



Health-related quality of life among adolescents with eating disorders



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ABSTRACT

Objective: Health-related quality of life (HRQoL) is an emerging area of research in eating disorders (EDs) that has not been examined in adolescents in detail. The aim of the current study is to investigate HRQoL in an adolescent ED sample, examining the impact of ED symptoms on HRQoL.

Methods: Sixty-seven treatment-seeking adolescents (57 females) with anorexia nervosa (AN), bulimia nervosa (BN), or eating disorder not otherwise specified (EDNOS) completed self-report measures of HRQoL and ED symptoms.

Results: Participants reported poorer HRQoL in mental health domains than in physical health domains. Disordered attitudes, binge eating, and compensatory behaviors were associated with poorer mental health HRQoL, and body dissatisfaction was associated with poorer physical health HRQoL.

Conclusion: The current study assessed HRQoL among adolescents with EDs, finding several consistencies with the literature on adults with EDs. Future research should compare adolescents and adults with EDs on HRQoL.

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Introduction

Eating disorders (EDs) are costly to treat [1], have high mortality rates [2,3], and are associated with impaired health-related quality of life (HRQoL). Measures of HRQoL assess an individual's subjective evaluation of his or her health and its impact on functioning in various domains, such as performance at work or physical activity. Compared to measures that focus only on symptomatology, an assessment of quality of life (QoL) may consider a broader range of factors that influence a person's well-being, such as adequacy of housing or quality of social relationships. Both QoL and HRQoL have become increasingly popular areas of mental health research, with such measurement covering areas that might be overlooked by measures that simply assess symptoms (e.g., see [4]). Assessing HRQoL has important implications for clinical practice as well, as it represents a major goal of treatment in addition to symptom reduction (e.g., [5–7]).

Several recent studies have found that ED sufferers report poorer HRQoL than healthy comparison groups, recovered ED patients, or

those suffering from physical health problems such as angina (see [8], for a review). Quality of life in adults with EDs varies with body mass index (BMI), showing a curvilinear relationship with QoL generally poorer at extremes of BMI (e.g., [9]). Gender may also moderate this relationship, with poorer QoL seen in obese women compared to obese males [10], and some limited findings also reported in ED samples (e.g., [11]). Mental health domains have been found to be more affected by the presence of ED symptoms than physical health domains (e.g., [12]). In addition, ED symptoms may be differentially related to HRQoL. In a large community sample of young adult females, for example, Mond, Hay, Rodgers, Owen, and Mitchell [13] found that extreme dietary restriction for purposes of weight control was the best predictor of functional impairment among disordered eating behaviors. A similar study by Latner et al. [14] looked at the contribution of ED symptoms to impaired functioning in a sample of females (both clinical and non-clinical). In addition to finding some associations with ED behaviors (such as dietary restriction, laxative use, and binge eating), functional impairment was also affected by extreme levels of concern (often referred to as “overvaluation”) with weight and shape. This recent work has highlighted the importance of assessing not only behavioral features of an ED, but also those of a cognitive, or attitudinal, nature.

The majority of information available on HRQoL among ED patients is based on studies of adults, with younger samples seldom being

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assessed. In adolescents, the finding that obesity is frequently associated with poorer HRQoL appears well-established (e.g., [15,16]), but less is known about HRQoL and EDs among adolescents. Some studies have found associations between ED behaviors and impaired HRQoL [17,18]. Herpertz-Dahlmann and colleagues [19] provide data on 1895 individuals aged 11–17 selected from a nationally representative sample of German families. Alongside other self-report measures, participants completed brief measures of ED symptoms (the SCOFF; [20]) and HRQoL (the KINDL-R; [21]). Associations were found between ED symptoms and general psychopathology, as well as poorer HRQoL in adolescents with self-reported disordered eating.

There is also some evidence that adolescents with EDs (including sub-threshold forms) show greater functional impairment than healthy controls (e.g., [22]). Thus it may be the case that ED behaviors and attitudes are associated with poorer HRQoL in adolescents, although few studies in this area have been conducted on clinical samples, despite the fact that EDs typically begin during adolescence [23]. Studies on HRQoL among individuals with EDs have typically grouped younger patients and adults together, but there is good reason to study adolescents as a distinct group [24]. Differences have been found between younger and older non-ED populations, with young adolescents generally reporting less impaired HRQoL compared to older adolescents and adults (e.g., [25,26]). In addition, adolescents' perception of their HRQoL may be different from their adult counterparts, and the effects of an ED during a time of dramatic change, such as adolescence, may differ from the impact of an ED on adults. Information obtained on younger samples may also give clues as to the developmental trajectory of EDs, and what factors are important in an adolescent's perception of his or her HRQoL. Furthermore, as in the treatment of adult EDs, where assessment of HRQoL is an emerging area, more information about HRQoL can help to provide an index of how ED symptoms impact functioning and determine if subjective improvements in quality of life accompany improvements in symptoms [4,6].

