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Patient factors predicting early dropout from psychiatric outpatient care for borderline personality disorder

Chiara De Panfilis [a,*], Carlo Marchesi [a], Chiara Cabrino [b], Alberto Monici [b], Virginia Politi [b], Matteo Rossi [b], Carlo Maggini [a]

[a] Section of Psychiatry, Department of Neuroscience, University of Parma, Parma, Italy
[b] Post-Graduate School of Psychiatry, University of Parma, Parma, Italy

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ABSTRACT

Despite obvious clinical need, factors underlying early treatment discontinuation among 'real world' borderline personality disorder (BPD) patients are still unknown. This study investigates individual characteristics that can predict early (< three months) dropout among BPD outpatients at a general psychiatric service. Out of a sample of 1437 consecutively treatment-seeking psychiatric outpatients, 162 BPD subjects have been identified by means of the Structured Interview for Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) Personality. Sociodemographic, clinical and personality variables potentially relevant for dropout were assessed for all participants at baseline. Early dropouts ($n=54$) were compared to continuers ($n=108$) on all measures. Logistic regression was then used to identify independent predictors of early dropout. A history of suicide attempts predicted early discontinuation, whereas the presence of an eating disorder and of avoidant personality features protected from early dropout. If confirmed, these findings may help clinicians operating in general psychiatric settings with estimating the risk of premature treatment discontinuation, and stress the need to specifically address suicidal behaviours in order to improve treatment retention among borderline outpatients. In this regard, implementing general psychiatric care with specialised, evidence-based psychotherapeutic interventions may be deemed necessary.

1. Introduction

Patients with borderline personality disorder (BPD) are notoriously hard to engage in treatment. Satisfactory treatment compliance is difficult to achieve, and high dropout rates (15–77%) have been reported in all treatment settings, including hospital-based treatments (Gunderson et al., 1989; Skodol et al., 1983), community treatment by experts (Doering et al., 2010; Linehan et al., 2006), structured general psychiatric management for BPD (Bateman and Fonagy, 2009; McMain et al., 2009), treatment as usual conditions (Davidson et al., 2006; Verheul et al., 2003; Farrell et al., 2009) and in research settings (Kelly et al., 1992; Links et al., 1990). Most strikingly, dropout rates are not ideal even in specialised, empirically supported, effective psychotherapies for BPD, with a high degree of heterogeneity in completion rates between studies and an overall dropout rate of 25% for interventions of < 12 months' duration, and 29% for longer interventions (Barnicot et al., 2011).

Thus, premature treatment termination is a prevalent and ubiquitous problem for BPD. Insight into patient factors related to dropout at the initial assessment may directly help clinicians identify which patients are likely to have difficulty continuing with treatment; in turn, this could facilitate the development of strategies to reduce premature termination (Clarkin and Levy, 2004).

However, available empirical data on BPD patient characteristics that may predispose them to dropout are often contradictory. A broad range of variables have been reported to be involved, but for most of them a significant effect in one study stands in contrast to an inverse or absent effect in another. Potential predictive variables include: (1) sociodemographic variables (younger age, low education and occupational status) in some studies (Smith et al., 1995; Perroud et al., 2010; Nysaeter et al., 2010) but not others (Barnicot et al., 2011); (2) personality and psychological variables (lack of motivation for change, higher initial anger-hostility, impulsiveness, anxiety, experiential avoidance, schizoid traits and narcissistic features) (Soler et al., 2008; Heinssen and McGlashan, 1988; Kelly et al., 1992; Black et al., 2009; Rüsch et al., 2008; Smith et al., 1995; Clarkin et al., 2001; Perroud et al., 2010; Yeomans et al., 1994); (3) clinical variables comprising symptom severity (more or less baseline psychopathology) (Gunderson et al., 1989; Kelly et al., 1992;

* Correspondence to: Dipartimento di Neuroscienze, Sezione di Psichiatria, Università di Parma, c/o Ospedale Maggiore, pad. 21 Braga, viale A. Gramsci 14,43126 Parma, Italy. Tel.: +39 0521 903594; fax :+39 0521 347047.
E-mail address: chiara.depanfilis@unipr.it (C. De Panfilis).

