



Attrition from self-directed interventions: Investigating the relationship between psychological predictors, intervention content and dropout from a body dissatisfaction intervention

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ABSTRACT

The aims of this study were to (a) identify the predictors of attrition from a fully self-directed intervention, and (b) to test whether an intervention to increase gratitude is an effective way to reduce body dissatisfaction. Participants ($N = 479$, from the United Kingdom) aged 18–76 years took part in a self-help study via the Internet and were randomized to receive one of two interventions, gratitude diaries ($n = 130$), or thought monitoring and restructuring ($n = 118$) or a waitlist control ($n = 231$) for a two week body dissatisfaction intervention. The gratitude intervention ($n = 40$) was as effective as monitoring and restructuring ($n = 22$) in reducing body dissatisfaction, and both interventions were significantly more effective than the control condition ($n = 120$). Participants in the gratitude group were more than twice as likely to complete the intervention compared to those in the monitoring and restructuring group. Intervention content, baseline expectancy and internal locus of control significantly predicted attrition. This study shows that a gratitude intervention can be as effective as a technique commonly used in cognitive therapy and is superior in retaining participants. Prediction of attrition is possible from both intervention content and psychological variables.

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Self-directed interventions have the potential to substantially increase access to health improvement strategies (Bennett & Glasgow, 2009). Provision via the Internet allows for a significant reduction in costs associated with intervention administration (Muñoz & Mendelson, 2005). Self-directed interventions have been evaluated and shown to be beneficial for a broad range of health challenges including smoking cessation and diabetes management (McKay, Glasgow, Feil, Boles, & Barrera, 2002; Muñoz et al., 2006) as well as medical and psychological conditions including obesity, depression and body dissatisfaction (Christensen, Griffiths, Mackinnon, & Brittliffe, 2006; Hrabosky & Cash, 2007; Latner & Wilson, 2007). However, when these interventions are fully self-directed, that is, without human contact or guidance, attrition is consistently high (Eysenbach, 2005). From a methodological perspective, attrition compromises internal and external validity. From a health care systems perspective, attrition represents a behavior that can inform our understanding of psychological processes that are important to health outcome. An understanding of

the underlying processes of attrition will help guide the creation of interventions that prevent dropout (Davis & Addis, 1999). In this paper we have two aims. First we model predictors of attrition using an Internet-administered intervention to reduce body dissatisfaction. We test the prediction of attrition from person-based psychological variables (health locus of control and outcome expectancy) and intervention content (thought monitoring and restructuring vs. gratitude). Second, we test whether a brief gratitude intervention successfully reduces body dissatisfaction compared to thought monitoring and restructuring intervention and a waitlist control.

Definitions of attrition vary from non-completion of follow-up measures, early dropout/late dropout distinctions (Davis & Addis, 1999) to 'nonusage attrition' in Internet interventions, where participants may stop using the intervention but still provide post-intervention data (Eysenbach, 2005). All forms of attrition are likely to be related however, in part representing 'disenchantment' with intervention content (Eysenbach, 2005), and more broadly disengagement from a goal to reduce a health-related problem. Unless otherwise stated, use of attrition in the current study refers to non-completion of post-intervention measures.

In fully self-directed interventions, high levels of attrition remain consistent across target symptom/behavior. Rabinus, Pike,

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Wiatrek, and McAlister (2008) reported 62% attrition from an Internet based smoking cessation trial. Attrition from studies of fully self-directed therapies for depression and anxiety can be as high as 99% and 79.6% (Christensen et al., 2006; Farvolden, Denisoff, Selby, Bagby, & Rudy, 2005) and a study evaluating an unguided body image intervention reported dropout rates of 53% (Strachan & Cash, 2002). Despite high attrition rates, those participants who complete fully self-directed interventions consistently report significant improvements across targeted outcomes (Christensen, Griffiths, Korten, Brittliffe, & Groves, 2004; Etter, 2005; Farvolden et al., 2005; Muñoz et al., 2006). In addition, interventions without face-to-face contact may widen participation to those who would reject or avoid health improvement interventions with high levels of social interaction (Carlbring, Furmark, Steczko, Ekselius, & Andersson, 2006). Therefore, rather than abandon fully self-directed interventions due to high dropout, what is needed is increased study and management of the attrition process.

Predicting attrition

Identifying variables that predict attrition is critical (Bennett & Glasgow, 2009). With this information interventions can be manipulated, and individuals most at risk of dropout can be targeted with enhanced interventions or guidance and therapist contact. Attempts to predict attrition from unguided self-help trials have produced inconsistent results (Glasgow et al., 2007). This inconsistency is found not only in self-help research but also in studies that include face-to-face contact (see Davis & Addis, 1999). Age has been one of the more consistent demographic predictors of attrition from self-directed therapy, with being older increasing the chances of completion of post-intervention measures (Buller, Woodall, & Zimmerman, 2008; Couper, Peytchev, Strecher, Rothert, & Anderson, 2007). However, the relationship between age and intervention behavior is complex, and younger age has been related to greater use of intervention websites (Christensen, Griffiths, & Farrer, 2009).