As the presence of any disordered eating has been suggested to negatively impact HRQoL ([19,27]; see also [28]), the purpose of the present study was to examine the subjective impact of the presence or absence of various ED behaviors and attitudes on HRQoL among a clinical sample of eating disordered adolescents. Based on previous research (e.g., [9]; see also [8]), the variables of BMI and gender will be controlled for in these analyses.

Method

Participants and procedure

Sixty-seven adolescents ($n = 57$ female; 85.1%; age range = 11–18 years) seeking outpatient treatment at multiple sites (University of North Dakota, ND; The Center for Balanced Living, OH; University of South Florida, FL; and The University of Chicago, IL) between 2000 and 2004 were included in this study. The majority of sites treat primarily adult patients, but all were referred for disordered eating and completed self-report assessment measures at baseline. This study was approved by Institutional Review Boards of the participating institutions. Demographic data for the total sample are shown in Table 1. Five individuals (7.5%) met criteria for anorexia nervosa (AN), 18 (26.9%) for bulimia nervosa (BN), and the remainder ($n = 44$; 65.7%) were classified as eating disorder not otherwise specified (EDNOS); that is, individuals with an ED of clinical severity not meeting full criteria for either AN or BN.

Measures

SF-36 Health Survey [29]

The SF-36 is a widely-used and well-validated 36-item self-report measure that assesses HRQoL across eight domains: (a) Physical Functioning assesses the impact of health on a range of physical activities,

Table 1
Characteristics of the current sample

	N (%) or Mean (SD)
	Total Sample
Age, years	16.5 (2.0)
Gender, female	57 (85.1%)
BMI	19.68 (5.36)
Ethnicity	
Non-Hispanic White	61 (91%)
African-American	2 (3%)
Hispanic	3 (4.5%)
EDE-Q Global	3.49 (1.69)
PCS	69.26 (19.74)
MCS	49.60 (25.18)

Note: BMI = body mass index; EDE-Q Global = Eating Disorder Examination–Questionnaire Global score; PCS = Physical Health Composite Score; MCS = Mental Health Composite Score. Note: One participant did not provide information on ethnicity.

(b) Role-Physical assesses limitations in daily activities as a result of physical health, (c) Role-Emotional assesses limitations in daily activities as a result of emotional health, (d) Social Functioning measures the impact of physical health on social functioning, (e) Mental Health measures the presence and severity of depression and anxiety, (f) Vitality measures an individual's energy level and level of fatigue, (g) Bodily Pain assesses the presence and degree of pain and the extent to which bodily pain has interfered with daily functioning, and (h) General Health assesses an individual's estimate of his or her overall physical health. Two summary scores can be computed measuring physical HRQoL (Physical Health Composite Score, PCS) and emotional HRQoL (Mental Health Composite Score, MCS), which were used in the current study. Summary scores on the SF-36 are norm-based (from a US population sample) and transformed to have a mean of 50 and standard deviation of 10 (range = 0–100), with higher scores indicating better functioning. Adolescent norms for a Swedish population are also available [25], with data from a similar sample that permit some comparison. As the SF-36 summary scores are made up of weighted combinations of the eight subscales, and are therefore closely related, it was decided to only include the MCS and PCS in order to decrease the risk of Type I error. The two summary scores were therefore used to provide broad measures of physical and emotional well-being [30] that have been shown as useful in ED samples [12,31]. For the current sample, Cronbach's α was .90 for the PCS and .93 for the MCS.

Eating Disorder Examination-Questionnaire (EDE-Q) [32]

The EDE-Q is a widely-used 36-item self-report measure that asks respondents to report symptom occurrence in the past 28 days. It consists of four subscales: Restraint; Eating Concern; Shape Concern; and Weight Concern, as well as a Global score. These are scored on a 0–6 scale, with greater scores indicating more frequent experience of those symptoms. The measure also assesses behavioral symptoms including binge eating, and distinguishes between objective binge episodes (OBEs; where a large amount of food is consumed with an associated loss of control), and subjective binge episodes (SBEs; where a 'normal'-sized, or even small, amount of food is consumed with an associated loss of control). The EDE-Q also provides a measure of compensatory behaviors, namely laxative use, diuretic use, self-induced vomiting, and compulsive exercise. It demonstrates good psychometric properties [33] and has been supported for use with adolescent populations [34,35]. For the current sample, Cronbach's α was as follows: Restraint = .82; Eating Concern = .81; Shape Concern = .92; Weight Concern = .83; and Global score = .95.

In addition, Q2 ("Have you gone for long periods of time [8 waking hours or more] without eating anything at all to influence your shape or weight?") was used as a measure of extreme dietary restriction (e.g., [13]; see also [36]). 'Undue influence of weight and shape' was

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