

will have to include both patients recently established on depot neuroleptics and patients who have been receiving it on a long-term basis.

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## Neurotic Patients who Terminate their own Treatment

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**Summary:** 40 new neurotic patients who lapsed from out-patient treatment were compared with 40 new neurotic patients who remained in treatment. The lapsed patients more often reported marital disharmony and 40% of them no longer felt ill at follow-up.

Previous studies of psychiatric out-patients who default from treatment suggest that lapse is a widespread phenomenon, which occurs in relation to almost any treatment programme. Furthermore, the proportion lapsing is with a few exceptions (e.g. Leif *et al*, 1961) similar, even in areas geographically widely separated from each other. Attempts to determine the reason for lapse have so far yielded results which are inconclusive (Brandt, 1965;

Baekeland & Landerall, 1975).

However, previous research has not included an assessment of the mental state or a social assessment after lapse. As the decision to attend for medical treatment is related to social factors (Mechanic, 1966), it is possible that social factors may also be relevant to lapse. In addition, a social assessment may indicate whether lapsed patients are at risk for a recurrence of their illness (Brown &

Harris, 1978). This research did include a post-lapse mental state assessment and social assessment.

### Method

A consecutive series of new neurotic out-patients living within the London Postal Area, who first attended out-patient clinics at the Maudsley Hospital during the same month, were studied four months after their first attendance.

The sample studied was obtained from the out-patient records of the hospital, and patients were included if they had been assigned a diagnosis of neurosis in the medical notes. The patients were categorised as 'lapsed' or 'under treatment'. A patient was designated 'lapsed' if he had not attended the hospital for two months or more and appointments had been made for him during that time. A patient was 'under treatment' if he had attended all his appointments, or had failed to attend but had resumed attendance. The notes of all new neurotic patients who fell into either of these two categories were studied, until approximately 40 patients were obtained in each group.

A patient was accepted as neurotic if his clinical picture was consistent with the definition of neurosis in the ICD 9, but no patient with depression was included if he showed evidence of delusions, hallucinations, agitation, or retardation. Patients attending for the treatment of alcoholism, drug abuse, or sexual deviancy, as well as those with evidence of organic brain disease and under 18 years of age were excluded. The patients had attended either general psychiatric out-patients, the day hospital, the emergency clinic, or psychotherapy out-patients sessions.

A letter was sent to each lapsed patient, stating that the interviewer would call, and giving him the option of not participating. Attempts were made to contact patients who had moved; patients under treatment were contacted at the hospital and were either interviewed at home or at the hospital. The time-interval between initial attendance and the research interview was approximately four months for all patients.

The data obtained from the patients was coded on five documents:

- 1 Information from case notes (e.g. age, sex, marital status etc.)
- 2 A standardised psychiatric interview (Goldberg *et al.*, 1970).
- 3 A standardised interview to assess social performance in the community (Leff & Vaughan, 1972). In this schedule, nine areas of social functioning are rated for impairment and patient dissatisfaction: viz—marital, child-rearing, other relationships, heterosexual relationships, sociability, leisure activities, household, employment and unemployment.
- 4 A schedule to assess the patient's attitude to service and contact (Leff & Vaughan, 1972).
- 5 A document recording factual information (distance travelled to the out-patient clinic, recent change of employment, recent change of address, type of home occupation, duration of illness, number of children in household, time taken to travel to the out-patient clinic).

The reliability of the author's ratings was established in co-operation with another research worker.

### Results

#### The sample

The total sample consisted of 91 patients, 50 of whom had lapsed and 41 who were still under treatment; 40 of the lapsed patients were interviewed, while ten patients either refused interview or were untraced.

Of the 41 patients under treatment, 40 were interviewed, while one refused interview.

Of the patients, 43 (47%) were aged under 30, 62 (68%) were female, 31 (34%) had a family history of mental illness, and 31 (34%) a previous history of mental illness. The duration of symptoms prior to referral was over six months in 46 (52%) of the patients and under one month in 13 (14%). Thirteen (14%) of the patients were self-referred, 65 (71%) were referred by their general practitioners and 7 (8%) referred from another hospital.

Half the patients initially attended the Emergency Clinic and half an out-patient clinic; 28 (31%) of the lapsed patients attended only once or twice.

#### Comparison of 'lapsed' patients with those 'under treatment'

No significant difference was found between the two groups for the following variables: age, sex, marital status, nationality, social class, family history of mental illness, past history of mental illness, duration of symptoms before key referral, mode of referral. Significantly more patients in the group under treatment had a diagnosis of phobic neurosis or were under treatment with behaviour therapy or benzodiazepines. Significantly more lapsed patients were not receiving any treatment ( $n = 8$ ) or were referred to the Emergency Clinic.