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Rüsch et al., 2008; Skodol et al., 1983), treatment history (more or less prior psychiatric treatment depending on the studies) (Gunderson et al., 1989; Kelly et al., 1992) and co-morbidity variables (substance use disorder) (Kelly et al., 1992).

Furthermore, studies that systematically addressed this issue are rare and highly heterogeneous in terms of sample composition, outpatient vs. inpatient settings and type of treatment delivered (mainly various forms of psychotherapies). To the best of our knowledge, no study has specifically investigated which patient variables are related to dropout from general outpatient psychiatric services in 'real world' BPD subjects receiving treatments as applied in current practice. A deeper understanding of this phenomenon is mandatory for several reasons. First, BPD is frequently diagnosed among outpatients attending general psychiatric settings (Zimmerman et al., 2005). Second, despite specific psychotherapeutic interventions for BPD recommended as the primary treatment (American Psychiatric Association (APA), 2001; National Institute for Clinical Excellence (NICE), 2009; Oldham, 2005), most patients with BPD are not receiving such specialised treatments due to their cost and complexity, and are currently treated with non-specialist standard psychiatric treatments (Bateman and Fonagy, 2009; Gunderson, 2009). Third, there is evidence that some forms of structured general psychiatric management improve BPD outcome (Bateman and Fonagy, 2009; McMain et al., 2009). Fourth, dropout frequency among outpatient psychiatric services users may be substantial, varying between 17% and 82% (Edlund et al., 2002; Glyngdal et al., 2002; Morlino et al., 1995; Rossi et al., 2002; Reneses et al., 2009). Therefore, premature withdrawal from treatment is a significant hindrance to the delivery of effective mental health services for BPD, and insight into predictors of dropout would help clinicians to improve the quality of psychiatric care for borderline patients.

Finally, previous studies also differed with respect to the definitions of dropout adopted, making the research findings difficult to compare. In the course of outpatient psychosocial treatments, the dropout risk is highest at initial appointments (Carpenter et al., 1981), and early discontinuation is associated with a poorer outcome than late dropout in both mixed (Baruch et al., 1998; Hynan, 1990; Pekarik, 1992; Reis and Brown, 1999) and BPD samples (Kelly et al., 1992; Waldinger and Gunderson, 1994). In the context of psychiatric services, cost-effectiveness may suffer when funding assessment and treatment sessions for those who eventually drop out early. Thus, focusing on early premature withdrawal is particularly relevant when studying predictors of attrition from outpatient psychiatric treatment for BPD.

This study evaluates patient characteristics that can predict early (< three months) dropout of treatment by borderline outpatients seeking treatment at a general psychiatric service. Patient variables were selected based on past research on factors that may influence dropout in BPD (i.e., historical, sociodemographic, severity, co-morbidity and personality variables).

2. Methods

2.1. Sample recruitment and procedure

Participants were recruited from individuals consecutively seeking outpatient treatment at the Psychiatry Unit of the Parma University Hospital in Parma, Italy, between September, 2004 and August, 2007. The psychiatric unit caters to people with all kinds of psychiatric diagnoses. Patients are generally either referred by their general practitioner or by other specialists. After the first visit, patients can be recommended for subsequent psychiatric care where clinically necessary; if not, they are returned to their family physician or sent to other specialist services for ongoing care.

The study sample was recruited (Fig. 1) among all new outpatients admitted to the unit during the above specified period ($n=1437$). A new patient was defined as one who had not been in contact with the psychiatric unit during the past six months, in agreement with administrative conditions of the outpatient services of the hospital. However, patients admitted for just one consultation ($n=311$) were excluded *a priori*, as were patients <18 and >65 years of age ($n=269$), patients with cognitive impairment and language barriers that would impede completion of diagnostic interviews ($n=41$) and patients presenting with current substances/alcohol intoxication or withdrawal ($n=14$). The remaining subjects ($n=802$) were asked to take part in a follow-up study on treatment attrition among psychiatric outpatients. Patients who agreed to participate ($n=592$) then underwent a thorough baseline assessment with a psychiatrist or an expert resident in clinical psychiatry, following a full explanation of the study and after having signed informed consent. All individuals who did not have a diagnosis of mental disorder due to medical conditions, bipolar I disorder, schizophrenia, schizoaffective or delusional disorder at the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, fourth edition text revision (DSM-IV-TR) Axis I disorders Research Version (SCID-I/P-RV) (First et al., 2002) and who met BPD criteria at the Structured Interview for DSM-IV Personality (SIDP-IV) (Pfohl et al., 1997) were finally included in the current investigation ($n=162$) (Fig. 1).

