RESEARCH ARTICLE

Let Eating Disorder Patients Decide: Providing Choice May Reduce Early Drop-out from Inpatient Treatment

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Abstract

Premature drop-out from treatment is a highly prevalent phenomenon among eating disorder (ED) patients. In a specialized inpatient treatment unit a major change was made in the admission strategy in 2001, giving a maximum of personal choice to the patients. A quasi-experimental research was carried out comparing 87 patients treated till 2000 ('old' strategy) with 87 patients treated from 2001 on ('new' strategy). The results indicate that the provision of choice at the beginning of treatment significantly reduced drop-out during the first weeks of inpatient treatment. No differences between both strategies on later drop-out and weight change (in anorexia nervosa patients) during inpatient treatment were found. The results are discussed in the light of the importance placed on dynamics of personal choice, autonomy and volition within the framework of the self-determination theory (SDT). Copyright © 2009 John Wiley & Sons, Ltd and Eating Disorders Association.

Keywords

autonomy; choice; drop-out; eating disorders; inpatient treatment; self-determination theory

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Introduction

Premature termination of treatment, commonly called drop-out, is often considered to be symptomatic of the difficulties in treating eating disorder (ED) patients. Drop-out is usually viewed as a sign of non-compliance, resistance or treatment failure. Most studies on this issue have focused on patient characteristics, associated with a greater likelihood of drop-out, including demographic and clinical features (e.g. Bandini, Antonelli, Moretti, Pampanelli, Quartesan, & Perriello, 2006; Swan-Kremeier, Mitchell, Twardowski, Lancaster, & Crosby, 2005; Woodside, Carter, & Blackmore, 2004), self-esteem (e.g. Björck, Björk, Clinton, Sohlberg, & Norring, 2008; Halmi et al., 2005), attachment (Tasca, Taylor, Bissada, Ritchie, & Balfour, 2004), temperamental and personality features (e.g. Dalle Grave, Calugi, Brambilla, & Marchesini, 2008; Fassino, Daga, Pierò, & Rovera, 2002, Fassino, Abbate-Daga, Pierò, Leombruni, & Rovera, 2003). With respect to inpatient treatment of anorexia nervosa patients, premature discharge was also found to be mainly related to clinical characteristics (Kahn & Pike, 2001; Masson, Perlman, Ross, & Gates, 2007; Vandereycken & Pierloot, 1983; Zeeck & Herzog, 2000; Zeeck, Hartmann, Buchholz, & Herzog, 2005). Surprisingly, few studies have paid attention to treatment characteristics or aspects of the therapeutic relationship (Clinton, 1996; Morlino et al., 2007; Vandereycken & Pierloot, 1983).

In our specialized inpatient treatment programme, for many years, we were faced with a frustrating number of drop-outs. A discussion within the team revealed some growing doubts about the adequacy of our approach,

especially with respect to the way we dealt with the patients' motivation to enter treatment. As a highly specialized unit, we accept all indications for inpatient treatment except for compulsory admissions (legally forced hospitalization). But many patients, in particular those diagnosed with anorexia nervosa, are coming under external pressure from their social surrounding (parents, friends, spouse, physicians, therapists). As a result of such pressure, some patients overtly rebel against inpatient treatment, making the admission sometimes into a serious battle, whereas others seemingly comply but just do so 'to please important others'.

Becoming more aware of the motivational issues involved, in particular the critical importance of the experience of a sense of volition or self-determination (Vansteenkiste, Soenens, & Vandereycken, 2005), we decided to change drastically our admission strategy in 2001. Whereas in the 'old' approach inpatient treatment was externally pressured with little or no personal choice, patients' personal responsibility and sense of choice were maximized in the 'new' strategy (for details, see Box 1). The aim of the present research was to compare the two strategies in terms of short-term outcome, measured by the number of drop-outs and (in case of anorexia nervosa patients) the amount of weight change during treatment. Since the newly implemented strategy was designed to increase patients' autonomous motivation to engage in treatment through the provision of choice, we expected a lower number of premature drop-outs and a quicker weight gain in the new strategy compared to the old strategy.

