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Understanding Prior Dropout in Psychotherapy

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Abstract

Little is known about clients who, although in need of a treatment and having the opportunity to take treatment, do not start it. To explore this topic, we conducted a retrospective study comparing 37 prior dropouts with 28 clients who underwent treatment (family therapy). Results showed that prior dropout clients presented symptoms for a longer period, attended previous family therapy and previous psychiatric urgency; while clients with previous psychiatric internment presented a strong tendency not to dropout. The findings suggest that previous experiences with specific mental health assistance influence the engagement in future treatments. Recommendations are made for the use of retrospective studies based on clinical records of clients, in order to detect predicting variables of prior dropout and avoid nonresponse problems at the time of design prevention strategies.
Key words: dropout, family therapy, prevention strategies, retrospective studies

Resumen

Poco se sabe sobre los pacientes que, necesitando determinado tratamiento y habiendo solicitado su incorporación a la intervención, no logran empezarlo. Para explorar este tema, hemos realizado un estudio retrospectivo comparando 37 pacientes que abandonaron prematuramente el tratamiento con 28 pacientes que se incorporaron al mismo (terapia familiar). Los resultados muestran que los pacientes que abandonaran prematuramente presentan mayor duración de los síntomas, habían recibido tratamientos anteriores de terapia familiar y de urgencia psiquiátrica; mientras que los pacientes con ingresos psiquiátricos anteriores presentan fuerte tendencia para incorporarse al tratamiento. Estos datos sugieren que la experiencia previa en dispositivos específicos de Salud Mental influye en la adhesión a futuros tratamientos. Se sugieren estrategias metodológicas para estudios retrospectivos basados en los procesos clínicos de los pacientes, como forma de detectar variables preditivas del abandono previo y evitar problemas de no-respuesta a la hora de planificar estrategias de prevención.
Palabras-clave: abandono terapéutico, terapia familiar, estrategias de prevención, estudios retrospectivos

Understanding why people skip treatment is important: 30-40% of the patients fail to present themselves for medical appointments, thus imposing negative consequences

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upon themselves as well as the health system. In order to understand why, in general, patients abandon treatment and in order to prevent such abandoning, health psychology has extensively studied adherence to treatment. However, psychotherapy dropout literature is replete with conflicting findings, replication failures, and absence of a profile of the individuals who discontinue treatment (Di Matteo & DiNicola, 1982; Kazdin & Mazurick, 1994; Klein & Carroll, 1986; Koltun & Stone, 1986; Hays & DiMatteo, 1987; Sackett & Snow, 1979; Warzak *et al.*, 1987; Wierzbicki & Pekarik, 1993).

The inconsistency of the findings has been attributed to divergent operational definitions of dropout. Dropouts often include individuals who fail to engage treatment at different points (e.g., while waiting for treatment, after a few treatment sessions, or later in treatment). It has been argued that the characteristics of the dropout person may vary as a function of the point in time at which she terminates; therefore, dropout research should test the existence of temporal subgroups for dropout, according to the moment of its occurrence over the course of treatment (Baekeland & Lundwall, 1975; Kazdin & Mazurick, 1994). According to this recommendation, variables associated with dropout at different points in treatment have been investigated. Still, there is a lack of studies that elucidate about the patients who apply for treatment but break off the clinical contact before the first treatment session. Some exploratory studies have tried to link failure to keep initial mental health appointments with variables such as gender, age, diagnosis, geographic area of residence, socioeconomic status, length of time on a waiting list, symptom duration (Carpenter *et al*., 1981; Errera *et al*., 1965; Lowman *et al*., 1984; Otero *et al*., 2001; Weighill *et al*., 1983). The range of studied variables restricts almost exclusively to sociodemographic variables or other non-complex variables, due to the difficulty of obtaining information about this subgroup of dropout population. There usually is no contact with, or information about, patients who simply do not come. The limited range of investigated variables and the divergence of results call for studies that carefully replicate and expand the factors associated to dropouts that occur prior to treatment. By the format of the intake procedures in our psychiatric service, we could obtain information about all patients who apply for therapy, including those who failed to engage. We could therefore replicate some results (concerning some demographic and clinical variables) and investigate more complex variables associated with prior dropout (pattern of relationship with mental health services).

Another reason attributed to the discrepancy of results among dropout studies concerns the sampling criteria. There is evidence that different variables are related to adult and child dropout. Most of the existing research does not distinguish between these two groups of age, which can obscure the specific effects that differently predict dropout within these two groups and can lead to divergent results (Kazdin & Mazurick, 1994; Pekarik & Stephenson, 1988; Wierzbicki & Pekarik, 1993). As a precaution, we explored data separately in order to ascertain whether the studied variables predicted prior dropout differently for the total sample and for the sub-samples of adults and children.

