ABANDONO TERAPÉUTICO EN TCAs.
Factores y nuevas perspectivas

1.La ambivalencia

2. El término

DROPOUT

Interrupción no consensuada del tratamiento por parte del paciente o alta del mismo (por parte del equipo terapéutico)debido a la incapacidad del paciente para conseguir sus metas terapéuticas. Carter O. et al ,2012

- Cambio del lugar de tratamiento
- Cambio de domicilio
- Abandono por mejora clínica
- Abandono por falta de resultados
- Abandono por dificultades con el terapeuta

3.Las cifras

DROPOUT

Ingresados
20-51%

No ingresados
29-73%

Fassino et al 2009

NO ADHERENCIA TERAPÉUTICA

HTA y diabetes
50%

Asma
70%

Patología psiquiátrica crónica
60-70%

4.Razones para estudiarlo

Razones

- Pérdida de dinero y recursos
- Fiabilidad y utilidad de estudios
- Afecta a la moral del terapeuta

5.Factores implicados

Factores protectores sin clara evidencia

- Cambio positivo de síntomas en primeras fases
- Ausencia de atracones y vómitos
- Mayor motivación basal
- Menor preocupación por figura y peso
- Buena relaciones interpersonales

Factores favorecedores sin clara evidencia

- Comorbilidad
- Múltiples tratamientos previos
- Disfunción familiar
- Insatisfacción corporal
- Perfeccionismo
- Bajo nivel educacional en menores de 18 años
- Baja conciencia en mayores de 18 años
- Familia monoparental en menores de 18 años

Factores favorecedores con cierta evidencia

Historia de bajo peso

Evitar vínculos emocionales

Pasar largo tiempo en lista de espera

Factores importantes no evidenciados

- Diagnóstico
- Duración de la enfermedad
- Terapia (DeJong H. et al 2012)

Abandono
100% intervenciones dietéticas
11-57% farmacológicas
4-27% intervenciones familiares

Sobre el abandono del tratamiento en tres C.S.M.

425 historias
119 abandonos
Fernández E. et al 1996
Rev. Asoc. Esp. Neuropsiq

Clase social baja
Terapeutas menos expertos
Terapeutas masculinos
Terapeutas del mismo sexo
Terapeutas de distinta etnia

34 variables
Profesión, accesibilidad, medio,número de terapeutas, sexo , edad y titulación del terapeuta, privada previa, quién deriva...

Riesgo mayor
En primeras fases
Derivación desde privada
Derivación desde infantil

Riesgo menor
Si se confirman expectativas
Coincidencia de estilo

Factores protectores

Baja evidencia, en general

Cambio temprano de la psicopatología

Ausencia de síntomas purgativos

6. Dropout y pronóstico

Dropout y pronóstico

Mal pronóstico

- IMC bajo
- Atracones y vómitos
- Baja motivación
- Preocupación figura y peso
- Comorbilidad
- Problemas familiares
- Problemas interpersonales

Keel PK, et al 2010

Favorecen dropout

- Purgas en anorexia n.
- Baja motivación
- Alta impulsividad
- Comorbilidad
- Atracones desde inicio

Vall E. et al 2015

7. Dropout y otras cosas..

Dropout y alianza terapéutica

AN IDEA WORTH RESEARCHING

Is the Therapeutic Alliance Overvalued in the Treatment of Eating Disorders?

Amy Brown, DClinPsy[1]*
Victoria A. Mountford, DClinPsy[1,2]
Glenn Waller, DPhil[3]

ABSTRACT

In this article, we make the case for a systematic program of research into the causal relationship between the therapeutic alliance and outcomes of psychological treatments for the eating disorders. To make that case, we need to begin by considering the validity of existing assumptions about that alliance-outcome relationship. We will then suggest what research is needed to allow clinicians to structure their work to best effect (e.g., should therapists focus on establishing a strong alliance even if it means not applying more therapy-specific techniques, or should they stress the application of those techniques even when the working alliance might seem likely to be weakened as a result). Although the authors have a background in cognitive-behavioral therapy (CBT), our aim is to suggest a research base that applies to a variety of psychotherapies, allowing for common or different conclusions about the alliance-outcome relationship, depending on what the proposed research indicates. © 2013 Wiley Periodicals, Inc.