In a review of attrition research, Davis and Addis (1999) suggested the need to supplement demographic predictors of attrition with psychological variables. Health locus of control has been considered an important psychological factor in attrition from face-to-face interventions (Bennett & Jones, 1986), and Mahalik and Kivlighan (1988) have suggested internal locus of control may be important in self-help therapy. Outcome expectancies are important determinants of behavior and have been reported as critical in psychotherapy for both outcome and engagement in the process (Hyland, Geraghty, Joy, & Turner, 2006; Hyland, Whalley, & Geraghty, 2007; Kirsch, 1999). Outcome expectancy may play a critical role in the decision to complete or disengage with a self-directed program, with low expectancies potentially leading to dropout. In this study we directly investigate internal health locus of control and outcome expectancy in an unguided or “pure” self-help context.

The relation between intervention content and dropout

Fully self-directed interventions feature two key components, (a) the core therapeutic content and (b) procedures and methods designed to encourage engagement with the therapeutic content and solicit feedback response such as follow-up methods. From the users' perspective, (a) is more important than (b). From the researcher's perspective (b) is more important than (a), for without (b) it is impossible to evaluate the effectiveness of the therapeutic content. In self-directed interventions for psychological symptoms, core therapeutic content is primarily based around cognitive

behavioral techniques. Researchers then implement complex cohort maintenance strategies in order to attempt to maintain interest in the core therapeutic content and obtain feedback responses. Both factors (a) and (b) are important from a research perspective; however, from a user's perspective (b) is less important. Previous research has addressed cohort maintenance (see Clarke et al., 2005). In this study we test whether altering the core therapeutic content alone will affect disengagement processes and increase retention in a brief self-directed body dissatisfaction intervention.

Body dissatisfaction is a common cause of distress in women (Cash & Henry, 1995), and is growing among men (McCabe & Ricciardelli, 2004). Body dissatisfaction can have a large impact on quality of life (Cash & Fleming, 2002) and lead to serious psychopathology such as body dysmorphic syndrome, bulimia, and anorexia (Stice & Shaw, 2002). As well as reductions in self-esteem, body dissatisfaction frequently results in restrained eating behaviors (Fett, Lattimore, Roefs, Geschwind, & Jansen, 2009). Therapeutic approaches currently used in body dissatisfaction interventions are inherently pathology focused. Cognitive Behavioral Therapy (CBT) techniques such as thought monitoring and restructuring involve working to correct negative assumptions about physical appearance. Jarry and Berardi (2004) and Jarry and Ip (2005) conducted a systematic review and a meta-analysis on stand-alone body image interventions where they surveyed body dissatisfaction, body image attitude, investment, and body image behavior and perception. They concluded that CBT approaches were effective; however they noted a distinct lack of alternative approaches and encouraged the investigation of differing techniques.

In order to test whether intervention content would significantly predict dropout, we compared two very different theoretical approaches. We chose thought monitoring and thought restructuring for one group. Identifying activating situations, negative thoughts (Cash (1997) refers to this as ‘private body talk’) and working to dispute and correct the problem thoughts are common techniques used in body image interventions (see Cash, 1997; Rosen, Reiter, & Orosan, 1995). An alternative intervention was drawn from the positive psychology literature. Cash (2002) has suggested that positive psychology – where focus is placed on positive experience and interpretations – may provide a useful framework for future body image research. The study of gratitude has shown the greatest potential for health applications (Bono, Emmons, & McCullough, 2004).

Gratitude is perhaps the quintessential positive psychology trait, being a “life orientation towards the positive” (Wood, Joseph, Lloyd, & Atkins, 2009, p. 43) involving a worldview towards noticing and appreciating the positive in life (Wood, Maltby, Stewart, & Joseph, 2008). Trait gratitude is strongly linked to well-being (Wood, Maltby, et al., 2008), positive coping (Wood, Joseph, & Linley, 2007), authenticity (Wood, Linley, Maltby, Baliouis, & Joseph, 2008), improved sleep (Wood et al., 2009), and naturally leads to lower stress and depression during a life transition (Wood, Maltby, Gillett, Linley, & Joseph, 2008). Given the benefits of being grateful, interventions have been developed to increase well-being through fostering gratitude (Emmons & McCullough, 2003). Although gratitude interventions were shown to increase well-being by Emmons and McCullough (2003), it is difficult to determine the broader efficacy of their intervention, as control groups used were not intended to be therapeutic. Geraghty, Wood, and Hyland (2010) conducted the first study to compare a gratitude intervention to cognitive therapy techniques, and showed that gratitude was equally effective in reducing worry. Gratitude may reduce body dissatisfaction through increasing positive affect and well-being; unhappiness has been found to invoke comparison with a gender stereotype of physical attractiveness (Barber, 2001), and low mood

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