The terms “dropout”, “early dropout”, “premature dropout”, and “premature terminator” have been indiscriminately used to designate patients who do not accomplish a certain number of therapy sessions (Frayn, 1992; Kazdin & Mazurick, 1994; Mohl *et*

al., 1991; Shapiro, 1974) and to designate patients who fail to engage a new treatment, not honoring the first scheduled session (Hillis *et al.*, 1993; Weisz *et al*., 1987). In order to avoid any of these divergent definitions, we use the term "prior dropout" to designate patients who ask for treatment, but fail to attend the first treatment session; including the situation where the patient attended an intake interview.

METHOD

Context of the research

The study was conducted in a psychiatric day care unit in Seville, Spain. It is a specialized mental health service that receives patients referred from other mental health services because of their clinical severity or because of their need for specialized treatments not available at the referring centers.

Participants

The participants consisted of 65 out patients, 44 women and 21 men, all white Spanish, assigned for family therapy treatment at the Unit. Thirty-seven of the participants were prior dropouts (25 women and 12 men; mean age was 30.43 years, SD = 11.08); the remaining 28 participants were randomly drawn from patients who did attend the first session of family therapy and served as a control group (19 women and 9 men; mean age was 28.93, SD = 13.70).

Procedures

In this Unit in Seville, patients are routinely submitted to an intake interview for evaluation, performed by a psychiatrist or a psychologist. A clinical file is organized for each patient, containing the intake interview report and further information gathered from different sources (patient's self-reports, collateral reports of the referring professionals, and objective measures such as urine/blood analysis, and other physiological measures).

For the purpose of this study, data were collected from these clinical files by the same person (a family therapist), not knowing in advance the dropout behavior of any participant. Additional data were collected and analyzed by Sales *et al.* (2000).

Variables

The selection of variables took into consideration its theoretical relevance, as pointed out by the literature on treatment adherence, and the limits imposed by the data offered by the clinical files. The following variables were considered:

Sociodemographic variables

Age. Age of the patient at the time of the intake interview.

Gender.

Clinical variables

Diagnosis. Diagnosis given by the intake interviewer, assuming the following categories: Anxiety disorders, depressive disorders, family conflict, non-specific food disorders, anorexia nervosa, impulse control disorders, psychotic disorders, and personality disorders.

Duration of symptoms. Number of years that symptomathology persisted.

Physical risk.This variable evaluated whether there were any risks for the patients' physical integrity, or for other family member (for instance, violent behavior involved, serious suicidal intents, etc).

Social damage for the patient. This variable evaluated whether the social life of the patient had been seriously damaged due to symptomathology (for instance, impossibility of social relations, impossibility of maintaining a professional life).

Social damage for the family. Whether social life of the patient's family had been damaged due to the symptomathology.

Problem attribution. This variable evaluated whether the patient included the family in the definition of the problem.

Variables of relationship with mental health services

Number of previous treatments.

Previous psychiatric urgency.

Previous psychiatric internment.

Previous treatments at the Day Care Unit.

Incongruence Patient-referral. Whether the information given by the patient or family about the disease was coincident with the information given by the referent.

Interviewer. Identification of the professional who conducted the intake interview.

Results

Total sample analysis

The means and standard deviations (for numerical variables) and proportions (for categorical variables) for the total sample appear in table 1. The prior dropout group and the control group were compared by means of bivariate analyses (*t* test, chi-square, and Mann Whitney test). Table 1 displays the results. Significant differences were found in four variables: Duration of the symptoms, previous psychiatric urgency attendance, previous psychiatric internment, and previous family therapy attendance.

The remaining variables do not distinguish significantly the prior dropout group and the control group. Additionally, we investigated the relationship between prior dropout and a damage index (*D*) constructed from the items *Physical Risk (PR)*, *Social Damage for the Patient (SDC)* and *Social Damage for the Family (SDF)*. It is given by the formula: $D = 9 - PR - SDC - SDF$. It intended to measure direct damage due to

disease. Higher values represented more evidence of direct damage due to diseases. This variable showed to be significantly related to prior dropout.

Table 1. Means (and Standard Derivations or Proportions) for the total sample (N=65).

