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Personality predicts drop-out from therapist-guided internet-based cognitive behavioural therapy for eating disorders. Results from a randomized controlled trial

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ABSTRACT

Internet-based guided self-help cognitive behavioural therapy (ICBT) seems a promising way of delivering eating disorder treatment. However, treatment drop-out is a common problem and little is known about the correlates, especially in clinical settings. The study aimed to explore prediction of drop-out in the context of a randomized controlled trial within specialized eating disorder care in terms of eating disorder symptomatology, personality traits, comorbidity, and demographic characteristics. 109 outpatients diagnosed with bulimia nervosa or similar eating disorder were randomized to two types of ICBT. Participants were assessed with several clinical- and self-ratings. The average drop-out rate was 36%. Drop-out was predicted by lower scores in the personality traits Dutifulness and Assertiveness as measured by the NEO Personality Inventory Revised, and by higher scores in Self-affirm as measured by the Structural Analysis of Social Behaviour. Drop-out was also predicted by therapist factors: one therapist had significantly more drop-outs (82%) than the other three (M = 30%). Theoretical and clinical implications of the impact of the predictors are discussed.

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1. Introduction

Internet-based interventions are becoming more and more popular as a way of providing self-help treatments (Dunn et al., 2012), and therapist-guided internet-based cognitive behavioural therapy (ICBT) seems a promising way of delivering eating disorder (ED) treatment (Aardoom et al., 2013). Evidence-based self-help programs and CBT (although not necessarily internet-based), are considered treatments of choice (NICE-guidelines, 2004) but when treatment drop-out is considered, the effectiveness of ICBT is less than assumed (Melville et al., 2010). We need to know more about relevant factors for drop-out. This study therefore aimed to investigate the predictive power of several factors for drop-out.

Two of the most common EDs; Bulimia nervosa (BN), and BN-like ED not otherwise specified (EDNOS) have an estimated lifetime prevalence of about 1% BN, and 2% EDNOS of bulimic type (Smink et al., 2012). Most commonly affected are young women (Fairburn and Harrison, 2003). BN is characterized by recurrent binge eating: episodes of eating considerably larger amounts than most people would eat within a limited time-period, and experiencing an inability to stop eating or a lack of control over how much or what one is eating. The binge eating is usually followed by inappropriate compensatory behaviours such as self-induced vomiting, laxative or diuretics misuse, excessive exercise, or fasting. There is also a severe over-valuation of body shape and weight (APA, 2000).

The term drop-out refers to premature termination of treatment, but for both internet-based treatment and traditional treatment consensus on a more exact definition is lacking, making drop-out research difficult to interpret (Aardoom et al., 2013; Fassino et al., 2009b; Mahon, 2000). In traditional CBT drop-out has for instance been referred to as ending treatment before reaching therapeutic objectives, against the therapist's advice, without having discussed it with the therapist (Bados et al., 2007), or simply whether the participant terminated therapy prematurely or finished as planned (Schnicker et al., 2013). In internet-based treatment for psychological disorders in general it has been defined as ending without completing all treatment steps, or without completing enough treatment steps or percentage of treatment according to a predefined cut-off (Melville et al., 2010), thus in internet-based treatment drop-out definition usually concerns proportions rather than clinical relevance. However, due to the fact that there is no consensus on a drop-out definition we chose a definition resembling Bados et at., (2007); a pragmatic and clinically relevant definition. One review on internet-based ED treatment reported that some distinguish between study- and treatment drop-out (Dolemeyer et al., 2013). In studies on traditional ED treatment early and late drop-out has been examined (Fassino et al., 2009b), as well as whether failure to engage should be considered a drop-out category of its own (Bell, 2001; Waller, 1997; Watson et al., 2013).

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Treatment drop-out is common among psychiatric patients generally but especially so regarding ED (Swift and Greenberg, 2014; Zaitsoff et al., 2015). However, there is a large variation. One review found drop-out rates from internet-based ED treatment to be 9%–47.2% (Dolemeyer et al., 2013) and another reported 5%–24% (Beintner et al., 2014). Two other studies on ICBT, specifically Salut BN (see below), showed drop-out rates to be 82% (Nevonen et al., 2006) and 45% (Fernandez-Aranda et al., 2009), respectively. Taken together, rates roughly compare to drop-out rates from traditional ED outpatient treatment with rates ranging from 29%–73% (Fassino et al., 2009a,b). Although the problem has been long known, it has still not been solved; on the contrary some authors suggest that drop-out rates from ED treatment studies more than doubled during 1993–2009 (Campbell, 2009).

Drop-out may be problematic for a number of both clinical- and research reasons. It puts a strain on health care resources since administration and clinical assessments are both time-consuming and costly and efforts may be in vain should the patient choose to end prematurely. The administration around drop-out causes delay for other patients who wait for treatment (Watson et al., 2013). It is also possible that patients who drop out because they are somewhat improved would have reached an even better outcome had they remained in treatment, and that patients who drop out because they do not perceive the treatment to be effective would nonetheless have improved had they persisted. Also, high drop-out rates make it difficult to assess treatment effectiveness (Hoste et al., 2007).

