Predictors of quality of life in patients with eating disorders

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A B S T R A C T

Background: The aims of this study were to analyse the quality of life (QoL) of a broad sample of patients with eating disorders (ED) and to identify potential factors that predict QoL.

Methods: This prospective cohort study involved 528 patients diagnosed with ED and treated over a 15-year period in the Eating Disorders Outpatient Clinic. Information on sociodemographic and clinical data were gathered. Patients completed five self-administered instruments: the Eating Attitudes Test-26 (EAT-26); the Eating Disorder Diagnostic Scale (EDDS); the Hospital Anxiety and Depression Scale (HADS); the Short-Form 12 (SF-12); and the Quality of Life in ED-short form (HeRQoLED-s). Descriptive, univariate analyses and multivariate linear regression models were applied to identify factors associated with QoL.

Results: Predictive variables for a low level of QoL in patients with anorexia nervosa (AN) included antidepressant treatment (P = 0.009), substance abuse disorder, (P = 0.03) and other organic comorbidities (P < 0.0001). For patients with bulimia nervosa (BN), they included osteoporosis (P < 0.0001), obesity (P = 0.0004) or being a student (P = 0.04). For patients with eating disorders not otherwise specified (EDNOS), they included anxiolytic treatment (P = 0.003), having circulatory disease (P = 0.001), more years since start of ED treatment (P = 0.03) and living alone (P < 0.0001).

Conclusions: We found a significant difference in QoL between the diagnostic ED groups. With regard to the variables predicting QoL in ED patients, the findings of this study suggest that organic or psychiatric comorbidities and some data of social normality might be more relevant to QoL in ED than age, type of compensatory behaviour, BMI or number of visits to hospital emergency department.

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1. Introduction

Eating disorders (ED) are serious psychiatric illnesses. They impair quality of life (QoL) [1,2] and have other profoundly negative effects on patients’ lives [3]. The severity of the disorder combined with the risk of chronicity can substantially affect a patient’s physical health [4,5], mental health and social adjustment [6].

1.1. Study objectives

Examining QoL has the advantage of providing a more holistic picture of the patient and their recovery and gives researchers and clinicians an understanding of the impact of the ED on the individual [7]. There has been increased interest in studying quality of life in ED in the last two decades [8]. A meta-analysis on QoL by Engel et al. (2009) [9] confirms that ED individuals of all subtypes [e.g., anorexia nervosa (AN), bulimia nervosa (BN) and eating disorders not otherwise specified (EDNOS)] experience poorer QoL compared to normal controls and compared to other psychiatric disorders [10]. Poor QoL was also seen in all ED individuals, regardless of the severity of diagnostic status. It is unclear whether there are differences between the ED diagnostic groups, although a recent review found that patients with binge eating disorder tended to report the lowest QoL [11].

González-Pinto et al. (2004) [12] found that the presence of another psychiatric disorder was associated with poorer QoL, particularly in mental health domains [using the Short-Form 36 (SF-36)]

Abbreviations: AN, Anorexia Nervosa; BMI, Body Mass Index; BN, Bulimia Nervosa; DSM-IV, diagnostic and statistical manual of mental disorders, 4th edition; ED, eating disorders; EDNOS, eating disorders not otherwise specified; PCS, physical component scale; QoL, quality of life; SF, standard deviations; EAT-26, the Eating Attitudes Test-26; EDDS, the Eating Disorder Diagnostic Scale; HeRQoLED-s, the Health-Related Quality of Life in ED-short form; HADS, the Hospital Anxiety and Depression Scale; MCS, the mental component scale; SF-12, the Short-Form 12.

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A review of ED-related QoL [1] reported that an ED specific measure of QoL was needed and that future research should also measure comorbidity with mood disorders at the QoL level. To overcome this limitation, we use a specific measure of health-related quality of life (HRQoL) in patients with ED [Health-Related Quality of Life in ED-short form (HeRQoL-s)] and also measure anxiety and depression comorbidity. Recently, De Jong et al. (2013) [15] concluded that further studies are needed to examine possible predictors of QoL in EDs, since it seems likely that the relationships between clinical variables and QoL may be complex. A recent study [16] defined the research agenda for ED and the first item on the final top ten research priorities for the ED agenda was “Which factors influence the duration of recovery and the possibility of complete recovery?” To our knowledge, no previous studies have been able to identify predictive factors for the physical and mental symptom components of QoL in the three diagnostic ED groups (AN, BN, EDNOS) simultaneously. We designed this cross-sectional study to analyse the QoL of a broad sample of ED patients and to identify potential factors that predict QoL.

