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Drop-out from adolescent and young adult inpatient treatment for anorexia nervosa



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ABSTRACT

We examined factors predictive of dropout from inpatient treatment for anorexia nervosa (AN) among adolescents in a prospective study of 359 consecutive hospitalizations for AN (DSM-IV). Patients were assessed at admission (clinical, socio-demographic, and psychological data). Multivariate analyses were performed. Drop-out (i.e. leaving hospital before the target weight is achieved) occurred in 24% ($n=86$) of hospitalizations; in 42.3% ($n=30$) of the cases, dropout was initiated by the treatment team and in 58.6% ($n=41$) by the patients and/or their parents. 18.6% (16/86) occurred during the first half of the inpatient program. Frequency of drop-out was significantly higher when the patient was living with only one parent, had been hospitalized previously, had a lower BMI at admission and was over 18 at admission. These elements should draw the attention of the clinician, so that he/she can prepare hospitalization with patients presenting lower admission BMI, particularly by motivational interventions for a better therapeutic alliance, and by the deployment of intensive accompaniment of single parents. Further studies aiming to replicate these results, and including the evaluation of other clinical dimensions such as impulsivity and other personality traits, are needed to elucidate this important topic.

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1. Introduction

Patients with the most severe forms of anorexia nervosa (AN) often require hospitalization because of malnutrition, the chronic course of their illness, or their psychological state (American Psychiatric Association, 2006). However, a significant percentage of patients with AN do not successfully complete inpatient treatment. Reported drop-out rates range from 20.2% (Surgenor et al., 2004) to 57.6% (Vanderheiken and Pierloot, 1983). Dropping out from inpatient treatment for AN also appears to have a negative impact on the successful long-term treatment overall. More specifically, leaving the hospital before the care program is complete (i.e. target weight achieved) predicts poorer outcome, with an increased risk of relapse

within the first year (Baran et al., 1995; Strober et al., 1997; Carter et al., 2004). Furthermore, patients who have dropped out from inpatient care display more eating disorder symptoms in follow-up (Baran et al., 1995) and a more chronic and severe course of illness. In addition it has been shown that compliance is a major factor among treatment-resistant eating-disordered in-patients, and facilitates recovery and successful treatment (Towell et al., 2001).

Very few studies have examined pre-admission factors predictive of drop-out (see Wallier and Fassino for a comprehensive review (Wallier et al., 2009; Fassino et al., 2009)). Socio-demographic, psychological and other clinical factors have been associated with drop-out, although only a small number of predictors have been identified in more than one study. In multivariate analysis, only a few factors have emerged as predictive of drop-out: lower Body Mass Index (BMI) among adults at admission (Surgenor et al., 2004), higher BMI among adolescents at admission (Godart et al., 2005), low desired BMI at admission (Huas et al., 2010), binge eating/purging AN subtype (Surgenor et al., 2004), the

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absence of comorbid depression (Zeeck et al., 2005), later age at onset, factors related to the eating disorder (weight concerns, restraint, maturity fears, number of symptoms at admission, general psychopathology, eating behavior symptoms) (Kahn and Pike, 2001; Woodside et al., 2004; Surgenor et al., 2004; Huas et al., 2010), having one or more children (Huas et al., 2010), and low educational status (Huas et al., 2010).

Although these studies have unearthed a certain number of predictors of drop-out, they have all focused on samples mostly in an adult age range. We have already published preliminary results in a letter concerning both pre-admission and pre-hospitalization factors in an adolescent population (Godart et al., 2005). We postulated that the reasons why adolescents drop out from care may be different from those for adults, and that this requires further study: the treatment programs and clinical characteristics of these two patient populations are somewhat different. For example, the family environment of adolescent patients, and the parents in particular, has an important role in the success of the treatment (Lock et al., 2006; Pereira et al., 2006). In addition, non-adult patients are under the legal care of their parents, and hospitalization is possible only with parental approval. Little research has examined these topics.

An understanding of the factors associated with adolescents dropping out of care would theoretically make it possible to develop strategies to reduce drop-out rates and improve treatment success rates for the most severe cases of adolescent AN (i.e. needing inpatient treatment), this being a predictive factor for a better long-term outcome (Steinhausen, 2002).

Therefore the purpose of this study was to examine factors related to drop-out from inpatient treatment in a large sample of adolescent inpatients with AN. More specifically, this research explored the factors cited above that have been shown to predict drop-out in adult populations, as well as some further elements that we hypothesized could be linked to drop-out (socio-demographic features of parents and patients, and clinical characteristics that describe the severity of patient condition).

2. Methods

2.1. Recruitment and assessment procedures

For this study, all patients aged from 12 to 22 discharged from our eating disorders inpatient unit between May 1996 and February 2006 ($N=328$) were considered. These subjects were hospitalized in our care unit during the inclusion period for a life-threatening physical and/or mental state or states (BMI below 14 and/or rapid weight loss and/or compromised vital functions, severe depression, high suicide risk, chronic under-nutrition with low weight, and failure of outpatient care. Failure of outpatient treatment is defined as a significant deterioration, or the absence of any significant improvement, in terms of weight gain, eating disorders symptoms and/or psychological severity).

