Treatment dropout in web-based cognitive behavioral therapy for patients with eating disorders

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A B S T R A C T

Treatment dropout is an important concern in eating disorder treatments as it has negative implications for patients’ outcome, clinicians’ motivation, and research studies. Our main objective was to conduct an exploratory study on treatment dropout in a two-part web-based cognitive behavioral therapy with asynchronous therapeutic support. The analysis included 205 female patients with eating disorders. Reasons for dropout, treatment experiences, and predictors of dropout were analyzed. Overall treatment dropout was 37.6%, with 18.5% early dropout (before or during treatment part 1) and 19.0% late dropout (after part 1 or during part 2). Almost half of the participants identified personal circumstances as reason for dropout. The other participants mostly reported reasons related to the online delivery or treatment protocol. Predictors of early dropout included reporting less vigor and smoking at baseline and a longer average duration per completed treatment module of part 1. Late dropout was predicted by reporting less vigor at baseline and uncertainty about recommendation of the treatment to others after completion of treatment part 1. Generally, the web-based treatment and online therapeutic support were evaluated positively, although dropouts rated the treatment as significantly less helpful and effective than completers did.

1. Introduction

Treatment adherence is crucial to achieve positive outcomes in patients with eating disorders (Aardoom et al., 2013; Neve et al., 2010; Schlegl et al., 2015). However, dropout rates in eating disorder treatments range from 20% to 73% (Fassino et al., 2009). Patients who drop out are more likely to have a poor long-term outcome (Beumont et al., 1993), with their eating disorder becoming more severe and sometimes even chronic (Strober et al., 1997).

Dropout rates seem to be higher in eHealth interventions than in face-to-face treatments (Eysenbach, 2005; Kelders et al., 2012). In Internet-based treatments for patients with eating disorders treatment dropout rates are also high (Schlegl et al., 2015), although often different definitions for dropout are used (Aardoom et al., 2013). The variety of ways in which dropout is operationalized is one of the main difficulties in the study on treatment dropout (Aardoom et al., 2013; Fassino et al., 2009; Schlegl et al., 2015; Wallier et al., 2009). In the studies by Ruwaard et al. (2013) and Ljotsson et al. (2007), dropout is defined as a failure to complete all treatment sessions. Several other studies, however, define dropout as the number of patients that fail to complete a certain number, or a percentage of available treatment sessions (Paxton et al., 2007; Wagner et al., 2013). In addition, sometimes patients are considered dropouts after 4 weeks without any connection or therapeutic contact (Carrard et al., 2011b), whereas other studies only report on compliance levels (Aardoom et al., 2016). This heterogeneity in reporting dropout affects the dropout rates and also complicates the comparison of studies.

In our randomized controlled trial (RCT; n=214) on the effectiveness of a web-based cognitive behavioral treatment (CBT) with intensive therapeutic support for patients with eating disorders, 33% of the participants of the web-based CBT group (36/108) were considered treatment dropouts (ter Huurne et al., 2015a). Those participants did not start the web-based CBT after allocation or they stopped the treatment program before completion of all 16 treatment
modules and 10 assignments.

Several factors are related to dropout rates such as type of treatment, type of eating disorder, and definition of dropout (Fassino et al., 2009). A few review studies have been conducted on predictors of treatment dropout for patients with eating disorders (Fassino et al., 2009; Vall and Wade, 2015), or specifically for patients with anorexia nervosa (AN) (Dejong et al., 2012; Wallier et al., 2009). Most recently, Vall and Wade (2015) reported five predictors of treatment dropout: the purging subtype of AN, more frequent binge/purge behaviors at baseline, lower motivation to recover, higher impulsivity, and greater comorbid psychopathology. Although Fassino et al. (2009) also found several individual studies that reported psychiatric comorbidity as a predictor of dropout, most other studies included in their review found no predictive value for this variable, so the authors concluded that there was insufficient evidence that baseline psychiatric comorbidity affects dropout. The only consistent predictor found in their review was the purging subtype of AN (Fassino et al., 2009). Importantly, most studies included in the reviews concerned patients with AN or bulimia nervosa (BN), and only rarely patients with binge eating disorder (BED).

For web-based treatments, several differences have been found in baseline characteristics between treatment completers and dropouts (Aardoom et al., 2013), such as a higher frequency of (subjective) binge eating (Carrard et al., 2006; Ljotsson et al., 2007), a higher frequency of vomiting (Carrard et al., 2006), more concerns about body shape (Carrard et al., 2011a), and a higher drive for thinness in treatment dropouts (Carrard et al., 2011a). However, only a few studies have examined predictors for treatment dropout. Studies that evaluated a guided internet self-treatment program for patients with (subthreshold) BN (Carrard et al., 2011b) and an internet-assisted CBT for (subthreshold) BN and BED (Ljotsson et al., 2007) could not find any reliable predictor of treatment dropout, whereas lower BMI, higher anxiety scores, lower hyperactivity, and lower reward dependence showed to be predictors of dropout in an internet-based CBT for patients with BN (Fernandez-Aranda et al., 2009), and more severe depression and lower self-directedness in a guided self-help intervention with weekly e-mail support for patients with (subthreshold) BN (Wagner et al., 2015). Given the variability in outcomes, more research on predictors of dropout in web-based treatments is highly preferred.