Method

Treatment approaches

The setting is a 35-bed unit for ED patients within a general psychiatric hospital. Patients (females only) are admitted from the age of 15 onwards and the treatment is covered by the national health insurance system. Patients usually stay for a minimum of 2 and a maximum of 6 months of which the last 4 weeks may be in day treatment. The multidisciplinary treatment programme in all its components is offered in a group format (except for a few individual sessions at admission and when necessary). All newly admitted patients start in group 1 (formerly known as 'observation group' and now known as 'motivation group'). After this pre-treatment phase, they move to the treatment groups: either to group 2 or 3 for a therapy programme focusing on the ED as main target or they go to treatment group 4 where the eating symptomatology is considered to be of secondary importance. The basic ingredients of the treatment programme and the composition of the team remained largely similar for the three treatment groups (2, 3 & 4) since 1995. The major change took place in the pre-treatment phase (group 1) in 2001.

Participants

A quasi-experimental design was used to compare both treatment strategies. An initial sample of 117 ED patients treated in the new strategy was gathered in the years 2002–2004. Next, we selected the files of patients treated between 1995 and 2000 in the old strategy to find a comparable sample. Since the new strategy was implemented in 2001, we did not include patients from that transition year. The two subsamples were matched with respect to subtype of ED (according to DSM-IV criteria), age and duration of illness. Because of insufficient matching possibilities, we had to drop 30 patients and ended up with two groups of 87 patients for each strategy. In terms of distribution across ED subtypes, each subsample consisted of 34 (39.1%) patients with anorexia nervosa restricting type, 12 (13.8%) anorexia nervosa bingeing-purging type, 28 (32.2%) bulimia nervosa and 13 (14.9%) ED not otherwise specified. Chi-square analyses indicated that the old and new treatment subsample did not differ with respect to the distribution of ED subcategories ($\chi^2(3, N = 174) = 0$, *ns*). The mean age was 21 years in both subsamples (ranging between 15–45 and 15–43 in the old and new subsample, respectively); an independent sample *t*-test indicated no difference between both groups ($t\ (172) = -.35$, *ns*). The mean duration of illness was 4.3 years in the old strategy and 4.2 years in the new strategy; in both subsamples, the great majority showed an illness history between 1 and 5 years (77.0% and 80.4%, respectively). Patients of both treatments did not differ in terms of duration illness ($t\ (172) = -.08$, *ns*). No differences between both subsamples emerged with respect to demographic variables such as family of origin (intact versus broken homes), living situation (with parents, alone, with partner) and educational level.

Since drop-out rates and weight change during treatment can be influenced by the treatment history, we compared both subsamples on this variable. As can

Comparison of pre-treatment strategies.

'Old' Strategy: The patients started in the 'observation' group 1 for 1–2 weeks including basic medical and psychosocial assessment and preparation for involvement in the treatment programme. Patients were offered standard meals with nurses encouraging them to eat and to avoid vomiting afterwards. The staff took all decisions concerning further treatment, including the choice of the treatment group (i.e. 2, 3 or 4) and the duration of treatment. The family (parents, spouse) was asked to endorse this decision and to 'motivate' the patient to stay in the treatment programme. Both staff and family used various ways to convince patients to stay in the treatment, including medical arguments (e.g. 'necessary for your health') and psychological pressure with direct or indirect guilt-inducing messages (e.g. 'an untreated ED will undermine your further development' or 'it will be a burden for your family'). If patients ran away or refused to return after a weekend at home, the family was supposed to bring them back to the hospital. In case patients continued to display low cooperation, adult patients and parents of minors had to sign a form stating they accepted complete responsibility for this 'discharge against medical advice'.

