



Empirical Research

Acceptance-based treatment and quality of life among patients with an eating disorder



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ABSTRACT

This study assessed the relationship between acceptance-based constructs and quality of life (QOL) among patients with an eating disorder, as well as whether an acceptance-based treatment group could improve QOL. Patients ($n=105$) at a residential treatment center received treatment as usual (TAU) or TAU plus twice-weekly acceptance and commitment therapy groups (TAU+ACT), and completed assessments at admission and discharge. Higher scores on several acceptance-related constructs at admission were associated with better psychological QOL, and pre- to post-treatment improvements in the ability to defuse from distressing internal experiences were associated with improved QOL. However, no differences in pre- to post-treatment changes in QOL were observed between treatment conditions. These results suggest that while some acceptance-related variables (e.g. defusion, impulse control, access to emotion regulation skills) may contribute to QOL, ACT does not appear to incrementally improve these variables or QOL beyond standard treatment programs. Additional research is needed to evaluate whether ACT may confer greater benefit for improving QOL in an outpatient setting where patients have more opportunity to utilize ACT skills, or when a stronger dose of treatment is administered.

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1. Introduction

Eating disorders (EDs) and subthreshold disordered eating behaviors are associated with significant impairments in quality of life (QOL), especially in the psychological domain (Engel, Adair, Hayas, & Abraham, 2009; Jenkins, Hoste, Meyer, & Blissett, 2011; Winkler et al., 2014). QOL is generally inversely associated with the severity of ED symptoms (Padierna, Quintana, Arostegui, Gonzalez, & Horcajo, 2000; Bamford & Sly, 2010), and poorer pre-treatment QOL is associated with greater risk of treatment dropout (Abd Elbaky et al., 2014). Although ED treatment completion is associated with moderate improvements in QOL, QOL in treated patients tends to remain below population norms (Engel et al., 2009; Jenkins et al., 2011), perhaps because of continuing symptoms and ED-related cognitions and/or affective experiences (e.g., continued body image disturbances, continued urges to binge). Continued impairment in QOL also may reflect the fact that existing treatments' primary goal is symptom reduction rather than improvement in QOL more broadly. Given that many individuals

experience ED symptomatology for years even with treatment (Steinhausen, 2002; Wonderlich et al., 2012), an increased focus on improving QOL independent of symptom reduction may benefit many patients.

One set of variables that may impact QOL among patients with EDs are those targeted by acceptance-based treatments. These variables, including mindfulness (i.e., non-judgmental awareness of one's present-moment experience), psychological acceptance (i.e., welcoming one's internal experiences without trying to avoid, suppress, or change them), emotion regulation (i.e. reducing one's vulnerability to negative emotions, learning to experience positive emotions, and learning to reduce emotional suffering), defusion (i.e., achieving psychological distance from one's thoughts and feelings), and committed action (i.e., developing patterns of behavior consistent with one's chosen values), relate to and are strategies that can be used to develop psychological flexibility (i.e., the ability to persist in or change behavior when doing so serves valued ends; Biglan, Hayes, & Pistorello, 2008). Greater psychological flexibility and related constructs may reduce the impact of ED symptoms on QOL, as individuals with a greater ability to persist in or change behaviors in the service of one's values likely perceive their position in life more positively. Additionally, patients high in psychological flexibility and related constructs likely maintain a higher QOL even in the presence of ED symptoms, as they

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presumably perceive these symptoms as less disruptive and are less likely to allow these symptoms to interfere with their behavioral goals. For example, a patient who experiences ED symptoms but is able to take a welcoming stance toward her ED cognitions, fears, and insecurities and does not allow these symptoms to control her interpersonal and professional life would likely experience less impairment of QOL compared to the patient who is unwilling to tolerate these internal experiences and therefore struggles to live consistently with her values.

By targeting psychological flexibility and its related constructs, acceptance-based therapies such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012) may be well-suited to improving QOL among ED patients. A growing number of case and pilot studies utilizing mindfulness and acceptance-based therapies to treat EDs have yielded promising results for symptom improvement, suggesting the potential utility of this treatment paradigm (Manlick, Cochran & Koon, 2013; Masuda & Hill, 2013). In addition, prior research with populations with other psychiatric and health conditions has shown that acceptance-based treatments can improve QOL (e.g., Lillis, Hayes, Bunting, & Masuda, 2009; Roemer, Orsillo, & Salters-Pedneault, 2008). To date, however, pilot studies of acceptance-based treatment for EDs have focused largely on symptom reduction, despite the fact that the primary goal of these treatments is to improve values-consistent behavior as opposed to symptom reduction per se (Forman & Herbert, 2009). Assessing the impact of acceptance-based treatments on QOL in addition to symptom reduction appears warranted.