Keywords: eating disorder; therapeutic alliance; outcome

(Int J Eat Disord 2013; 46:779–782)

Chicken or Egg? Some Assumptions, and Some Early Evidence

The therapeutic alliance is one of the oldest concepts associated with psychotherapy. We would not argue whether a good alliance is necessary for effective therapy—it is vital to keep the patient engaged. The question is whether that alliance is sufficient to drive therapeutic change. It is commonly assumed that the alliance is a major nonspecific factor driving therapy outcomes, and there is some suggestion that this causal link might be the case for some therapies.[1] However, substantial exploration of the association between alliance strength and therapy outcomes does not support that assumption. Across psychopathologies and psychotherapies, the alliance-outcome correlation is about 0.22—in other words, the alliance explains about 5% of therapeutic gains.[2] Even then, more than one causal explanation is possible.[3] The alliance might indeed be causing clinical improvement: however, it is equally possible that clinical improvement is driving the alliance, or that some third factor is responsible for both. DeRubeis and colleagues[3] summarize the possible causal routes that we need to consider.

As an example, in the field of cognitive therapy for depression, a set of well-designed studies exploring the temporal relationship between therapeutic alliance and symptom change has identified a pattern at odds with that traditional assumption.[4,5] They indicate that initial symptom change leads to improvements in the therapeutic alliance, and that this change initiates a cyclical process, where the enhanced alliance predicted further symptom change. Furthermore, there was some indication that this pattern of linkage was related to the theory underlying the intervention. The aspect of the alliance that predicted symptom change in CBT was "agreement" (on goals and tasks), as one might expect with the task- and goal-oriented nature of CBT. In contrast, symptom change resulted in subsequent improvements on both the "agreement" and "relationship" elements of the working alliance, suggesting that patients feel closer to their therapist as a result of benefitting from treatment.[5]

However, despite this evidence in other disorders, there seem to be different beliefs among clinicians in the field of eating disorders. A survey of eating disorder clinicians showed that 90% endorse the belief that a strong early therapeutic alliance will result in subsequent weight gain during CBT for anorexia nervosa.[6] Moreover, many clinicians report that they are prepared, to some extent, to prioritize the therapeutic alliance over other aspects of CBT.

We recently tested this widely endorsed belief that the alliance is a causal agent in clinical

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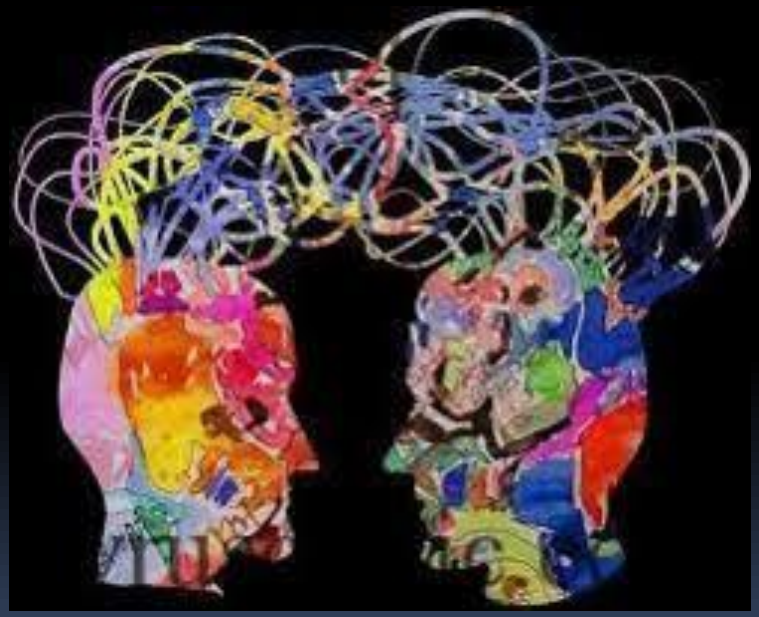

Dropout y alianza terapéutica

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- Huevo o gallina??
- Tipo de terapia e importancia
- La edad
- Refuerzo del terapeuta

Brow A. et al
Int J Eat Disord 2013, 46:779-782

Dropout por mejora

Vellisca M.Y. et al 2016

Dropout y buen pronóstico

ORIGINAL RESEARCH PAPER

What happens to eating disorder outpatients who withdrew from therapy?

