



Unique contributions of individual eating disorder symptoms to eating disorder-related impairment



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ABSTRACT

This study examined the unique contribution of individual eating disorder symptoms and related features to overall eating disorder-related impairment. Participants ($N = 113$) from the community with eating disorders completed assessments including the Clinical Impairment Assessment (CIA) and the Eating Disorder Examination Questionnaire. A multiple linear regression analysis indicated that 58.6% of variance in the CIA was accounted for by binge eating frequency, weight and shape concerns, and depression. These findings indicate that certain eating disorder symptoms uniquely account for impairment and that depression is a substantial contributor. It is possible that purging, restrictive eating, and body mass index did not significantly contribute to impairment because these features are consistent with many individuals' weight and shape goals. The results imply that eating disorder-related impairment may be more a result of cognitive features and binge eating rather than body weight and compensatory behaviors.

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1. Introduction

Eating disorders (EDs) are an important and growing health burden, as indicated by a 38% increase in disability-adjusted life years (i.e., the amount of years lost due to non-fatal illness or impairment) between 1990 and 2010 (Murray et al., 2012). EDs also create substantial annual costs ranging from \$1288 to \$8042 per patient depending on the type of intervention and therapeutic techniques utilized, although this number may underestimate their economic burden (Stuhldreher et al., 2012). In addition, EDs are associated with a near fivefold risk of suicide attempts requiring hospitalization compared to general population controls (Suokas et al., 2014).

Another method of quantifying the impact of these disorders is to measure their subjective impairment on quality of life (QoL). This includes an indication of individuals' perception of their ability to carry out everyday activities such as physical functioning, role limitations due to personal, emotional, or physical health problems, emotional well-being, and social functioning (Ware & Sherbourne, 1992). Quantification of the impact of EDs on individuals' lives is important for appreciating the consequences of the disorders themselves and informing the public and funding institutions, whose advocacy and support may improve treatment and management of these disorders.

On broad measures of QoL, individuals with EDs, recruited from the community, report more impairment than controls without EDs (Cook & Hausenblas, 2011). Furthermore, there are varying degrees of

impairment in QoL between the EDs. Generally, individuals with anorexia nervosa (AN) report worse overall QoL compared to individuals with bulimia nervosa (BN) and eating disorder not otherwise specified (EDNOS; Abraham, Brown, Boyd, Luscombe, & Russell, 2006; Bamford & Sly, 2010). However, individuals with the restrictive subtype of AN have also been found to report comparable QoL to control subjects (Doll, Petersen, & Stewart-Brown, 2005; Mond, Hay, Rodgers, Owen, & Beumont, 2005). Notably, these findings were generated using a general measure of QoL rather than an ED-specific measure. Such findings may support Mond et al. (2005) assertion that "reliance on any one instrument is likely to be misleading in assessing the quality of life of ED patients" (p. 177). In further support, ED-specific measures of QoL appear more sensitive to differences in QoL between individuals with EDs and clinical controls than measures of general QoL, which may miss important aspects of the impact of these disorders on people's lives (Ackard, Richter, Egan, Engel, & Cronemeyer, 2014).

Although ED diagnoses are exclusive of one another (American Psychiatric Association, 2013), they share common behavioral and psychological features that may include binge eating, compensatory behaviors such as purging, restrictive eating behaviors, and undue influence of weight and shape concerns on self-evaluation, which has led some to suggest they share core psychopathology (Fairburn, Cooper, & Shafran, 2003). Additionally, approximately 75% of individuals presenting with EDs do not meet formal diagnostic criteria for an ED (Le Grange, Swanson, Crow, & Merikangas, 2012). It is therefore important to understand how ED symptoms individually affect impairment. Such an understanding may explain observed differences in impairment between diagnoses if certain symptoms are more impairing than others (e.g., very low body weight compared to binge eating), or are more

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common in (or exclusive to) certain diagnoses. This information will also increase our understanding of impairment due to ED symptoms in individuals who present with EDs that do not meet formal diagnostic criteria.

Only limited research exists to address these issues. One study examined the impact of binge eating, dietary restriction, purging, and overvaluation of body weight or shape on QoL in men and women and found that binge eating was associated with greater health impairment in men, whereas overvaluation of weight and shape had a greater impact on impairment in women (Mitchison, Mond, Slewa-Younan, & Hay, 2013). Another study found that individuals with binge-eating disorder (BED) who reported extreme weight and shape concerns had significantly higher levels of psychosocial impairment than those without extreme weight and shape concerns, indicating the impact of weight and shape concerns on impairment (Mond, Hay, Rodgers, & Owen, 2007). Together, these findings suggest that individual ED symptoms may contribute to QoL impairment differently and quantifying their individual impact will clarify the source of the burden on those affected.

No studies have yet quantified individual symptoms' unique contribution to QoL impairment, which is critical because these symptoms typically co-occur and do so in a number of different patterns. By understanding their individual contributions to impairment, treatments may be directed toward alleviating the most direct detrimental symptoms to improve individuals' lives. The purpose of this study was to examine how ED symptoms and related features uniquely contribute to psychosocial impairment using a measure to quantify impairment developed specifically for EDs. We had no priori hypotheses about which symptoms in particular may relate most strongly with impairment.

