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Quality of life and motivation to change in eating disorders. Perception patient–psychiatrist

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ABSTRACT

Purpose: To assess motivation to change (Mch) of patients with an eating disorder (ED) and its relationship with quality-of-life (QoL) by comparing patient and psychiatrist perceptions.
Method: Patients (n = 358) with an ED completed the disease-specific Health-Related Quality of Life for Eating Disorders (HeRQoLED) questionnaire, the Eating Attitudes Test (EAT-26) and the Short-Form Health Survey (SF-12) at baseline; 273 completed them after 1 year of treatment. The relationship between health-related quality of life (HRQoL) and the Mch stage was assessed using analysis of variance. Chi-square and Kappa statistical analysis assessed congruence in motivational change perception of the patients and psychiatrists.
Results: Higher patient-reported Mch was associated with higher HRQoL at the study beginning and end but not using the patient Mch as perceived by the psychiatrist. Initially, the patient and psychiatrist perceptions of Mch differed (kappa coefficient, −0.01); after 1 year they tended to converge (k = 0.34).
Conclusions: Higher Mch and higher QoL are positively associated. However, patient and psychiatrist perceptions of Mch and the relationship with QoL differ. After 1 year of treatment, these differences decreased.

1. Introduction

A primary obstacle in treating eating disorders (EDs) is the lack of motivation to change (Mch) by patients and their ambivalence regarding treatment (Geller, Cockell, & Drab, 2001).

The transtheoretical model of Prochaska (Prochaska & Di Clemente, 1992) describes this concept well, and several authors have attempted to apply it to EDs (Blake, Turnbull, & Treasure, 1997; Engel & Wilms, 1986; Hasler, Delsignore, Milos, Buddeberg, & Schnyder, 2004; Sullivan & Ch., 2001; Vansteenkiste, Soenens, & Vandereycken, 2005; Wilson & Schlam, 2004). According to this model, patients are said to be at different disease stages based on their degree of motivation and attitude toward change.

The aims of the current study were to assess the evolution of the MCh stage in patients with an ED after 1 year of treatment and its relationship with patients' health-related quality of life (HRQoL) and with their psychopathology, and identify potential differences between patient and psychiatrist perceptions of these variables.

2. Method

2.1. Participants and procedures

Four psychiatrists experienced with EDs from three health centers in Bizkaia, Spain, collaborated in the patient recruitment. The criteria for study inclusion were that participants were diagnosed with an ED according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994); be treated on a regular basis in one of the three centers; not have a clinically serious multiorgan disorder, cerebral organic deterioration, or acute psychosis preventing them from completing questionnaires; and agree to participate voluntarily after being informed personally by his or her psychiatrist of the details of the study and after providing informed consent. The ethics review board of each center approved the study.

A total of 435 patients fulfilled these criteria. All the measurement instruments were mailed to the participants.

During the year, each patient participated in a psychopharmacologic and psychotherapeutic treatment program consisting of cognitive behavioral therapy, nutritional orientation and counseling, psychoeducation; motivational therapy, social skills training, and therapy to modify a distorted perception of body image. Evaluation

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of the effect of the treatment on the Mch stage was beyond the scope of this study.

2.2. Measures

Patients completed the following questionnaires at baseline and after one year of treatment. The EAT 26 (Garner & Garfinkel, 1979; Garner, Olmsted, Bohr, & Garfinkel, 1982), the SF-12 (Ware, Kosinsky, & Keller, 1996) and the Health-Related Quality of Life in Eating Disorders (HeRQoLED) (Las Hayas, Quintana, Padierna, & Muñoz, 2003a; Las Hayas, Urresti, Madrazo, & Cook, 2003b; Las Hayas et al., 2007, 2006) questionnaires are the first version of a new specific questionnaire for evaluating the impact of an ED on the quality of life of the individual. Lower scores indicating better QoL.

The psychiatrists completed the clinical record sheet which gathered information regarding various patient aspects, including the diagnosis according to the DSM-IV criteria, sociodemographic and family data, weight and height, referring center, family history, time elapsed since disease onset and treatment, current treatment, previous admissions and previous suicide attempts.

The Mch stage was measured using one item that reflected the various stages of Prochaska (Prochaska & Di Clemente, 1992).

2.3. Statistical analysis

The mean and standard deviations were calculated for the HeRQoLED domains and numbers in each category and corresponding percentages for the Mch levels. Analysis of variance (ANOVA) was used to compare the means of the HeRQoLED domains, the EAT-26 and the SF-12 summarized scales as a function of the different Mch stages. The Scheffe method was used for post-hoc comparisons.

To assess the association between the Mch perceived by the psychiatrist and that of the patient, the chi-square test was used. Finally, weighted Kappa coefficients with their confidence intervals (CI) at 95% level were calculated to measure the agreement between the clinician and the patient.

All statistical analyses were calculated with the SAS statistical software (v9.1). $p<0.05$ was considered significant.

3. Results

A total of 358 patients returned the battery of tests completed (response rate, 82%) of which 61 were diagnosed by their psychiatrist with anorexia nervosa, 47 with bulimia nervosa, and 245 with an ED not otherwise specified (EDNOS). In five cases, reaching a diagnosis was impossible. A total of 96.6% patients were women (mean age, 27 years; mean body mass index, 21.4). Each of the 358 patients in the initial sample received the battery of questionnaires again 1 year later. The protocol followed was the same as in the first phase. The response rate this time was 76%, meaning that the final list of participants included 273 patients.