'New' Strategy: Before entering the hospital, all patients are seen by a staff member for a brief interview. If inpatient treatment is considered to be a preferable option, a short visit is made to the unit together with a brief explanation of the programme. Then the patient is proposed to come at least for an introductory week: a minimum commitment of 5 days (Monday to Friday) with the explicit promise that she will be free to leave the hospital even if her family would prefer her to stay. However, if her medical condition were at serious risk, she would be transferred to the internal medicine department of a general hospital nearby. The family receives an information package explaining the key components and rationale behind our approach and is asked to avoid any battle around the patient's decision. After 1 week, the decision of the patient is fully respected. If the patient decides to seek no further help, no attempts are undertaken to change her mind; if she prefers outpatient treatment we assist her in finding a specialist in her region; if she decides to stay after the introductory week, she enters into the 'motivation programme' including psycho-education and exploratory group sessions. In line with motivational interviewing (Miller & Rollnick, 2002), these sessions focus, among on other things, on the clarification of the patient's motivational ambivalence, thereby considering the pro's and con's of therapeutic change. As long as her physical condition is not in danger, the patient is free to eat or not, to lose weight or not; and neither do we watch the patients' use of vomiting nor taking laxatives. The general idea is to convey to the patient that it is her responsibility to take care of her health and that the decision to enter the inpatient treatment programme can better be her own. If she is interested in continuing, she can choose the treatment group (2, 3 or 4) and then passes a 'motivational test' to see whether she is ready for this programme. This includes 1-day participation in the group of choice and trying out the basic rules of the treatment programme (for example, gaining a minimum of 750 g/week and/or stopping any purging behaviour). If the patient cannot accept the basic conditions of the treatment programme or if she shows too much ambivalence at the end of the fourth week, discharge follows with the proposal that she can always come back when she feels 'she is ready for it'.

be noticed in Table 1, a chi-square difference test indicated that patients in the new strategy had been more often in outpatient therapy ($\chi^2(4, N = 173) = 29.2$, $p < .01$), whereas both subsamples did not differ in terms of the number of previous hospitalizations ($\chi^2(5, N = 174) = 4.27$, *ns*).

Outcome variables

Drop-out

Each case of non-negotiated termination of treatment, unilaterally decided by either the staff or the patient, was considered a drop-out. We made a difference between 'early' drop-outs, that is, those who stopped treatment within 1 month after admission, and 'later' drop-outs, 2 or 3 months after admission.

Weight change

In anorexia nervosa patients we calculated the evolution of body mass index (BMI) every 4 weeks from admission (baseline) to discharge. For the bulimic patients we could not use a comparable objective parameter of short-term evolution.

Table 1 Number of previous outpatient and inpatient treatments for both groups

	Outpatient Treatment		Inpatient Treatment	
	'Old'	'New'	'Old'	'New'
	N (%)	*N* (%)	*N* (%)	*N* (%)
No	2 (2.3)	4 (4.6)	58 (66.6)	53 (60.9)
1 time	52 (60.5)	23 (26.4)	16 (18.4)	19 (21.8)
2 times	18 (20.9)	25 (28.7)	10 (11.5)	7 (8.0)
3 times	10 (11.6)	9 (10.3)	1 (1.1)	2 (2.3)
4 and more	4 (4.7)	26 (29.9)	2 (2.3)	6 (6.9)

Table 2 Cumulative absolute number and cumulative percentage of patients dropping out as a function of treatment strategy

	'New'		'Old'	
	N	%	*N*	%
Total	20	23.3	20	23.5
<1 month	2	2.3	8	9.4
<2 months	9	10.5	12	14.1
<3 months	14	16.3	16	18.8
<4 months	17	19.8	16	18.8

Results

Drop-out

We obtained drop-out information for 171 out of 174 ED patients. Because of the small number of patients that dropped out of therapy based on the staff's unilateral decision ($N = 7$; 4.1%), they were collapsed with the patients who decided themselves to quit treatment. Across both types of treatment, 40 patients prematurely terminated treatment (21.4%): 10 (5.8%) patients before the end of the first month, 21 (12.3%) before the end of the second month, 30 (17.5%) before the end of the third month, 33 (19.3%) before the end of the fourth month.

Using a logistic regression analysis, we tested whether dropping-out from treatment was predicted by treatment strategy, number of previous inpatient and outpatient treatments, and duration of illness. The cumulative absolute number and relative percentage of drop-outs in both treatment programmes can be found in Table 2. Figure 1 graphically displays these percentages. As can be noticed, the percentage of early drop-outs was considerably higher in the old compared to the new treatment programme. This trend was statistically confirmed in the regression analyses (Table 3). Drop-out before 1 month of treatment was found to be significantly predicted by the inserted independent variables ($\chi^2(1, N = 171) = 21.24$, $p < .001$). Specifically, type of strategy and number of previous outpatient treatment were significantly related to drop-out in the first month, with patients being involved in the new treatment having a lower chance of premature drop-out and patients being more often engaged in outpatient treatment having a higher chance of premature drop-out. Neither the overall model for the subsequent months nor the overall drop-out model was found significant.

