

Work and social adjustment in patients with anorexia nervosa

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Abstract

Objective and methods: The Work and Social Adjustment Scale (WSAS) assesses patients' perceptions of impairment in everyday functioning and has been reported as a simple and reliable self-report measure in different psychiatric disorders. This study compared WSAS data from an anorexia nervosa (AN) patient group with that from healthy controls (HCs) and published data from other patient groups. A total of 160 female participants (AN, 77; HC, 83) completed the WSAS as well as measures of eating disorder symptom severity and brief assessments of anxiety and depression.

Results: Work and Social Adjustment Scale scores for the AN group were found to be in the severely impaired range, whereas the scores for those within the HC group indicated very little, or no impairment. Total WSAS scores in the AN group were significantly correlated with severity of clinical symptoms, and eating disorder-specific symptoms were the best predictor of social and occupational functional impairment. The greatest impairment in the AN group was reported in the realm of social leisure.

Conclusions: Consistent with reports in other clinical populations, it is suggested that the WSAS could be an extremely useful and meaningful measure to assess social and occupational functioning in people with eating disorders, in addition to eating disorder-specific assessments.

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1. Introduction

Anorexia nervosa (AN) is a complex psychiatric disorder with severe clinical symptoms and poor psychosocial functioning [1]. Attempts to measure functioning in everyday life are challenging, and the definition of recovery remains problematic [2]. An important aspect to consider when evaluating the severity of any health problem and how individuals measure their progress toward recovery is the extent to which individuals subjectively believe that their illness impairs their everyday functioning.

The Work and Social Adjustment Scale (WSAS) [3] has been reported in the literature as a quick and reliable measure of social and occupational functioning in different mental and physical health disorders (eg, see Refs [4,5]). This measure has robust psychometric properties and comprises 5 brief questions that are easy to administer

and score. Self-report WSAS scores have also been found to correlate highly with scores assigned by trained clinicians [4], although this has been found to differ between disorders [6]. As a result, the WSAS is often used as an outcome measure in treatment studies outside of the eating disorders (EDs) field. It has been reported that the WSAS is a sensitive measure of posttreatment changes in bipolar disorder [5], unipolar depression [7], obsessive-compulsive disorder (OCD) [4,8], and chronic fatigue syndrome [9]. In the ED population, however, only 2 published reports [10,11] are available that consider WSAS data. One study [10] compared 14 outpatients with AN to individuals with ED not otherwise specified (EDNOS) and bulimia nervosa (BN). This study concluded that this small group of patients with AN had a greater degree of functional impairment than those with EDNOS or BN. The second study [11] focused on a larger group of 123 participants with binge eating disorder, BN, or borderline ED diagnoses. The baseline WSAS scores reported in this study were lower compared with those reported in the Turner et al study [10]. However, the WSAS total scores in the Striegel-Moore et al study [11] were within the range that suggests significant functional impairment.

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Another body of research has explored social and functional impairment in EDs using more detailed but resource-expensive measures. For example, Rymaszewska et al [12] used a semistructured interview (the Groningen Social Disability Schedule [13]) to assess social disability in people with EDs and other psychiatric illness groups. This study found that individuals diagnosed with EDs had high levels of social disability that were not significantly different to individuals with schizophrenia or individuals with a personality disorder. In addition, the best predictor of the degree of social disability was severity of psychopathology, over and above other variables including diagnosis of mental disorder per se.

The current study sought to build on the existing evidence base and provide data regarding work and social adjustment in a relatively large group of individuals diagnosed with AN. The primary objective of this exploratory study was to compare the WSAS scores of individuals with AN to those of a healthy control (HC) sample, as well as with existing published WSAS data in people with other EDs and people with other psychiatric diagnoses. In addition, the study sought to explore whether there is a relationship between WSAS scores and the severity of illness in AN. Based on previous research, which has demonstrated a significant association between symptom severity and social disability in EDs and other psychiatric illnesses (eg, see Ref [12]), we specifically predicted that greater severity of illness (as indexed by body mass index [BMI], duration of illness, and responses to self-report measures of ED symptoms and anxiety and depression) would be significantly associated with higher WSAS scores (ie, greater functional impairment).

2. Method

2.1. Design

A cross-sectional independent-groups design was used. Two groups of participants were recruited. One consisted of females diagnosed with AN according to *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, criteria [14], and the other consisted of female HCs.

2.2. Participants

Seventy-seven women who fulfilled *DSM-IV* [14] criteria for AN were recruited into the study. A diagnosis of AN was established using the Structured Clinical Interview for *DSM-IV* (SCID) Axis I disorders [15]. Body mass index (in kilogram per square meters) was obtained on the day of testing from all participants. Patients for this study were recruited from ED specialist services (54% inpatient, 20% day care, 17% outpatients) and from the community (9%). Eighty-three female HC participants were recruited from the

local community by advertisement in local libraries, leisure centers, shops, newspapers, and email flyers.

All participants spoke fluent English, and 81.6% were British white. Exclusion criteria for all participants included a history of serious head injury, epilepsy, or psychosis. For the HC group, additional exclusion criteria included a family or personal history of psychiatric illness, current use of psychotropic medication, a low (<18 kg/m²) or very high (>26 kg/m²) BMI, and positive answers to screening questions suggesting evidence of ED symptomatology. Ethical approval was obtained from the local research ethics committee, and voluntary, informed, written consent was obtained from all participants.

2.3. Measures

2.3.1. Work and Social Adjustment Scale

The WSAS [3] is a simple and brief 5-item self-report scale designed to measure the degree of functional impairment. The scale items encompass different domains of functioning and include the following: ability to work, home management, social leisure, private leisure, and ability to form and maintain close relationships. Each item is rated on a 9-point Likert-type scale, ranging from 0 (no impairment) to 8 (very severe impairment). The maximum total score is 40, with higher scores representing greater impairment. The WSAS has demonstrated good internal consistency and test-retest reliability and is sensitive to patients' perceptions of disorder severity [4]. In the current study, internal consistency for the WSAS total score was high ($\alpha = .96$).

2.3.2. Eating Disorder Examination Questionnaire—Version 4

The Eating Disorder Examination Questionnaire—Version 4 (EDE-Q) [15] is a 36-item self-report measure of ED symptomatology and behaviors and provides severity scores across 4 subscales (dietary restraint, weight concern, shape concern, eating concern) and a global score, reflecting overall illness severity. The maximum score on each of the subscales is 6. The EDE-Q has demonstrated good psychometric properties [16,17], and in the current study, internal consistency for each subscale was high (dietary restriction $\alpha = .9$, weight concern $\alpha = .9$, shape concern $\alpha = .9$, eating concern $\alpha = .9$, global score $\alpha = .8$).

2.3.3. Hospital Anxiety and Depression Scale

The Hospital Anxiety and Depression Scale (HADS) [18] is a widely used self-report measure consisting of 14 items that are designed to detect adverse anxiety and depressive states. A cutoff score of 10 is recommended as an indication of "caseness" for both scales. As such, in the current study, the data from any HC participant who scored more than 10 on either of the HADS subscales was excluded from the final analyses. The HADS has strong psychometric properties [19], and in the current study, the internal consistency for

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