2. Methods

2.1. Participants

We conducted a prospective study of all patients diagnosed with and treated for an ED over a 15-year period in the Eating Disorders Outpatient Clinic, which forms part of the psychiatric services at Galdakao-Usansolo Hospital and the Ortuella Mental Health Centre in Bizkaia (Spain). The hospital serves a population of 300,000 inhabitants and is part of the Basque Health Care Service, which provides free, unrestricted care to nearly 100% of the population. Outpatients recruited between January 2014 and January 2016 were eligible for the study if they had been diagnosed by a psychiatrist having anorexia nervosa (AN), bulimia nervosa (BN) or an eating disorder not otherwise specified (EDNOS) based on criteria established in the diagnostic and statistical manual of mental disorders, 4th edition (DSM-IV) [17]. Patients were required to provide written informed consent before participating. Patients were excluded from participating if they had a malignant, severe organic disease, could not complete the questionnaires because of language barriers or did not give written informed consent to participate in the study.

Our study covered different treatments used for different diagnoses: cognitive behaviour therapy has been established as the treatment of choice for BN and EDNOS [18]; family-based intervention has been established as the treatment for adolescents with AN [19,20]; and nonspecific supportive clinical management has been established as the treatment for adults with AN; this treatment provided education and nutritional advice and used supportive psychotherapy principles in responding to the patient [21]. Each outpatient received a psychopharmacologic and psychotherapeutic treatment program consisting of cognitive-behavioural treatment; nutritional orientation and counselling; psycho-education; motivational therapy; social skills training; and therapy to modify distorted perception of body image. These interventions were adjusted to each patient’s needs by a multidisciplinary team.

A total of 733 ED patients were invited to participate in the study. Of these, 528 completed the questionnaires. Dropouts at the beginning of the study were due mainly to patients not consenting to participate or having deceased at the time of the study (n = 17). In addition, some patients could not be contacted due to changes in address or telephone number.

The study was approved by the institutional review board of Galdakao-Usansolo Hospital.

2.2. Measures

Patients provided sociodemographic data, including age, gender, marital status, educational level, employment status, living arrangements, number of children.

2.2.1. Clinical data included

Diagnosis; type of compensating behaviour; years from diagnosis to discharge; years from start of treatment to last medical consultation; years from diagnosis to the present; current Body Mass Index (BMI); BMI on diagnosis; whether currently consulting a physician for ED or for another psychiatric disorder, whether currently consulting a psychiatrist for ED or for another psychiatric disorder; psychiatric comorbidities (mood disorders, anxiety disorders, substance abuse disorders, psychotic disorders (birth and others) were clinical diagnoses made by psychiatrists (the comorbide psychiatric disorders were life time disorders); other psychiatric comorbidities indicate that an organic factor initiated and maintained the comorbid disturbance [22] (obesity, diabetes, heart disease, chronic pulmonary disease, asthma, circulatory disease, osteoporosis, skin diseases, other) (the comorbide organic disorders were current disorders); whether currently in psychiatric treatment; number of hospital admissions since diagnosis of ED–for eating disorders, for other reasons; total number of hospital admissions in the last year; total number of hospital admissions in the last 15 years; suicide attempts; number of medical consultations–in the last year and in the last 15 years; number of visits to hospital emergency–in the last year and in the last 15 years; parents’ psychiatric history; Smoking; general health status with respect to a year ago; ED status with respect to a year ago.

2.2.2. Questionnaires

Patients also completed Spanish-language versions of five self-administered instruments (EAT-26, EDDS, HADS, SF-12, HeRQoL-s). The ED patients completed the Eating Attitudes Test (EAT-26) [23], which assesses the behavioural and cognitive characteristics of ED patients. It consists of 26 items covering three scales: diet, bulimia and food worries and oral control. The EAT-26 provides a total score of between 0 and 76. Scores above 20 indicate the presence of behaviours or thoughts characteristic of ED individuals. It has been validated in the Spanish population [23].

The Eating Disorder Diagnostic Scale (EDDS) [24] contains 22 items assessing the DSM-IV diagnostic criteria for AN, BN and binge eating disorder. Responses can be used to generate DSM-IV diagnoses for the three eating disorders. Items can also be standardized (to check for different response formats) and aggregated (except the items on height and use of the birth control pill) to create an overall eating disorder symptom composite. The preliminary psychometric study [25] provided evidence that the EDDS was reliable and valid within a sample containing both adolescents and adults. We used a version validated in Spanish [26].

The Hospital Anxiety and Depression Scale (HADS) is a 14-item instrument used to screen for anxiety and depression in non-psychiatric settings [27]. It is divided into 2 subscales. A score of 0 to 7 on any subscale indicates absence of anxiety or depressive

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