Behavioural and Cognitive Psychotherapy, 1998, 26, 177–181
Cambridge University Press. Printed in the United Kingdom

Brief Clinical Reports

SOME REASONS WHY PATIENTS SUFFERING FROM CHRONIC SCHIZOPHRENIA FAIL TO CONTINUE IN PSYCHOLOGICAL TREATMENT

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Abstract. The study aimed to investigate why patients suffering from chronic schizophrenia discontinue psychological therapy. Patients who dropped out of a randomized controlled trial of cognitive-behaviour therapy and supportive counselling in the treatment of persistent positive psychotic symptoms were asked to complete a questionnaire on their reasons for doing so. Nine out of 12 patients who dropped out completed the questionnaire which consisted of 22 items that could be rated true or false. Although the size of the sample was small, the response rate was acceptable at 75%. The median number of reasons given was 7 (range 3 to 12), with the most common reason being that therapy was not perceived as suitable for the individual's particular problems. The characteristics of the patients who dropped out are described.

Keywords: Cognitive behaviour therapy, chronic schizophrenia, treatment dropout, psychological treatment.

Introduction

There is now accumulating evidence to suggest that cognitive behaviour therapy can have significant benefits in reducing persistent hallucinations and delusion experienced by schizophrenic patients (Haddock et al., in press). However, as with family interventions (Tarrier, 1991) there is a noticeable attrition rate amongst patients who enter trials of this type of therapy. In a comparison of coping strategy enhancement with problem solving Tarrier and colleagues (1993) reported that of 49 patients considered eligible for the study, 10 dropped out before initial assessment and a further 12 dropped out before or early into treatment. Failure to continue into treatment occurred for a wide range of reasons and 9 of the 22 drop-outs were because the patient refused to

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https://doi.org/10.1017/S1352465898000198 Published online by Cambridge University Press

participate (or in one case because his partner persuaded him to drop out). Thus 18.4% of eligible patients refused to participate or continue in the study.

It would be wrong to conclude that refusal to participate in such studies is because CBT is particularly unacceptable to schizophrenic patients. Indeed the opposite is probably the case. In comparison to pharmacological treatment, CBT is probably more acceptable to the majority of patients. But there are patients who refuse CBT or who drop out of treatment at an early stage. Given that this intervention may result in benefit to them, the question of why they refuse treatment is worthy of investigation. However, by the nature of the problem it is not easy to research the reasons why people have refused to participate in research! We are in the final stages of a randomized controlled trial of CBT plus routine care compared to supportive counselling plus routine care and routine care alone (Tarrier et al., 1998; Tarrier, 1997) and as part of this project we devised a short questionnaire that we gave to patients who dropped out of treatment. The questionnaire surveyed their possible reasons for discontinuation. This was a small exploratory study and we did not set out to test clear a priori hypotheses.

Method

A questionnaire was constructed that consisted of 22-items representing possible reasons for discontinuation. Items were included because they appeared plausible reasons why someone would not wish to attend treatment. In the instructions the respondent was reminded that they had been offered therapy. They were asked to read the list of reasons for not attending and asked to tick whether each item was either "true" or "false". There was no limit on the number of reasons they could affirm. There were also two open questions in which they were asked to state whether there "were any other reasons for non-attendance other than those given" and what was "the single most important reason for not attending".

Sample

Eighty-seven patients suffering from schizophrenia who experienced persistent hallucinations and/or delusions identified in a defined geographical catchment area entered the study and were randomly allocated to CBT plus routine care, supportive counselling plus routine care, or routine care alone. Twelve patients (14%) refused to continue in treatment and nine of these completed the reasons for drop-out questionnaires. Although the size of the sample is small, the response rate of 75% is acceptable. One of these patients later returned to continue with treatment. Because actual numbers of drop-outs were small we gave the questionnaire to patients who failed to continue with either CBT or supportive counselling.

Results

The results of the number of patients endorsing each reason are presented in Table 1. The median number of reasons given was 7, with a range of 3 to 12. Five respondents said that their main reason for dropping out was that they thought treatment would

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Table 1. Reasons given for failing to attend treatment

