

Methods

Setting

The naturalistic sample of $N = 1,056$ patients is based on data from the University Outpatient Clinic of Trier, Germany. Treatment was based on cognitive-behavioral therapy including interpersonal elements. This integrative approach contained elaborate diagnosis tools during the indication-, process- and follow-up-period. Instruments that were used in this study will be explained below. A detailed description of the clinic and the process can be found in Lutz, Mocaanu and Weinmann-Lutz (2010).

Prior to the first session with the designated treating therapist, each patient is going through a clarification process. It starts with different diagnosis questionnaires, which are handed out before the first session. The first session is designed to get initial information about the patient and to give him an overview about the therapy in the polyclinic. To get valid diagnoses a session including a structured clinical interview is administered in the second session (Wittchen, Wunderlich, Gruschwitz, & Zaudig, 1997). Based on all gathered information a team of experienced therapists decide whether a therapy is indicated and which therapist should treat which patient. One objective is that each therapist should treat equally distributed impaired patients and that the diagnoses are also spread across the therapists. The first meeting with the treating therapist is at session three. Because of this procedure, only patients who had at least three sessions were included in this sample.

Therapists

With each therapist having seen at least 10 patients, the sample consisted of $N = 1,056$ patients and $N = 58$ therapists. The mean number of patients per therapist was 18.2 ($SD = 6.8$) with a range from 10 to 43. Treatment was given by therapists in education under supervision or by therapists who had already finished their formal education. $N = 46$ (79.3%) of the therapists were female.

Patients

The data for age and gender of the patients was available for 97.3% ($N = 1,004$) respectively 95.1% ($N = 1,028$). The mean age of the outpatients was 35.6 ($SD = 12.8$; range: 15 - 74) of whom 67.4% were female. Based on structured clinical interviews for DSM-IV (Wittchen et al., 1997) 89.7% ($N = 947$) of the diagnoses were available. 33% of the patients had a major depressive disorder, 5.1% ($N = 54$) had a dysthymic disorder, 16.8% ($N = 159$) had an adjustment disorder, 19.7% ($N = 187$) had an anxiety disorder, 4.2% ($N = 40$) had an eating disorder, and 16.7% ($N = 158$) had different diagnoses as their primary diagnosis. 46.1% ($N = 437$) of the patients had

only one diagnosis whereas 53.9 % ($N = 510$) had two or more comorbid diagnoses. The mean session number per patient was 29.4 ($SD = 20.2$) with a mean of 38.1 ($SD = 18.2$) for the completer sample, a mean of 22.3 for the patients, who quit their therapy with granted sessions and a mean of 4.7 ($SD = 1.21$) for the patients, who quit their therapy within the probatoric sessions. From the $N = 876$ (83.0%) patients for which the marital status was available $n = 498$ (56.8%) patients were single, $n = 244$ (27.9%) were married, $n = 118$ (13.4%) were divorced or lived alone and $n = 16$ (1.8%) were widowed.

Measures

Dropout

The dropout criterion was assessed via the final documentation each therapist has to fill out when a therapy ends. The designated dropout item differentiates between a regular ending, an ending within the probatoric sessions and an ending with already granted sessions. All analyses are conducted for two different dropout criteria: Dropout criterion A includes all patients and defines dropout as an abortion of therapy within either the probatoric sessions or the regular sessions. Dropout criterion B only includes patients who had a regular ending or a termination with already granted sessions. Hence, the event of dropout is defined as an unexpected leave from therapy during the regular sessions. Therefore, the sample size decreases for the analyses using criterion B.

Initial Impairment

Initial impairment was assessed using the Global Severity Index (GSI) of the Brief Symptom Inventory (BSI; Franke, 2000). This 53-item questionnaire is a short version of the Symptom Checklist-90-Revised. Symptom statements are self-rated on a Likert scale ranging from 0 (not at all) to 4 (very strongly). The BSI showed an excellent internal consistency of $\alpha = .96$.

Therapeutic Alliance, Social Support, Motivation and Life events

Therapeutic Alliance, Social Support, Motivation and Life events were assessed with a German version of the Assessment for Signal Clients (ASC; Lambert et al., 2007). The ASC was designed as an additional tool, which should be used for clients who are not developing as intended in therapy. The internal consistencies could be regarded as between acceptable and good ($.77 \leq \alpha \leq .81$). Therapeutic alliance was measured with 11 items ($\alpha = .80$), Social support with 11 items ($\alpha = .81$), Motivation with 9 items ($\alpha = .80$), and Life Events with 9 Items ($\alpha = .77$). In the outpatient center this instrument is administered regularly every 5th session. The instrument provides a

brief measure of important factors, which might affect the dropout of a patient. The means for each scale were calculated for all clients.

Interpersonal problems

The severity of interpersonal problems was assessed using a German short version of the Inventory of Interpersonal Problems (IIP-32; Thomas, Brähler, & Strauß, 2011). This measure consists of 8 scales each with 4 items asking about difficulties in different interpersonal situations. The scale ranges from 0 (no problems) to 4 (very strong problems) and showed an internal consistency of $\alpha = .85$. To calculate the level of interpersonal problems the mean score over all items was calculated.

Data Analysis Strategy

Since patients were nested within therapists a multilevel approach should be used (Eid, Gollwitzer, & Schmitt, 2010). To estimate the variance, which is explained by therapists as well as the estimation of the impact of explaining variables, a multilevel logistic regression model for dichotomous data was used (Hox, 2010). The data was analyzed with the software R version 3.0.2 (R Core Team, 2013) and the package lme4 (Bates, Maechler, Bolker, & Walker, 2013). In a multilevel logistic regression the probability distribution for π_{ij} is binomial (μ) with the mean μ . The multilevel regression equation for η is, for example, $\eta = \gamma_{00} + \gamma_{10}X_{ij} + \gamma_{01}X_{ij}Z_j + u_{1j}X_{ij} + u_{0j}$ and the link function is given by $\eta = \text{logit}(\mu)$ (Hox, 2010). In the maximum likelihood estimation procedure the inverse of the link function is used to predict the response value. Since the inverse function for the logit link function is $g(x) = e^x / (1 + e^x)$ the regression model with one predictor can be defined as:

$$\pi_{ij} = \frac{e^{(\beta_0 + \beta_1 x_{ij} + u_j)}}{1 + e^{(\beta_0 + \beta_1 x_{ij} + u_j)}}$$

To get an estimate of the variance, which could be attributed to therapists, the intra-class correlation coefficient (ICC) was calculated. For the logistic model it is defined

as:

$$p = \frac{\sigma_u^2}{\sigma_u^2 + \sigma_e^2}$$

With a fixed variance for the error term $\sigma_e^2 = \frac{\pi^2}{3}$ and σ_u^2 as the estimated variance of the random intercept the proportion of the therapist variance to the total variance could be calculated (Moineddin, Matheson, & Glazier, 2007).

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