For web-based treatments, studies on predictors of dropout have not differentiated between participants who drop out early in treatment and participants who stop treatment at a later time (Carrard et al., 2011b; Fernandez-Aranda et al., 2009; Ljotsson et al., 2007; Wagner et al., 2015). This assumes no relation between the timing of dropout and characteristics related to dropout, while some studies found several differences between early and late dropouts of inpatient treatments for AN. In one study, early dropout seemed to be associated with later age of onset of AN, older age at admission, lower socio-economic status, and lower educational achievement (Vandereycken and Pierloot, 1983). Other studies showed more previous hospitalizations (Kahn and Pike, 2001) and a trend to more obsessive compulsive and perfectionist features (Zeeck et al., 2005) for early dropouts. These differences suggest different predictive factors for early and late dropout, and probably also a different approach for preventing dropout at the beginning of the treatment compared to when treatment has progressed. It would therefore be interesting to differentiate between early and late dropouts, and to examine whether predictors differ for the timing of dropout.

In the study on predictors of treatment dropout, research mostly focuses on studying patient characteristics, although the predictive capacity of those variables is often limited (Sly, 2009). The importance to include other variables, such as treatment process characteristics and therapeutic alliance, has been emphasized several times (Kahn and Pike, 2001; Mahon, 2000; Sly, 2009; Zeeck et al., 2005). A review on web-based interventions to promote health showed that a substantial amount of variance in treatment adherence was explained by intervention characteristics such as increased interaction with a therapist, more frequent intended usage, more frequent updates, and more extensive employment of dialogue support (Kelders et al., 2012). Prediction studies on treatment dropout for patients with eating disorders have rarely included treatment and therapist-related characteristics, although early treatment experiences may affect patients’ motivation for (dis)continuing treatment. Considering that web-based treatment is relatively new and includes a different way of communicating with a therapist and active self-participation, treatment evaluation, and probably reasons for dropout as well, may be different for this type of treatment compared to regular face-to-face treatment. In addition, in recent decades patients have become more assertive and critical regarding the provided care. It is likely that those who are less positive or satisfied, choose to stop treatment faster. This may be particularly applicable for web-based treatment, given the relative ease with which this type of treatment can be stopped. Studies on patients’ (early) treatment experiences and their reasons for dropout are lacking in existing literature (Aardoom et al., 2013; Carrard et al., 2011b), while a better understanding of these issues can help to improve the implementation and utilization of web-based treatments, and to provide more personalized treatments tailored to the needs of the individual patients. Therefore, more research into these topics would be useful.

The goals of this exploratory study on treatment dropout in a web-based CBT for patients with eating disorders are: (a) to identify participants’ reasons for treatment dropout; (b) to explore participants’ experiences with the web-based treatment; and (c) to determine predictors of early and late treatment dropout.

2. Methods

2.1. Participants

The participants included 205 female patients with a diagnosis of bulimia nervosa (BN), binge eating disorder (BED) or eating disorder not otherwise specified (EDNOS). The data were derived from our previously conducted RCT, that was designed to evaluate the effectiveness of a web-based treatment program for eating disorder psychopathology and health related outcomes (ter Huurne et al., 2015a). Participants were self-recruited users between March 2011 and December 2013 of the Dutch website www.etendebaas.nl (English translation: ‘Look at your eating’). All female patients who met DSM-IV criteria for BN, BED or EDNOS, had access to the Internet, were fluent in Dutch, and had a referral from their general practitioner, were eligible to participate. Patients had to be within 85% of their target weight according to the MINI-Plus (Sheehan et al., 1998; van Vliet et al., 2000). Further exclusion criteria were suicidal ideation, receiving psychological or pharmaceutical treatment for any eating disorder within the prior six months, pregnancy, or expected absence for 4 weeks or longer during the treatment period of 15 weeks. All participants provided written informed consent and the study was approved by the Medical Ethics Committee Twente (NL31717.044.010, P10-31) and registered in the Netherlands Trial Registry (NTR2415).

2.2. Procedure

The study design, procedures and results of the RCT are described in detail elsewhere (ter Huurne et al., 2015a, 2013a). In summary, participants were randomized to the web-based CBT group or a waiting list control (WL) group, stratified by type of eating disorder (BN, BED, EDNOS). Participants of the WL had to wait 15 weeks after randomization before they could start the treatment whereas participants of the web-based CBT immediately started the treatment program. In total, 214 participants were included in the RCT of whom 108 were randomized to the web-based CBT group and 106 to the WL group. As the current analysis focused on predictors of treatment dropout and
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