Variables	Prior Dropouts (N=37)		No-Prior Dropouts (N=28)		T-test			Chi-square		
	M or %	SD	M or %	SD	t	df	p	χ^2	df	p
Age	30.4	11.08	28.93	13.70	-0.489	63	0.626			
Gender (% men)	57.1		42.90					0.001	1	0.980
Diagnosis (%)										
- Anxiety disorders	16.2		35.7							
- Depressive disorders	37.8		14.3							
- Family conflict	21.6		17.9							
- Non-specific food disorders	5.4		7.1							
- Anorexia nervosa	2.7		3.6							
- Impulse control disorders	2.7		10.7							
- Psychotic disorders	5,4		10.7							
- Personality disorders	8.1		0							
Duration of the Symptoms	5.5	0.26	1.59	1.26	-4.218	39	0.000***		1	
Physical Risk (% "yes")	16.2		28.57					1.440	1	0.230
Social Damage for the Patient (% "yes")	21.6		25.00					0.102	1	0.749
Social Damage for the Family (% "yes")	5.4		14.29					1.500	1	0.221
Number of Previous Treatments	2.2	2.2	1.6	1.6	-1.296	63	0.20		1	
Prev Psychiatric Urgency (% "yes")	18.9		3.57					3.478	1	0.062*
Prev Psychiatric Internment (% "yes")	8.1		28.57					4.747	1	0.029**
Prev Treat. At Day Care Unit (% "yes")	8.1		3.57					0.568	1	0.451
Prev Family Therapy (% "yes")	18.9		3.57					3.478	1	0.062*
Attrib. (% family inclusion)	74.2		68.18					0.229	1	0.632
Incongruence Patient-Referral (% "yes")	9.4		3.70					0.745	1	0.388
Interviewer (%)								12.857	10	0.232
A	13.5		7.1							
B	32.4		32.1							
C	5.4		10.7							
D	21.6		7.1							
E	8.1		14.3							
F	5.4		10.7							
G	10.8		0							
H	0		3.6							
I	0		7.1							
J	0		3.6							
K	2.7		3.6							
Damage (%)								5.962	2	0.051**
Level 1	73.0		50.0							
Level 2	10.8		35.7							
Level 3	16.2		14.3							

Note: *p < 0.10 **p < 0.05 ***p < 0.01

Table 2. Means (and Standard Deviations or Proportions) for child sub-sample (N=11) and for adults sub-sample (N=54).

Variables	Prior Dropout Cildren (N=4)		No-Prior Droput Children (N=7)		Prior Dropout Adults (N=33)		No-Prior Dropout Adults (N=21)		Prior Dropout Adults v.s. No-Prior Dropout Adults				
									Mann Whitney Test		Chi-square Test		
	M or %	SD	M or %	SD	M or %	SD	M or %	SD	Z	P	χ^2	df	p
Age	14.7	1.9	15.4	2.9	32.3	10.2	33.4	12.88	-0.178	0.859			
Gender (% men)	50.0		42.9		32.4		32.1				0.018	1	0.089
Diagnosis (%)											9.728	6	0.137
- Anxiety disorders	50.0		28.6		16.2		35.7						
- Depressive disorders	0		0		37.8		14.3						
- Family conflict	0		0		21.6		17.9						
- Non-specific food disorders	0		14.3		5.4		7.1						
- Anorexia nervosa	25.0		0		2.7		3.6						
- Impulse control disorders	25.0		42.9		2.7		10.7						
- Psychotic disorders	0		14.3		5.4		10.7						
- Personality disorders	0		0		8.1		0						
Duration of the Symptoms	0.8	1.0	2.2	2.0	6.1	5.3	1.4	0.82	-4.149	0.000***		1	
Physical Risk (% “yes”)	50.0		28.6		16.2		28.6				2.302	1	0.129
Social Damage for the Patient (% “yes”)	0		42.9		21.6		25				0.200	1	0.654
Social Damage for the Family (% “yes”)	0		38.6		5.4		14.3				0.224	1	0.636
Number of Previous Treatments	1.2	0.9	1.7	0.76	2.4		1.6		-1.051	0.293		1	
Prev Psychiatric Urgency (% “yes”)	50.0		14.3		18.9		3.6				3.506	1	0.061*
Prev Psychiatric Internment (% “yes”)	0		42.9		8.1		28.6				2.203	1	0.138
Prev Treat. At Day Care Unit (% “yes”)	0		0		8.1		3.6				0.351	1	0.554
Prev Family Therapy (% “yes”)	0		0		18.9		3.6				2.752	1	0.097*
Attrib. (% family inclusion)	75.0		40.0		74.2		68.2				0.032	1	0.858
Incongruence Patient-Referral (% “yes”)	25.0		14.3		9.4		3.7				1.491	1	0.222
Interviewer (%)											10.78	9	0.291
A	25.0		0		12.1		9.5						
B	0		42.9		36.4		28.6						
C	0		0		6.1		14.3						
D	50.0		14.3		18.2		4.8						
E	0		0		9.1		19.0						
F	25.0		14.3		3.0		9.5						
G	0		0		12.1		0						
H	0		0		0		4.8						
I	0		14.3		0		4.8						
J	0		14.3		0		0						
K	0		0		3.0		4.8						
Damage (%)											7.026	2	0.030**
Level 1	50.0		28.6		75.8		57.1						
Level 2	50.0		42.9		6.1		33.3						
Level 3	0		28.6		18.2		9.5						

