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Marital status and eating disorders
An analysis of its relevance

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Abstract

Objectives: This study attempts to understand the clinical impact of marital status on the psychopathology and symptomatology of anorexia (AN) and bulimia nervosa (BN) patients. **Method:** Eating disorder (ED) patients ($n=332$, 198 BN and 134 AN) consecutively admitted to our unit participated in the study. All subjects met DSM-IV criteria for those pathologies and were female. Our sample was divided retrospectively into three subgroups based on their marital status. For the assessment, commonly applied questionnaires in the field of ED were used [Eating Attitudes Test (EAT-40), Eating Disorder Inventory (EDI), Bulimic Investigatory Test Edinburgh (BITE), Body Shape Questionnaire (BSQ), Beck Depression Inventory (BDI) and Social Avoidance and Distress Scale (SAD)]. **Results:** 2×3 (Diagnostic $\times$ Marital status) ANOVA and ANCOVA (with age as covariance) designs were applied in the current study. Our results suggested that ED patients who lived with a partner were significantly different with respect to the other ED patients in the following variables: higher age ($P<.0001$), higher motivation for change ($P<.004$), perfectionism ($P<.03$) and purging behavior ($P<.04$). **Discussion:** The main finding in this study is that ED patients who live with a partner are those who presented greater eating symptomatology and psychopathology but even higher motivation for change. Interpersonal functionality has to be considered in the development and maintenance of ED.

Keywords: Marital status; Bulimia nervosa; Anorexia nervosa; Eating disorders

Introduction

Eating disorders (ED) in general and anorexia (AN) and bulimia nervosa (BN) in particular are complex disorders, in which problems are linked on a behavioral, cognitive and emotional level [1,2]. Several factors are implicated in the development and maintenance of those pathologies. Furthermore, as in other psychiatric disorders [3–5], some studies have demonstrated the relevance of interpersonal relationships as maintaining factor in EDs [6].

This topic has been considered in the ED literature from different theoretical frameworks: from psychoanalytical [7] and systemic approach [8–11] to behavioral-cognitive point of view [12–14].

The relationship between marital functioning and psychiatric disorders has been examined in several recent studies in general terms [15,16] and referred to specific pathologies such as affective disorders [17], anxiety disorders [18], obsessive-compulsive disorders [19] and addictive behaviors [20,21]. Even some authors suggested the high relevance of marital stability on the long-term recovery in general mental health disorders [22]. Nevertheless, this topic has surely received insufficient attention in the ED literature, as other authors suggested [23,24], mainly due to the fact that adult married women or those in long-term relationships were underrepresented in the ED clinical samples used [25,26].

The few studies where this topic was specifically examined evidenced that married patients with an ED may exhibit longer duration of the illness and were older [27] and even

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presented higher severity of the disorder [11]. Nevertheless, when the variable age was controlled, married ED patients did not present higher severity of the disorder [24], whereas it did when a general non-ED population was considered [23]. Furthermore, those married ED patients were commonly those who presented major dissatisfaction with their interpersonal relationships and higher deficits in conflict resolution skills [28] even when compared with controls [29].

Besides the methodological problems involved in this type of research, as mentioned above, few studies have been done about the impact of marital relationships in ED. In those studies, where this topic has been specifically assessed, important methodological limitations were present: lack of control of variables that may have an influence (i.e., age of the patients) or introduction of biases when selecting the samples (i.e., considering only married vs. unmarried patients, not giving enough importance to other subcategories).

In view of this criticism, the present study had the following objectives: (1) to check the hypothesis that married ED patients have more severe eating psychopathology even after controlling the variable age, (2) to assess the effect of the different subgroups of the category "marital status" on the severity of the disorder and (3) to ascertain whether there are differences with regard to this category between AN and BN patients.

Method

Sample

ED patients ($n = 332$, 198 BN and 134 AN) consecutively admitted to our unit between January 1998 and October 2000 participated in the study. All patients fulfilled the criteria for those pathologies according to DSM-IV [30] and all were female: 67.2% ($n = 223$) of the sample were of purging type (12.7% AN vs. 54.5% BN), 14.1% ($n = 46$) were unemployed, 34.9% ($n = 116$) employed and 41.3% ($n = 154$) were students. Furthermore, 74.6% ($n = 244$) lived with their parents and 87% ($n = 289$) were single. No divorced patients were included in the current study.

Assessment

The patients were assessed on several self-report measures: the Eating Attitudes Test (EAT-40) [31], the Eating Disorder Inventory (EDI) [32], the Bulimic Investigatory Test Edinburgh (BITE) [32], the Beck Depression Inventory (BDI) [33], the Body Shape Questionnaire (BSQ) [34] and the Social Avoidance and Distress Scale (SAD) [35], validated with Spanish samples. Demographic-clinical information, including age, weight, height, clinical-psychopathological variables and marital status, were also obtained. Thereby, the motivational stage was assessed through an analogical scale (see Appendix) that evaluates, through four different type of questions, the subjective wish of the ED patients to receive treatment (scale ranged between 0 and 8) [36]. This scale has been previously described and applied in a broader sample of EDs elsewhere [37].

Procedure

All the subjects were assessed by a face-to-face structured interview at the beginning of the treatment, before any psychological or pharmacological treatment, including specific questions about their current and past sentimental relationships. All interviews were carried out by experienced psychologists. Further psychometrical data were obtained from patients by the above mentioned self-report questionnaires.

Our sample was divided retrospectively into three categories based on their marital status (during at least the previous 6 months): (a) PA-L: living with a stable partner ($n = 41$), (b) PA-NL: having a stable partner but not living with him ($n = 129$) and (C) NPA: having no partner ($n = 162$). For further analysis, the sample of PA-L group was divided into patients who had the onset of their disorders before or after marriage.

Table 1
Sociodemographic and clinical characteristics in our sample of AN ($n = 134$) and BN ($n = 198$) patients

	AN ($n = 134$)			BN ($n = 198$)				
	Mean	S.D.	CI 95%	Mean	S.D.	CI 95%	Student's t	P
Age	22.4	5.3	21.5–23.3	23.3	5.7	22.5–24.0	−1.39	ns
Weight (kg)	44.4	5.8	43.0–45.8	57.7	11.4	55.7–59.7	−9.15	<.0001
Height (m)	1.63	0.6	1.62–1.65	1.63	0.7	1.61–1.63	0.78	ns
BMI	16.4	1.8	16.0–16.8	21.8	3.8	21.1–22.5	−10.6	<.0001
Age of onset	17.8	3.7	17.1–18.7	18.3	4.8	17.6–19.1	−0.76	ns
Duration of illness	4.3	4.7	3.3–5.3	4.9	4.4	4.3–5.6	−1.15	ns
n of treatments	1.0	2.1	0.6–1.5	1.0	1.5	0.8–1.2	0.12	ns
Weekly frequency of bingeing	1.6	4.6	0.6–2.6	8.1	8.1	6.6–9.5	−6.67	<.0001
Weekly frequency of vomiting	3.7	8.1	1.9–5.4	8.3	9.6	6.6–10.0	−3.63	<.0001
Motivational stage	6.4	2.2	6.0–6.8	7.0	1.6	6.8–7.2	−2.91	<.004

Homogeneity of variance tested using Levene's test between groups when necessary. BMI = body mass index [weight (kg)/height^2 (m^2)].