#### Status of patients four months after key referral

No difference was found at follow-up in the number or severity of symptoms in the two groups. Approximately 25% ( $n = 9$ ) of the lapsed patients were symptom-free and 40% ( $n = 17$ ) no longer felt ill. The social performance of the patients in the two groups was similar, except that the mean marital impairment scores and the dissatisfaction scores were significantly greater in the 'lapsed' group ( $P < 0.01$ ) (Table I).

TABLE I  
Marital performance scores

	Lapsed patients	Patients in treatment
a) Mean impairment score	4.62**	2.57
b) Dissatisfaction scores	<i>n</i>	<i>n</i>
None	9 (18.0%)	15 (36.6%)
Moderate	8 (16.0%)	5 (12.2%)
Severe	9 (18.0%)	1 (2.4%)
TOTAL	26 (52.0%)	21 (41.2%)

\* $P < 0.05$  \*\* $P < 0.01$ .

The total number of married patients was 51, but four were in the group that could not be interviewed.

TABLE II  
Reasons given by patient for lapse

Reason for lapse	No of patients	Reply to: "Are you sorry you stopped attending?"	
		Yes	No
1. Recovered	17	2	15
2. Domestic reasons	8	6	2
3. Distance	3	1	2
4. Did not think treatment would help	3	2	1
5. Change of doctor	2	2	0
6. Spouse needed treatment	2	0	2
7. Never been ill	1	0	1
8. Did not wish to recall childhood	1	0	1
9. Tablets made patient tired	1	1	0
10. Didn't receive appointment	1	1	0
11. No reason given	1		
	40		

#### Attitudes to service and treatment

Significantly more patients in the 'in-treatment' group expressed satisfaction with the treatment they received at the hospital. Fourteen patients who had lapsed said that their appointments were inconvenient, but few other criticisms were made; 11 expressed regret that they had stopped attending the clinic, and four were uncertain. These 15 patients had persistent symptoms. Approximately half of the patients who had lapsed wanted further treatment and of those with symptoms, nearly one-third wanted further hospital treatment. Significantly more of the lapsed patients had changed their address, but this did not appear to explain their lapse.

The reasons the patients gave for their lapse are listed in Table II. Those patients who lapsed because they felt well had few symptoms.

#### Discussion

The sample is small and 20% of the lapsed out-patients could not be interviewed; this represents an unavoidable source of bias often encountered in research of this kind (e.g. Greer, 1961; Kaeser & Cooper, 1971). A time interval rather than the number of hospital attendances was used in defining lapse because this was felt to be more relevant if the patients had recovered. The study was undertaken by one investigator and was not blind. However, observer bias or a halo effect are unlikely to account for the findings.

The sample resembles that of new neurotic out-patients attending hospital (Hare, 1971). Several clinics at this particular hospital specialise in the treatment of phobic disorders, and therefore the number of phobic patients in the total sample was large. This could explain the large number of patients in the 'in-treatment' group with phobic disorders and the large number in the 'in-treatment' group receiving behaviour therapy. More lapsed

patients initially attended the emergency clinic (Mindham *et al.*, 1973), and a similar finding has been reported by other workers (Taylor *et al.*, 1977). Nearly 30% of the lapsed out-patients reported that their appointments were inconvenient (mainly difficulties in making child-care arrangements and leaving work (c.f. Cartwright & Jeffries, 1958; Hare & Shaw, 1966; Brown *et al.*, 1975). However, these problems did not appear to be the cause of the lapse of most patients in this study. The reasons given for non-attendance should be viewed cautiously (Groid & Hill, 1962).

Fourteen of the lapsed out-patients were receiving treatment from their general practitioners, and two-thirds were dissatisfied with this. Only one of the patients had attended other hospitals and only three had visited social workers. This suggests that they did not identify the source of their dissatisfaction with the hospital; the fact that so few were attending social workers is surprising in view of the fact that so many had marital problems. When the lapsed patients were asked "was there anything you would like the hospital to have done that they did not do?", none of them asked for help with marital problems. It is of interest that Brown found that many of the women with depressive disorders in the community who failed to attend at all for treatment had poor marriages.

In conclusion, it is tentatively suggested that the lapse of these patients might be related to social factors. The fact that their marriages were poor suggests that they may be at risk for a recurrence of their illness (Brown *et al.*, 1975) and had the informality of the emergency clinic not been available, it is possible that many would have remained untreated in the community. Brief contact with the doctor can be sufficient to alter a

patient's attendance pattern (Skuse, 1975; Duehn & Procter, 1977; Tracey, 1977) and a discussion of the patient's expectations of treatment at the first out-patient appointment might reduce lapse. It is also possible that single-session interventions might be indicated with many of these patients. Finally, it might be worth writing to the lapsed patients to ask why they had stopped attending. The general practitioner could then be told which of his patients

had recovered, which were still ill, and which were likely to relapse. If patients of this kind require further treatment, it might best be undertaken at the primary care stage (Cooper *et al*, 1975; Johnson & Goldberg, 1976).

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