All subjects with a clinical diagnosis of AN (according to the DSM-IV criteria (1) confirmed by one of the senior psychiatrists in the team) were included in this research. Twelve patients who met all the diagnostic criteria except "amenorrhea for 3 months" were nevertheless included, as this criterion is not essential for the diagnosis of AN (5). Of these 12 patients, six were taking birth control pills, three had a 2 months duration of amenorrhea and three had a 1 month duration of amenorrhea.

A total of 35/328 (10.7%) patients were excluded from this research. Three patients were excluded because a severe somatic disease complicated the symptoms of AN (one had diabetes mellitus and two had Ewing's sarcoma). Thirteen patients, with eating disorders but who did not meet all the diagnostic criteria for AN and were hospitalized without a weight contract, were also excluded from this research. In addition, male patients were not included in this study because of their small number ($n=19$).

2.2. Patient characteristics

In the present study, the 359 consecutive hospitalizations of 293 patients were included. One patient was hospitalized five times, six were hospitalized four or three times, 32 were hospitalized twice and the others once ($n=248$). Mean age

admission was 16.6 years (S.D.=1.9), range: 12.2–22.8 (≤ 13 years: 6.6%; 14–17 years: 67.8%; ≥ 18 years: 25.6%). Most patients came from a "managerial and professional" category family (68.6%, $n=234$). They presented restrictive type AN for 78% ($n=281/359$) and purging type for 22% ($n=78/359$). The majority of the patients had menstruated before anorexia nervosa (85%, $n=304$) and 15% ($n=55$) had primary amenorrhea.

2.3. Procedure

The Patient Information Questionnaire was completed by each patient's psychiatrist or intern, using information gathered in clinical interviews. These questionnaires were completed in three distinct phases: at the time of the patient's admission to hospital, during hospitalization, and at the time of discharge. The content was double-checked by the psychiatrist responsible for the patient, and then by another psychiatrist with first-hand knowledge of the patient (N. Godart, F. Perdureau).

2.4. Patient information questionnaire

This questionnaire was used to record clinical information for all patients hospitalized in the department. It was created in 1996 by Godart (copies available on request) using the concept of systematic data collection as modeled by the Maudsley database (Wannan and Fombonne, 1998).

Part one collects general information concerning the patient, the diagnosis/es at discharge made by the clinician according to DSM-IV criteria, the treatment proposed at discharge, and socio-demographic data as previously described (Strik-Livers et al., 2009).

Part two concerns the patients with eating disorders and comprises information on DSM IV criteria for AN, Bulimia and non-specified eating disorders; patient history regarding weight, including weight and stature on admission to hospital, weight before AN, minimum weight (at what age for what stature), age at onset of the eating disorders, dates of first and last menstruation, duration of amenorrhea, duration of untreated AN (time that elapsed between the onset of AN and the first psychiatric consultation), use of oral contraception, any nasal-gastric tube use, period spent in intensive care, and comorbid diagnosis of major depressive disorder (according to DSM-IV criteria) during hospitalization. The predictive variables for drop-out reported in the literature (except for psychopathological features) were assessed in Part 2 of this questionnaire.

2.5. Terminology: definition of drop-out

The treatment in our inpatient eating disorders unit involves a multidisciplinary approach. It revolves around a therapeutic contract described in Godart et al. (2009). This verbal contract is established between the patient, the family and the staff, and defines two target weights: the "end of separation weight" and the "target discharge weight". The latter is the weight to attain before discharge. The former is an intermediate weight situated between the final weight goal and the weight of the patient upon arrival (within one or two kilos of the mean of these two weights). The patient must reach this weight in order to complete the first part of the hospital stay. During the first part of the inpatient program the patient remains in the unit every day. During the second part of inpatient program the patient stays 5/7 days in the hospital and spends the weekend at home (Godart et al., 2005).

The determination of final discharge weight is based on the following:

1. The weight and stature of the patient before AN (BMI before AN). This is based on family and/or patient report, the *carte de santé*¹ and medical records, and constitutes a reference for the normal state. However for a previously overweight patient, objectives are set lower, and for a previously underweight patient they are set higher in accordance with the growth chart.
2. The patient's desired weight (participant's desired BMI).
3. The parent's desired weight for their daughter.

The duration of hospitalization is therefore not defined at admission. The timing depends rather on the patient, who can regulate her weight gain to reach the final target weight and be discharged.

For this research, *drop-out* was defined as not completing the therapeutic contract (i.e. not reaching the discharge weight) regardless of whether the patient, the parents or the staff terminated the treatment. *Patient-initiated discharge* was defined as any drop-out initiated by the patient and/or her parents when patients were minors. *Staff discharge* refers to instances where the staff decides to discharge a patient who has not yet reached her target weight, usually because of a lack of

¹ The *carte de santé* contains medical information including detailed information regarding stature and weight development from birth. In France, all children have a *carte de santé* which is to be presented at each medical appointment.

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