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ABSTRACT. Objective: *Dropouts are frequent among eating disorder (ED) patients, but less is known about their natural history. This paper assesses the outcome of outpatients who dropped out from a therapy programme and its possible causes.* **Material and Methods:** *From 1992 to 1994, we assessed 222 ED subjects. Psychiatrists expert in EDs evaluated these subjects by defining baseline parameters and diagnosis was made according to the 3rd revisioned edition of the Diagnostic and Statistical Manual of Mental Disorders. One hundred and twenty-eight subjects (57%) dropped out during the treatment. In 1997, we contacted them, reassessed the same baseline parameters and asked for a self-judgment about their social and clinical condition during the previous 2-5 years. Patients were classified as "improved" and "not improved" (stationary or worse) according to their social, physical and psychological condition. The relation between baseline condition and outcome was determined statistically.* **Results:** *Seventy-one percent of subjects were "improved" and no deaths were recorded. A significant correlation was found between "duration of illness" and no treatment following a dropout.* **Discussion:** *The high percentage of improvement among dropouts was unexpected. Shorter duration of illness and lack of specific therapy in the improved patients suggest the existence of a subset of ED patients with acute onset and a spontaneous tendency to improve. This point obviously requires further investigation.*

(Eating Weight Disord. 7: 298-303, 2002).

INTRODUCTION

Various epidemiological aspects of eating disorders (EDs), namely incidence, prevalence (1, 2), short- and long-term outcome, prognostic factors (3-11) and mortality (12), have been investigated.

Most of those studies were conducted in English-speaking countries or Northern Europe, while a few others (13-15) have been directed to the Mediterranean area, particularly Italy. The patients concerned were often already being treated or followed-up and data were not acquired with respect to dropouts, whether from the study itself or treatment in general.

The dropout problem has long been recognized by clinicians and researchers, but its definition is disputed, and dissimilar, non-comparable percentages are thus observed. Vandeireyken et al. (16) and Kahan et al. (17), for example, reported dropout rates of 49.6% and 33.6% respectively. We have found an approximately 50% rate among outpatients with bulimia nervosa (BN) treated with group psychotherapy in the last 3 years.

This uncertainty with regard to dropouts as such is accompanied by a virtual absence of information concerning their long-tern outcome. Baran et al. (18) have indicated that premature exit from therapy is a risk factor for relapse in the first post-hospitalization year in anorexia nervosa (AN).

Investigation of the outcome of dropouts, who are always classed as a substantial ED subset, is thus of primary interest.

The study described in this paper assessed the clinical condition and social adaptation of patients who had dropped out of therapy 2-5 years earlier. Their baseline parameters were also reassessed to look for correlations with the outcome.

Key words: *Anorexia, bulimia, outcome, therapy, dropout.*

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Dropout y motivación al cambio

Eating Behaviors 13 (2012) 131–134

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Eating Behaviors

Quality of life and motivation to change in eating disorders. Perception patient–psychiatrist

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ABSTRACT

Purpose: To assess motivation to change (Mch) of patients with an eating disorder (ED) and its relationship with quality-of-life (QoL) by comparing patient and psychiatrist perceptions.
Method: Patients (n = 358) with an ED completed the disease-specific Health-Related Quality of Life for Eating Disorders (HeRQoLED) questionnaire, the Eating Attitudes Test (EAT-26) and the Short-Form Health Survey (SF-12) at baseline; 273 completed them after 1 year of treatment. The relationship between health-related quality of life (HRQoL) and the Mch stage was assessed using analysis of variance. Chi-square and Kappa statistical analysis assessed congruence in motivational change perception of the patients and psychiatrists.
Results: Higher patient-reported Mch was associated with higher HRQoL at the study beginning and end but not using the patient Mch as perceived by the psychiatrist. Initially, the patient and psychiatrist perceptions of Mch differed (kappa coefficient, −0.01); after 1 year they tended to converge (k = 0.34).
Conclusions: Higher Mch and higher QoL are positively associated. However, patient and psychiatrist perceptions of Mch and the relationship with QoL differ. After 1 year of treatment, these differences decreased.