Weight change

The average BMI at each measurement can be found in Table 4 and the trends in BMI increase in both strategies are graphically displayed in Figure 2. To examine differential change in weight gain among anorexia patients ($N = 46$), we performed a series of repeated measures ANOVA-analysis. A first ANOVA, including entrance BMI as a baseline measure and termination BMI as the outcome measure, indicated a significant increase in weight during treatment period, although

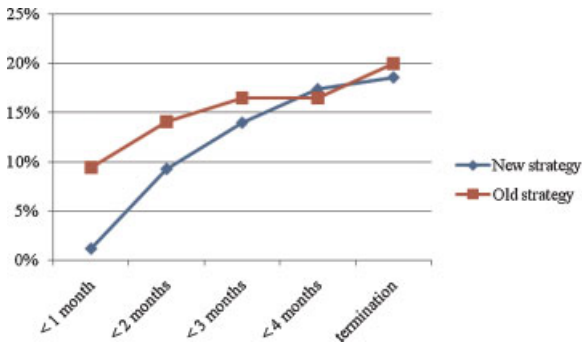

Figure 1 Cumulative absolute number and cumulative percentage of patients dropping out as a function of type of treatment strategy

Table 3 Logistic regression analyses predicting the chance of drop-out from treatment ($n = 171$)

	Total period	<1 month	<2 months	<3 months	<4 months
New vs. old strategy	.19	5.73*	.76	.41	.78
Duration of illness	.68	.29	1.18	.22	.36
Outpatient treatments	.10	.78	.13	.72	.78
Inpatient treatments	1.93	4.31*	.97	.10	.11

*$p < .05$; **$p < .01$.

Table 4 Means and standard deviations of BMI in anorexia nervosa patients at different moments of the two treatment strategies

	'New'		'Old'	
	N	*M* (*SD*)	*N*	*M* (*SD*)
Admission	46	14.77 (7.92)	46	14.63 (1.88)
1 month	41	16.25 (1.79)	42	15.87 (1.76)
2 months	37	17.33 (1.55)	37	16.93 (1.74)
3 months	29	18.20 (1.47)	30	17.83 (1.62)
4 months	26	18.86 (1.27)	26	18.49 (1.37)
5 months	22	19.12 (1.20)	21	18.99 (.95)
6 months	11	18.81 (1.29)	11	19.03 (1.10)

Table 5 Repeated measures ANOVA analysis predicting weight gain by time and time by strategy among anorexia nervosa patients for total and separate time periods

		Time effect		Time × strategy effect	
	N	F-value	Effect-size	F-value	Effect-size
Total period (weeks)	90	130.42**	.60	.00	.00
Separate time periods					
0–4 weeks	83	293.99**	.78	.03	.00
4–8 weeks	74	367.56**	.84	.75	.01
8–12 weeks	59	246.38**	.81	1.11	.02
12–16 weeks	52	56.18**	.53	.19	.00
16–20 weeks	43	7.08*	.15	.23	.01
20–24 weeks	22	4.73*	.19	2.63	.12

* $p < .05$; ** $p < .01$.

weight change was not moderated by type of treatment. These results can be found in Table 5. In subsequent analyses, we examined possible increases in weight gain over every consecutive 4-week period. In each case, a significant time effect of weight increase but no significant time by treatment strategy interaction was found.

Discussion

Within self-determination theory (SDT; Ryan & Deci, 2000), the experience of a sense of autonomy or volition with respect to one's behaviour represents a critical condition to foster the personal endorsement (i.e. internalization) of therapeutic change (Vansteenkiste & Sheldon, 2006; Vansteenkiste et al., 2005). When patients fully stand behind their decision to initiate and remain in treatment, they are less likely to drop-out, they should make greater therapeutic progress and display elevated well-being compared to when they feel forced to do so (Zuroff, Koestner, Moskowitz, McBride, Bagby, & Marshall, 2007). Although personality and (clinical) background variables are no doubt important in fostering change, the