Reason for not attending	Number and percentage endorsing reason
Therapy not useful for my problem	7 (78%)
Nothing has helped in the past	6 (67%)
Talking about my problems makes them worse	6 (67%)
My symptoms no longer bother me	5 (56%)
Assessment sessions were too long	5 (56%)
I did not think I could cope with the sessions	5 (56%)
My symptoms bother me but I cannot imagine life without them	4 (44%)
It was too much trouble to attend	3 (33%)
I have got too many helpers already	3 (33%)
I did not trust the therapist	3 (33%)
I found the sessions embarrassing or thought they might be	3 (33%)
I would have preferred a different therapist	3 (33%)
My symptoms are no longer there	2 (22%)
I do not think I had any problems in the first place	2 (22%)
I was too frightened, I did not know what was going to happen	2 (22%)
I did not understand what was going on	2 (22%)
I did not like/get on with my therapist	2 (22%)
The therapist did not like me	2 (22%)
The assessment session was too stressful	1 (11%)
Someone else said that I should not attend	1 (11%)
Appointment times were inconvenient	1 (11%)
Practical reason, travel/money, stopped me from attending	0

make them worse in some way or that it would not be helpful. One respondent gave each of the following as their main reason for discontinuation: their CPN had told them that treatment was causing them to worry and that they should not attend; they were physically unwell; the patient's mother had died suddenly and they had not felt up to continuing. One patient gave a delusional elaboration as their reason. Although five respondents expressed regret that they may have let the therapist down, only one expressed regret that they were no longer attending and none wished, at this point, a further opportunity to attend.

We further examined the characteristics of these drop-outs, although we excluded from this the one patient who returned to treatment. Five of them had been allocated to CBT and three to supportive counselling. Four dropped out within the first three sessions and a further three within the next three sessions. Their mean age was 35.4 (*SD* 13.8) years, 7 (87.5%) were male, all 8 (100%) were single, 3 (37.5%) lived alone, all 8 (100%) were unskilled and unemployed, all left full-time education by the time they were 16 years of age, and they had median pre-morbid IQ on the NARTWR of 77 (IQR 29.5). They had a median duration of 8 (IQR 11) years, a median number of admissions of 3 (IQR 2). They had a median depression score of 25 (IQR 23.8) on the Beck Depression Inventory and a median score of 10.5 (IQR 10.3) on the Beck Hopelessness Scale suggesting moderate/severe levels of depression and moderate levels of hopelessness. In terms of psychopathology, five were classified as low severity and three

https://doi.org/10.1017/S1352465898000198 Published online by Cambridge University Press

as high. Their median score on the Social Functioning Scale was 98.7 (IQR 14.2) which is an average level of functioning for this population as the scale has a standardized mean of 100 and standard deviation of 15 (Birchwood, Smith, Cochrane, Wetton, & Copestake, 1990). The only significant differences between the drop-outs and the main sample was a significant lower pre-morbid IQ in the drop-outs (77 compared to 100; $z = -2.22$, $p = .03$). However, it is worth noting that the median BDI score was 10 points greater in the drop-outs compared to non drop-outs, although this difference was not statistically significant. Four suffered from paranoid delusions although only one of these patients stated that they did not trust the therapist. However, 40% of the main sample suffered paranoid delusions so these delusions do not appear to be particularly over-represented in the drop-outs. None of the patients who dropped out experienced any grandiose delusions (i.e., delusions of assistance, grandiose delusions or grandiose identity) which may have been expected in treatment refusers.

Discussion

It is clear from Table 1 that patients who drop out do so mainly because they view the therapy as not being helpful for them or because they fear it will aggravate their symptoms. This view may be driven by the belief that nothing further can be done to help them. In a few cases there was a perceived poor relationship between patient and therapist, although where this did happen it was a different therapist each time. Practical issues did not appear to be a consideration.

Patients who drop out of treatment tend to be male, unemployed and unskilled, single, with a low level of educational attainment and a low pre-morbid IQ. They have a lengthy duration of illness although at the time of discontinuation they were not necessarily severely ill and they could function at a reasonable level. They suffer both hallucinations and delusions and are likely to be quite depressed and moderately hopeless. They are as liikely as not to be paranoid, although not necessarily suspicious of the therapist. They are unlikely to experience grandiose delusions. They do not see the point of entering therapy or they worry that it will make them worse, which suggests that they have not accepted or do not understand the rationale or the potential benefits of treatment. We also observed that some staff directly responsible for the patients' care were sometimes reticent in encouraging the patient to participate and to receive a "new treatment". One of the drop outs in this study was encouraged not to attend by their CPN.

Even though these observations are largely anecdotal and derived from a small number of patients, they suggest that in clinical practice it may be advisable to be aware that patients with these characteristics are at risk of discontinuation of therapy and to address these issues at a very early stage to see whether they can be resolved and drop-out avoided.

Acknowledgment

This research was carried out as part of a study funded by The Wellcome Trust through a project grant to the first author.

https://doi.org/10.1017/S1352465898000198 Published online by Cambridge University Press

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https://doi.org/10.1017/S1352465898000198 Published online by Cambridge University Press