Note: *p < 0.10 **p < 0.05 ***p < 0.01

Sub-sample analysis

In order to ascertain whether variables that predicted prior dropout varied for children and adult patients, we analyzed these two samples separately. All patients aged bellow 18 were included in the "children" sub-sample, whereas the remaining patients were included in the "adults" sub-sample. The means and standard deviations (for numerical variables) and proportions (for categorical variables) for the age sub-samples appear in table 2. The small size of children sub-sample was not suitable for bivariate statistical analysis. Instead, bivariate analysis that had been applied to the total sample was replicated for comparing prior dropout adults vs. non-prior dropout adults. Results are displayed in table 2. Significant differences were found in 4 variables: Duration of the symptoms, previous psychiatric urgency, previous family therapy and damage due to disease.

Discussion

Age and gender had no association with prior dropout for the total sample or for the adult sub-sample. The irrelevance of sociodemographic variables to all subgroups of dropout (including prior dropout) is unanimous in the adherence literature and was replicated by this study (Gaines & Stedman, 1981; Gould et al., 1985).

Patients who presented the disease for a longer period had greater tendency not to honor the appointment for the first session of family therapy. Similar results had been found for later dropout and can be explained by the tendency of people to adapt to chronic symptomatic conditions, thus underestimating their need of treatment (DiMatteo & DiNicola, 1982; Meichenbaum & Turk, 1987; Turk et al., 1985; Turk & Meichenbaum, 1991). Intermediate levels of damage caused by the disease were associated with lower rates of prior dropout behavior. This finding is of interest, given its clinical utility, and deserves further attention in subsequent studies.

Several variables of relationship with mental health services were found to predict prior dropout. Patients who had received family therapy before were more inclined not to attend the first session of a new family therapy treatment. This result replicates findings for dropout later in the treatment, and can be explained by the effect of previous unsuccessful exposures to treatment (Baekeland & Lundwall, 1975). Patients who had previously attended at a psychiatric urgency service also tended not to honor the appointment for the first session. This result is interesting when combined with another significant tendency found: Patients with previous hospitalization in a psychiatric service presented lower rates of prior dropout. Reasons for these findings are speculative, but presumably psychiatric hospitalization implies more intense suffering to the family and, consequently, family is more motivated for treatment. On the other hand, previous psychiatric urgency attendance may reveal an expectation for an immediate intervention that causes patients to move for other treatments while waiting for the first session in our service, or requesting our intervention while waiting for other treatments.

This differential pattern of effects for previous urgency and hospitalization had

not been anticipated and calls for further investigations that explore the underlying processes in detail, namely the impact of urgency attendance or hospitalization on future contacts with the mental health system in general, and family therapy in particular. It also indicates that dropout behavior must be understood in light of the patient's clinical history. This is especially relevant when we know that in a medium-long term, the majority of dropouts will ask for help again (Bueno Heredia *et al*., 2001;Sparr *et al*., 1993). A recent study on prior dropout was also performed in Sevilla (Otero *et al*., 2001) in a mental health center that frequently refers patients to our Unit. Those patients, when referred to us, will be in a different phase of their clinical path, that is, their relationship with the mental health system will be distinct from that of a person who demands professional help for the first time. It is of interest to compare results, in order to examine if variables have different effects on dropout behavior according to the phase of the patient's clinical path. In this particular case, convergence of results was found for age and gender; the remaining variables considered by both studies did not coincide and, hence, no further conclusions can be drawn.

Results suggested that dropout in adults and in mixed age sample were not differently affected by the variables studied. However, the failure to replicate age effects was probably due to the small size of the age sub-samples, as well as due to the heterogeneity of age sub-samples as to clinical variables and the relational pattern with mental health services. Therefore interpretations should be cautious and take further replications into consideration.

Conclusion

Two major conclusions result from this study. First, patients' previous experience with specific mental health assistance influence prior dropout. Therefore, a longitudinal research strategy along the clinical path of the patient is recommended for understanding dropout phenomena.

Second, prior dropout is partially governed by different factors than dropout occurring at later stages during the treatment. Such results suggest that more attention should be given to the study of prior dropout, as a distinct temporal sub-group.

Intake interviews, standardized in order to explore variables potentially associated with prior dropout, can provide a good data-collecting basis for retrospective studies, and can be an important step to the early identification of prior dropout patients and the development of effective prevention strategies.

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