The present study had two major goals: (1) Examine the relationship between QOL and acceptance-related constructs among a sample of ED patients, and (2) assess whether an ACT-based treatment for EDs could improve QOL beyond treatment as usual (TAU). As such, we randomized patients at a residential ED treatment center to receive TAU or TAU plus twice-weekly ACT groups (TAU+ACT), and assessed ED severity, QOL, and several acceptance-related variables at both admission to and discharge from treatment.

We proposed four hypotheses for the present study. First, we hypothesized that baseline levels of acceptance-related variables would be associated with QOL at admission to treatment, even when controlling for ED severity. Second, given previous findings that QOL among ED patients tends to improve with treatment, we hypothesized that individuals in both conditions would experience improvements in QOL from pre- to post-treatment. However, we hypothesized that participants in the TAU+ACT condition would exhibit greater improvements in QOL than those who received only TAU. Finally, we hypothesized that changes in acceptance-based constructs over the course of treatment would correlate with change in QOL, such that individuals who exhibited larger improvements on acceptance-related variables, regardless of treatment condition, would report greater gains in QOL, even when controlling for change in ED severity.

2. Methods

2.1. Overview

The present study utilized data obtained in a published outcome study (Juarascio et al., 2013). The study utilized a nonequivalent groups design whereby half of the participants received standard TAU and half received TAU+ twice-weekly acceptance-based treatment groups, which primarily utilized an ACT treatment approach. Pre-treatment assessment occurred within three days of admission; post-treatment assessment occurred between five and zero days before discharge. Participants in the TAU

condition received standard treatment at the treatment center. Participants in the TAU+ACT condition received all TAU elements and also received twice-weekly ACT group treatment in lieu of regularly programmed staff-run leisure groups. For additional information about the pre-treatment characteristics of the sample; the treatment approach utilized by the treatment center; the treatment manual, adherence, and competency; and a full list of administered measures, see Juarascio et al. (2013).

2.2. Participants

The study took place at a residential ED treatment facility for women in the Mid-Atlantic region of the United States. Any woman admitted to the facility with a diagnosis of AN, BN, or EDNOS in the AN or BN spectrum (based on the Structured Clinical Interview for DSM-IV Disorders; First, Spitzer, Gibbon, & Williams, 2002) was eligible. There were no other exclusion criteria. A total of 140 women consented to take part in the study, with an average age of 26.7 years ($SD=9.2$), and a range of 18–55. The sample was predominantly White (89.3%), with small proportions of other non-White groups (Black=3.6%, Asian=2.1%, Hispanic=2.9%, and Other=1.4%).

Of the 140 who consented to take part in the study, 85% returned pre-treatment questionnaires ($n=120$); 92.5% of those individuals also returned post-treatment questionnaires ($n=111$). Participants in the TAU+ACT condition attended 4.75 ($SD=2.51$, range 0–11) group sessions on average. Treatment completers, defined as those attending ≥ 3 sessions ($n=56$, of whom 52 completed post-treatment measures; 93%), were equivalent to non-group completers on demographic and baseline variables. The results described below used the completer samples (TAU+ACT: 52 patients who completed ≥ 3 groups and post-treatment measures; TAU: all 53 patients who completed post-treatment measures), though intent to treat analyses showed similar patterns of response.

2.3. Measures

2.3.1. Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994)

The EDE-Q covers a 4-week time period and assesses the core features of EDs. Four subscales may be derived from the instrument (Restraint, Weight Concern, Shape Concern, and Eating Concern), together with a global score. Internal consistency and test-retest reliability are excellent (Luce & Crowther, 1999). Cronbach's alphas for the current study were: Global=0.91, Restraint=0.82, Eating Concern=0.70, Shape Concern=0.90, and Weight Concern=0.86.

2.3.2. Eating Disorder Quality of Life (EDQoL; Engel et al., 2006)

The EDQoL is a 25-item measure that assesses the impact of ED symptoms on QOL in the last 30 days across four domains: Psychological, Physical/Cognitive, Work/School, and Financial. Sample items include "How often has your eating/weight resulted in less interest or pleasure in activities?" (Psychological), "How often has your eating/weight affected your ability to pay attention when you wanted to?" (Physical/Cognitive), "How often has your eating/weight led to low grades?" (Work/School), and "How often has your eating/weight resulted in significant financial debt?" (Financial). Subscores for each domain and a total score can be derived. The EDQoL has demonstrated excellent psychometric properties (Engel et al., 2006). Cronbach's alpha for the total score was .89 for the current study and subscale alphas for the current study ranged from 0.86 to 0.93. The EDQoL was chosen over a more general QOL measure because it results in a more accurate description of QOL

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