1. Introduction

A primary obstacle in treating eating disorders (EDs) is the lack of motivation to change (Mch) by patients and their ambivalence regarding treatment (Geller, Cockell, & Drab, 2001).

The transtheoretical model of Prochaska (Prochaska & Di Clemente, 1992) describes this concept well, and several authors have attempted to apply it to EDs (Blake, Turnbull, & Treasure, 1997; Engel & Wilms, 1986; Hasler, Delsignore, Milos, Buddeberg, & Schnyder, 2004; Sullivan & Ch., 2001; Vansteenkiste, Soenens, & Vandereycken, 2005; Wilson & Schlam, 2004). According to this model, patients are said to be at different disease stages based on their degree of motivation and attitude toward change.

The aims of the current study were to assess the evolution of the MCh stage in patients with an ED after 1 year of treatment and its relationship with patients' health-related quality of life (HRQoL) and with their psychopathology, and identify potential differences between patient and psychiatrist perceptions of these variables.

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2. Method

2.1. Participants and procedures

Four psychiatrists experienced with EDs from three health centers in Bizkaia, Spain, collaborated in the patient recruitment. The criteria for study inclusion were that participants were diagnosed with an ED according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994); be treated on a regular basis in one of the three centers; not have a clinically serious multiorgan disorder, cerebral organic deterioration, or acute psychosis preventing them from completing questionnaires; and agree to participate voluntarily after being informed personally by his or her psychiatrist of the details of the study and after providing informed consent. The ethics review board of each center approved the study.

A total of 435 patients fulfilled these criteria. All the measurement instruments were mailed to the participants.

During the year, each patient participated in a psychopharmacologic and psychotherapeutic treatment program consisting of cognitive behavioral therapy, nutritional orientation and counseling, psychoeducation; motivational therapy, social skills training, and therapy to modify a distorted perception of body image. Evaluation

MOTIVACION AL CAMBIO PSIQUIATRA Vs PACIENTE

	Inicio estudio		Final estudio	
Motivación al cambio	Pacientes n= 222 %	Psiquiatra n =269 %	Pacientes n =222 %	Psiquiatra n =269 %
1	1,3	21,1	0	0,37
2	4,05	52,4	4,4	2,95
3	13,9	21,5	11,6	22,5
4	50,4	4,4	56,2	45,0
5	30,1	0,37	28,1	29,1

p <0,001 según Ji cuadrado

Muñoz P.et al, Eating behaviors, 13 (2012)131-134

8. Intentos por evitarlo

Ter Huurne E.D et al 2017

9. Intentos por explicarlo

Teoría de la autodeterminación

R
Relación

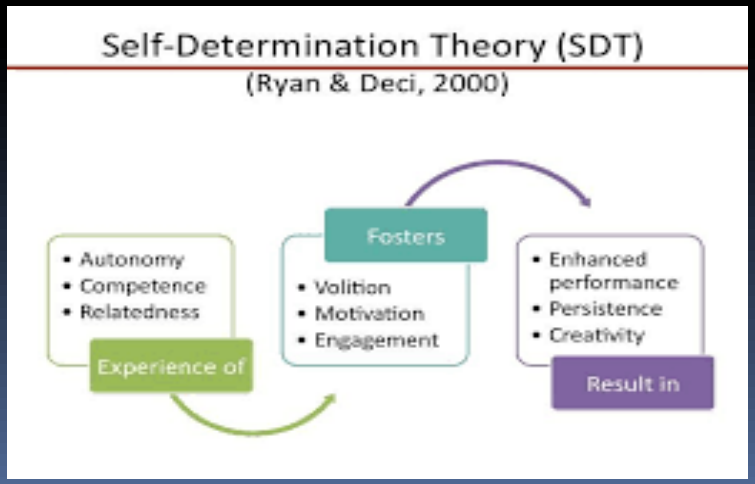
A
Autonomía

C
Competencia

Motivación intrínseca

Motivación extrínseca

Teoría de la evaluación cognitiva



Internalización

Motivación al cambio

Liderar el tratamiento
Distintas motivaciones y situaciones. Treasure 1996 y Rieger 2000
Actitud empática y diálogo abierto
Aceptación natural en la medida de lo posible