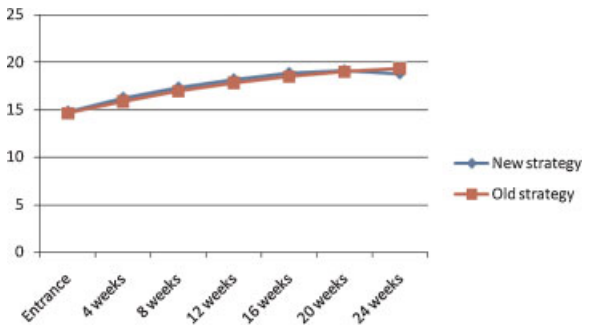

Figure 2 Means and standard deviations of BMI on different measurement moments as a function of treatment strategy

therapeutic environment can be more or less conducive of patients' basic need for autonomy. Within SDT, it is suggested that autonomy-supportive agents work as much as possible from the patients' internal frame of reference (Ryan & Deci, 2008). This can be achieved by taking an empathic stance, providing the desired amount of choice, the giving of meaningful rationale in case choice is constraint and the avoidance of pressuring language (Deci, Eghrari, Patrick, & Leone, 1994).

The present quasi-experimental study focused on one particular component of autonomy-support, that is the provision of choice with respect to entering a special treatment programme. The findings showed a significantly lower drop-out in the new approach, which is characterized by a greater degree of choice provision. This benefit was, however, limited to the first month of inpatient treatment and no differential impact was found on weight changes in anorexia nervosa patients. Since the primary difference between the old and new treatment programme involved the initial phase ('pre-treatment'), changes had to be expected first in the beginning of treatment. The fact that the drop-out rate after 1 month did not differ can be explained by the fact that the basic elements of the group treatment programme remained the same. This includes, for example, an expected minimum weekly weight gain in anorexics, which reflects a kind of external pressure to change. As such this partially pressuring approach, in contrast to the new pre-treatment strategy, seems to restrict the patients' sense of personal choice. A truly autonomy-supportive stance with respect to weight issues would involve the provision of choice with respect to the amount of desired weekly weight gain. This consideration is also shedding new light on the interpretation of weight changes in the early phase of treatment. If given a choice, anorexia nevosa patients appear to be able to increase their weight at a similar rate as patients do under external pressure. An interesting research question for the future would be: does this make a difference on the long run, for example, in terms of maintenance of weight changes?

Although drop-out is generally considered as a signal of poor compliance and/or, treatment failure, this not necessarily needs to be the case. Patients can decide to stop treatment for various reasons, including defiance against external authority figures that force them into treatment, a lack of confidence to make therapeutic change, or because the treatment programme does not meet the patients' needs or expectations. No qualitative distinction between different types of drop-out was made in the current project. Such a differentiation is, however, of critical importance because different treatment programmes might not only affect the number (i.e. quantity) of drop-outs but also the type (i.e. quality) of drop-outs. We would hypothesize the provision of choice to cause more self-chosen and less rebellious drop-out, a phenomenon highly prevalent among ED patients (Vitousek, Watson, & Wilson, 1998). Moreover, different reasons for dropping out are likely to yield a differential effect upon patients' decision to seek further treatment, with rebellious versus personally endorsed withdrawal being likely predictive of seeking less versus more subsequent help, respectively. In fact since we adopted our new strategy, we have seen many more patients coming back afterwards with a renewed treatment request. They had received our message: 'the door is always open when you feel ready for it'. In contrast, much fewer patients from the old strategy would return to us; they had left the hospital 'against advice' and sometimes in a battle atmosphere. If they were ready to engage into treatment, they more likely would prefer another setting than ours. These are only impressions we would like to corroborate in a follow-up study.

This brings us to a few limitations of the current project. First, the comparison was limited to short-term outcome only. As already suggested above, it would be interesting to follow-up the changes during the whole treatment process and afterwards. Moreover, it would have been better to include a measure of motivation, perceived volition and choice to examine whether the increased experience of autonomy in the new, relative to the old, strategy can account for the decreased drop-out. Further, no distinction was made between qualitatively different types of drop-out such that it remains to be seen whether the provision of choice results not only in a decreased number but also in different types of drop-out. Finally, a randomized clinical trial would have been the ideal design. But such a comparison is almost impossible to organize within the same treatment setting using a group treatment approach (see Vandereycken, 2003). Hence, we felt we had no other choice than this quasi-experimental design. We realize, however, that certain differences in outcome might be due to a cohort-effect or to changes in the clinical team rather than to the change in the treatment approach itself.

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