The type of outpatient treatment delivered to BPD patients at the study site consists of general psychiatric care, including symptom-targeted prescription of psychotropic medications (APA, 2001) and supportive psychotherapeutic interventions. Individual psychiatric visits for BPD patients were usually scheduled every three weeks. Psychoeducation sessions for family members were usually included in the treatment programme, if the patient agreed. Although the unit belonged to a university-based hospital, it practiced close collaboration with the local community-based Department of Mental Health (DMH) that, according to the Italian community psychiatry system, is in charge of planning and coordinating all mental health interventions provided to patients from a defined catchment area. Aside from clinical psychiatric management the DMH offers, when appropriate, different types of services provided by multidisciplinary teams (psychologists, nurses, social workers, educators and personnel with specific training in psychosocial rehabilitation) that are articulated in an individually tailored, ongoing treatment plan. Partial or full-time psychiatric hospitalisation can also be prescribed when considered clinically necessary (Piccinelli et al., 2002).

Thus, the type of care available to the current study participants reflects what is usually provided in Italy by the National Health Service (Servizio Sanitario Nazionale, SSN). The fee is almost entirely paid by the SSN; however, no specific form of empirically supported psychotherapy for BPD is offered.

2.2. Baseline assessment

2.2.1. Historical and sociodemographic variables

Information about family and personal history (psychiatric disorders in the family, numbers of previous psychiatric hospitalisations and suicide attempts and history of self-injuries) as well as sociodemographic data (educational, living, marital and occupational status) were collected from patients, family members, existing clinical records and the Local Health Agency register. Suicide attempts were defined as any suicide-related act with at least some intent to die that, at minimum, resulted in mild medical threat. Self-injurious behaviours were defined as all behaviours that involve deliberated infliction of direct physical harm to one's body with no intent to die as a consequence of this behaviour.

2.2.2. General severity variables

Current levels of functioning and clinical global severity were evaluated by means of the Global Assessment of Functioning (GAF) Scale (American Psychiatric Association (APA), 2000) and of the Clinical Global Impression scale-Severity (CGI-S) (Guy, 1976).

2.2.3. Personality variables

Personality variables were evaluated with the SIDP-IV (Pfohl et al., 1997), which is a well-regarded structured PDs interview to be adopted in BPD research practice (Zanarini et al., 2010b). The SIDP-IV assesses each of the criteria for all PDs with one or more questions, which are then rated on a 4-point scale (0=not present; 1=subthreshold; 2=present; and 3=strongly present). It requires that the criteria must be present and pervasive (scores ≥ 2) for most of the last five years to count toward a diagnosis. In this study, apart from establishing a BPD diagnosis, baseline SIDP-IV results were used to assess the number and type of BPD criteria endorsed by each patient, the prevalence of co-morbid PD and the number of endorsed criteria of other PD. Four experienced residents in psychiatry administered the SIDP-IV to the study participants. Training consisted of a review of the scoring of the interview and of DSM-IV criteria for Axis II disorders, and afterwards included a series of conjoint interviews, either conducted by a psychiatrist and observed by the raters or conducted by the raters and observed by the psychiatrist. All protocols were scored independently and were then followed by a discussion about the interview style and the rationale for scoring the criteria until a consensus was reached. Inter-rater reliability for a BPD diagnosis was then assessed using five more conjoint interviews that were rated by the four independent raters (median $\kappa=0.82$). During the course of the study, the raters met regularly with the first or second author to review the scored protocols and discuss uncertainties.