2. Method

2.1. Participants

Participants ($N = 113$) were men ($n = 21$) and women ($n = 92$) recruited from a northeastern city in the United States using flyers and from around the country using Craigslist.org who reported clinically significant eating pathology. Three participants discontinued their participation before completing the first study procedure (2 men and 1 woman), and they are not included in any of the following information. Participants ranged in age from 18 to 62 years and had a mean (SD) age of 32.68 (12.23) years. With regards to ethnicity, 71.8% self-identified as Caucasian, 9.1% as Asian/Pacific Islander, 8.2% as Black/African American, 7.3% as Hispanic, 0.9% as Native American, 1.8% indicated other/mixed, and 0.9% did not provide this information.

Inclusion criteria included being at least 18 years of age and having clinically significant eating pathology as indicated by at least one of the following: (1) low body weight (i.e., body mass index < 18 kg/m²) and undue influence of body weight or shape on self-evaluation; (2) purging (i.e., self-induced vomiting, laxative, diuretic, or enema misuse, or the abuse of medication such as insulin) at least once every two weeks over the previous 3 months and undue influence of body weight or shape on self-evaluation or marked distress about purging; (3) binge eating episodes at least once per week over the previous 3 months and undue influence of body weight or shape on self-evaluation or marked distress about binge eating. Table 1 details the percent of participants who met each of these inclusion criteria, as assessed by the Eating Disorder Diagnostic Scale (EDDS; Stice, Telch, & Rizvi, 2000). Eight participants met only inclusion criterion 1, thirty-one met only criterion 2, and ten participants met only inclusion criterion 3. Fifty-four participants met both criteria 2 and 3, four met criteria 1 and 3, and six participants met all three criteria. No participants met both criteria 1 and 2 without also meeting criterion 3.

2.2. Measures

The Clinical Impairment Assessment (CIA; Bohn & Fairburn, 2008) is a 16-item self-report measure of the severity of impairment due to ED

Table 1

Descriptive statistics of participants meeting inclusion criteria by eating disorder symptom.

Parameter	M	SD	Min	Max	% Meeting criterion threshold
Body mass index	26.15	9.38	14.7	78.37	15.9
Weight concerns	5.15	1.2	0	6	94.7 ^a
Shape concerns	5.13	1.08	0	6	
Self-induced vomiting/week	4.06	6.86	0	35	66.4 ^a
Laxative misuse/week	0.71	1.62	0	10	
Binge eating/week	5.67	6.17	0	32.5	80.5

^a Merged to represent weight and shape concerns and purging frequency, respectively.

symptoms that focuses on the aspects of life typically affected by ED pathology: mood and self-perception, cognitive functioning, interpersonal functioning, and work performance. The CIA was utilized to capture ED-specific impairment.

The Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Bèglin, 1994) is a self-report measure that focuses on the main cognitive and behavioral features of EDs (e.g., assesses the frequency at which individuals engaged in certain ED behaviors over the previous 28 days) and includes four subscales: dietary restraint, eating concern, shape concern, and weight concern. In the present study, it was used to determine binge eating and purging episode frequency over the preceding 28 days.

The EDDS was utilized to screen participants for eligibility via telephone, assessing study inclusion criteria. The EDDS is a 22-item self-report questionnaire that assesses ED psychopathology consistent with the DSM-IV-TR (APA, 2000) and is highly specific and sensitive for this purpose (Anderson, De Young, & Walker, 2009; Krabbenborg et al., 2012). Two items on this measure assess the importance of body weight and shape on self-evaluation. Participants were deemed to have satisfied the inclusion criterion of undue influence of weight and shape on self-evaluation if they rated themselves at least a "4" on one of these 7-point scales. Two supplemental items were added to this scale for the present study to assess the magnitude of distress over the presence of purging behaviors and binge eating separately on a 7-point scale from "not at all distressed" to "extremely distressed." Participants were deemed to have indicated marked distress regarding binge eating or purging if they indicated they were at least a "4" on these 7-point scales.

The Multidimensional Assessment of Eating Disorder Symptoms (MAEDS; Anderson, Williamson, Duchmann, Gleaves, & Barbin, 1999) is a reliable and valid self-report inventory that measures six symptom domains related to eating disorders: binge eating, restrictive eating, purgative behavior, fear of fatness, avoidance of forbidden foods, and depression. This inventory was used to determine participants' fear of fatness, dietary restriction, and depression.

2.3. Procedure

Individuals interested in participating ($N = 139$) were screened via telephone using the EDDS to determine eligibility. Eligible participants ($n = 113$) then completed various self-report questionnaires including the CIA and EDE-Q over the Internet over the course of 12 weeks. They completed a baseline assessment and a 6- and 12-week follow-up. In addition, they completed brief symptom frequency and mood assessments weekly during the 12 weeks that are not included in the present study (see De Young, Zander, & Anderson, 2014 for more details). Participants were compensated \$40 for completing all assessments. These procedures were approved by the institutional review board at the University at Albany, State University of New York.

2.4. Statistical analysis

A two-step multiple linear regression analysis was used to accomplish the aim of this study with baseline impairment as measured by

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