Table 1 shows the change in the HRQoL and the psychopathological severity over 1 year as a function of the Mch stage as perceived by the patient at the start of the study.

According to the HeRQoLED questionnaire, the HRQoL improved after 1 year of treatment. A higher Mch stage was associated with a higher level HRQoL ($p<0.001$). The highest reported HRQoL corresponded to patients who were classified in stage 5 (maximum motivation) at the beginning of the study. Patients at this stage reported significantly better QoL in most of the HeRQoLED domains ($p>0.001$), while the QoL worsened from Mch 1 to Mch 2.

However, patients who classified themselves as stage 1 and those who consistently classified themselves in stage 5 had the best QoL scores. Patients who denied the disorder (stage 1) also denied its impact on the QoL.

Table 1
Evolution of the Health-Related Quality of Life for Eating Disorders (HeRQoLED) and EAT-26 scores as a function of patients' motivation to change (Mch), as assessed by the patient, at the beginning of the study.

	Mch stage at the beginning (patient) quality of life at the beginning mean (SD)						Mch stage at the beginning (patient) quality of life 1 year later mean (SD)					
HeRQoLED	1[a]	2	3	4	5	*p*	1[a]	2	3	4	5	*p*
	n = 4	n = 23	n = 50	n = 166	n = 109		n = 4	n = 13	n = 38	n = 129	n = 86	
Symptoms	35.0(26.77)	49.9(19.03)[5]	48.1(20.12)[5]	41.9(19.3)[5]	28.4(16.87)[2,3,4]	<.0001	30.6(27.26)	46.5(17.28)[5]	39.7(20.04)[5]	35.6(18.35)[5]	24.(17.55)[2,3,4]	<.0001
Restrictive behaviors	37.3(33.88)	48.2(24.79)[4,5]	37.8(22.15)[5]	32.6(22.70)[5]	18.2(18.61)[2,3,4]	<.0001	40.(46.90)	41.1(28.05)[5]	34.3(24.28)[5]	28.(25.97)[5]	13.(19.17)[2,3,4]	<.0001
Body image	57.2(41.15)	65.3(25.83)[5]	66.9(22.09)[5]	60.7(25.30)[5]	47.4(25.73)[2,3,4]	<.0001	52.7(51.20)	70.(24.09)[5]	63.3(23.69)[5]	57.7(25.45)[5]	43.5(25.08)[2,3,4]	<.0001
Mental health	53.1(23.21)	64.7(21.09)[5]	56.7(18.96)[5]	53.4(18.96)[5]	42.9(19.90)[2,3,4]	<.0001	43.1(35.96)	58.8(22.18)	51.7(19.03)	51.1(20.29)[5]	40.6(20.20)[4]	0.0009
Emotional role	48.7(31.98)	47.2(26.08)	47.3(30.21)[5]	42.5(26.83)[3,5]	31.2(23.97)[3,4]	0.0009	33.7(38.16)	50.7(29.07)[5]	42.8(27.42)[5]	38.2(24.83)[5]	24.8(22.20)[2,3,4]	<.0001
Physical role	36.2(17.96)	44.7(29.93)[4,5]	36.(29.59)[4,5]	31.6(26.41)[3,5]	20.9(20.19)[3,4]	<.0001	20.(28.28)	45.(25.49)[5]	29.7(23.65)	30.3(25.68)[5]	19.3(20.53)[2,4]	0.0008
Personality traits	46.(31.06)	58.0(27.61)[5]	60.0(22.56)[4,5]	57.4(23.87)[3,5]	45.8(24.12)[2,3,4]	0.0008	45.(40.18)	54.4(22.83)	60.8(22.11)[5]	50.9(24.19)	42.3(22.12)[3]	0.0014
Social relations	42.7(33.74)	55.5(29.50)[5]	57.8(26.07)[4,5]	51.3(27.25)[3,5]	26.4(25.72)[2,3,4]	<.0001	36.4(41.01)	46.7(27.89)	47.2(24.75)[5]	43.5(27.93)[5]	23.9(26.43)[3,4]	<.0001
EAT-26	23.7(28.33)	34.8(17.69)[5]	31.7(16.59)[4,5]	26.9(16.62)[3,5]	14.6(14.22)[2,3,4]	<.0001	24.2(29.53)	28.2(16.11)[5]	27.7(16.92)[5]	23.9(17.58)[5]	12.8(14.16)[2,3,4]	<.0001
PCS-12	45.4(8.39)	44.6(10.52)	46.2(9.37)	47.5(9.88)	51.5(8.30)	0.0055	44.3(11.73)	47.6(5.60)	49.4(9.60)	50.(9.78)	51.7(8.03)	0.3925
MCS-12	33.9(14.77)	37.1(13.31)	35.7(10.56)	38.9(10.76)	41.6(11.04)	0.0725	30.(13.75)	45.1(10.85)	35.1(11.70)	38.6(11.04)	41.1(11.4)	0.0402

EAT-26: Eating Attitudes Test-26.
PCS-12 and MCS-12: physical and mental summary components of the SF-12 Health Survey.
Superscripts make reference to the Mch stage with respect to which there is a significant difference according to the Scheffe test.
SD: standard deviation.
[a] Prochaska stages: 1 Lacking consciousness of their illness and motivation to change; 2 Consciousness of illness without intention to change; 3 Motivation to change without taking action; 4 Working to solve the problem; and 5 She/he has solved their problem totally or almost totally.