As for treatment outcome however, drop-out from ED treatment is not necessarily negative for the patient (Schnicker et al., 2013). Regarding traditional ED-treatment, one review concluded that drop-outs often had better outcome at follow-up compared to completers (Fassino et al., 2009b). One study found that 71% of outpatient drop-outs were improved at a 2–5 year follow-up (Di Pietro et al., 2002), and another found outcome for drop-outs and completers not to be significantly different at follow-up, although completers had made a significantly greater clinical improvement (Bjork et al., 2009). On the other hand, others have found that patients with BN who dropped out from outpatient treatment continued to suffer from severe bulimic symptoms at 12 months follow-up (Fairburn et al., 1993). Outcome specifically for drop-outs from ICBT for EDs is yet unknown.

Results from previous research are mixed in terms of whether ED symptom severity, psychiatric comorbidity, or treatment factors predict drop-out from traditional ED treatment (Fassino et al., 2009a). For BN, longer duration of illness may be associated with drop-out (Hoste et al., 2007). There is however good evidence that personality traits such as impulsivity, low self-directedness, low cooperativeness, and borderline traits are associated with drop-out (Fassino et al., 2009b). Drop-out specifically from internet-based treatment is understudied, and previous research has emphasized the importance of more randomized controlled trials (RCT), direct comparisons of different internet-based treatments for ED (Wagner et al., 2015), and focus on personality variables such as conscientiousness and impulsivity since they may contribute to higher likelihood of drop-out due to lower tolerance for frustration, or less commitment to treatment (Melville et al., 2010).

Regarding drop-out prediction from ICBT for EDs, results have so far been inconsistent (Wagner et al., 2015). Two recent reviews showed that drop-out is associated with more pathology such as higher frequencies of binge eating and vomiting, higher drive for thinness, more shape concern, more severe comorbid symptoms of depression or anxiety (Aardoom et al., 2013), lower age, lower BMI, BN diagnosis, and higher restraint (Beintner et al., 2014). In one frequently used type of ICBT, Salut BN, predictors for drop-out have included therapist factors (Nevonen et al., 2006), more depression symptoms, lower self-directedness (Wagner et al., 2015), more anxiety symptoms, lower hyperactivity, lower BMI, lower reward dependence (Fernandez-Aranda et al., 2009), and more binges and vomiting (Carrard et al., 2006), whereas in one study no predictors were found (Carrard et al., 2011).

While focus on patient characteristics are common in drop-out studies, some have examined therapist factors in ED treatment and found that drop-out is predicted by poor therapeutic alliance (Zaitsoff et al., 2015), and the therapist's inability to listen and be understanding (Bjork et al., 2009). Dissatisfaction with the therapist has been found to predict drop-out in traditional CBT for various psychiatric disorders (Bados et al., 2007). However, since such studies have not examined ICBT it is unclear whether results can be generalized to this population.

Since research on predictors for drop-out from ICBT for EDs is scarce and findings are inconsistent, and since drop-out from traditional ED treatment has been shown to be predicted by personality traits, we explored possible predictors in both personality traits, ED symptoms, psychiatric comorbidity, and demographic variables. Thus, the aim of the current study was to explore possible predictors for drop-out from ICBT within a randomized controlled trial (RCT), with two ICBT treatments (Salut BN and BIB-ICBT) for BN and similar EDs, within specialized out-patient ED care. Although not a strict replication, the study resembles a study on Salut BN and bibliotherapy by Wagner et al. (2015).

2. Method

2.1. Participants and design

The current study was conducted within the context of an RCT (Controlled-trials.com/ISRCTN44999017) and carried out at the specialized clinic Stockholm Centre for Eating Disorders within the Stockholm county council, Sweden. The clinic provides a variety of different treatments for patients of all ages and various types of ED, and during the inclusion period enrolled about 650 new patients a year via self-enrolment or referral. 150 outpatients were recruited October 2009 through February 2013. A pocket calculator was used to allocate participants randomly to one of two types of ICBT ($N = 109$) or to a program oriented day patient program ($N = 41$). The latter was beyond the scope of the present study and will therefore not be considered further here.

Inclusion criteria required a diagnosis of DSM-IV BN, EDNOS of bulimic type, or binge eating disorder with a history of inappropriate compensatory behaviour within the past year, age ≥ 18 years, body mass index (BMI) 17.5–34, fluent Swedish, and access to the internet. Exclusion criteria were severe symptoms of depression, anxiety, or obsession–compulsion (with a maximum score of 15, 15, and 14 respectively according to the CPRS-S-A described below), drug- or alcohol abuse, suicide attempt within the past year, current suicide plans, psychosis, or concurrent participation in other ED treatment, with the exception of psychopharmacological treatment.

Non-engagers ($N = 11$) were defined as participants who failed to start treatment and were not included in the analyses. Drop-outs and completers were defined as in Bados et al. (2007): participants who terminated therapy prematurely versus finished as planned. For instance, participants who started but prematurely ended treatment either against the therapist recommendation, without informing the therapist, or without giving an explanation were defined as drop-outs. A total of 35 (36%) participants were considered drop-outs. Completers were defined as participants who completed at least the first treatment step and actively stayed in treatment either until a mutual agreement was reached to terminate treatment due to sufficient symptom reduction, until finishing all treatment steps, or until reaching the maximum allowed treatment time of 24 weeks. A total of 63 (64%) participants were considered completers.

2.2. Instruments

2.2.1. Clinical ratings

The Structured Eating Disorder Interview (SEDI) is a structured clinical diagnostic interview covering a maximum of 30 questions to assess DSM-IV ED diagnosis. A preliminary validation showed acceptable

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