwegian version of the EDE-Q has shown adequate psychometric properties (Reas, Wisting, Kapstad, & Lask, 2011; Rø, Reas, & Stedal, 2015). Excellent internal consistency for the global EDE-Q was found in the present study ($\alpha = 0.94$).

The *Clinical Impairment Assessment (CIA) questionnaire* version 3.0 (Bohn et al., 2008) is a 16-item self-report measure of functional impairment secondary to ED psychopathology during the past 28 days (Bohn et al., 2008). Items probe impairment in domains of life typically affected by an ED, including mood and self-perception, cognitive functioning, interpersonal functioning, and work performance over the past 4 weeks (e.g., “Over the past 28 days, to what extent have your eating habits, exercising, or feelings about your eating, shape, or weight...”). A global score and three domains (personal, social, and cognitive) are calculable to offer a global index and domain-specific indices of impairment. Respondents rate items using a forced-choice, 4-point Likert scale with responses ranging from ‘not at all’ to ‘a lot’. Global scores range from 0 to 48, and higher scores represent greater impairment. The Norwegian version of the CIA (Reas, Rø, Kapstad, & Lask, 2010; Reas, Stedal, Lindvall Dahlgren, & Rø, 2016) has shown satisfactory psychometric properties. Excellent internal consistency for the CIA global score was found in the present study ($\alpha = 0.93$).

2.3. Statistical analyses

Analyses were conducted using IBM SPSS Statistics version 21.0. Independent-samples *t*-tests or the non-parametric alternative Mann Whitney *U* test were used to investigate differences between AN

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