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Exploring Parental Perspectives on Dropout from Treatment for Adolescent Depression

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Talking therapies are the first line of treatment for adolescent depression, yet dropout rates are high. Despite parents being considered primary stakeholders in a child's mental health treatment, there is a lack of qualitative research on their perspectives on adolescent dropout. This study aimed to explore parents' perspectives on why their adolescent children dropped out of therapy. Interviews with 12 parents whose adolescent children had dropped out of therapy were purposively selected from a larger dataset to explore their understanding of why their children had stopped going to therapy. Interviews were analysed using thematic analysis and five key themes were identified: practical barriers to therapy; adolescent's readiness to work with the therapist; relationship difficulties between adolescent and therapist; perceived helpfulness of the therapy; and parents being unaware of why their child ended therapy. Involving parents throughout the therapeutic process could be helpful as they are uniquely positioned to suggest how best to support their child. Services should provide information on the types of therapy, and different therapists, available to adolescents prior to treatment starting. Difficulties in the therapeutic relationship should be addressed in the moment to reduce rupture and, therefore, risk of drop out.

Keywords: adolescence, depression, dropout, parent, psychotherapy

Introduction

Globally, depression is one of the leading causes of illness and disability among adolescents (World Health Organization, 2020). Psychological therapies are recommended by the National Institute for Health and Clinical Excellence (NICE) as the first line of treatment. Psychological therapies have a good evidence base, yet disengagement is a common occurrence with estimates of dropout between 16 and 72% in young people (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013). While there is no single definition that is universally applied, the most commonly used definition of dropout is that of the client ending treatment without the prior agreement of their therapist (Johnson, Mellor, & Brann, 2008). However, existing definitions do not acknowledge that adolescents themselves may be able to judge when they are ready to finish treatment. The perspectives of young people and parents have been largely neglected from the literature with regards to the reasons for treatment dropout, in part due to the difficulty in obtaining such information from families once they have discontinued treatment.

In an attempt to understand dropout from the adolescents' perspective, O'Keeffe, Martin, Target, and Midgley (2019) used a mixed-methods approach to investigate what types of adolescent dropout could be identified from the lived experience of undergoing therapy. Three types were identified: 'dissatisfied' dropouts were those who reported terminating therapy because they found it unhelpful, or believed it did not meet their needs; 'got-what-they-needed' dropouts referred to adolescents who got what they needed from therapy, or who felt better; and 'troubled' dropouts were adolescents who were experiencing additional difficulties in their lives, external to the therapy, which may have made attendance challenging.

Parents have been described as the "primary stakeholders" in a child's mental health treatment (Block & Greeno, 2011, p. 412) as they will often be the ones who request support for their child, facilitate their child's attendance and may also be involved in the treatment themselves. Research on the experience of parenting an adolescent with depression has shown parents of depressed adolescents experience a complex range of emotions, such as anxiety, guilt, distress, and frustration (Stapley, Midgley, & Target, 2015), as well as feelings of having failed and a need to blame something or someone for their child becoming depressed (Armitage, Parkinson, Halligan & Reynolds, 2020). These studies show the growing literature that describes the experience of parenting an adolescent with depression, yet less is understood about parents' experiences in relation to treatment dropout.

Pekarik (1992) cited perceived problem resolution, from the parents' perspective, as key for terminating treatment early, fitting with O'Keeffe et al's (2019) 'got-what-they-needed' type of dropout. Garcia and Weisz (2002) noted that parents' own feelings about therapy, and the therapist, can impact on the duration a child spends in treatment. If a parent has positive feelings towards therapy, they may perceive it as helpful, and this, in turn, could lead to their child spending longer in treatment. This is further supported by evidence that matching parental preference to type of treatment was significantly related to the number of sessions a child attended (Bannon & McKay, 2005). These studies shed some light on parents' perspectives on why their children may stop therapy, yet they have been limited by questionnaire designs, which restrict the responses parents can provide. Qualitative methods provide the opportunity to explore in depth the complex reasons as to why young people may stop going to therapy.

The aim of this study was to investigate parental perspectives on why their child

dropped out of therapy for adolescent depression, using in depth interviews.

Method

Setting for the study

This study was conducted following the IMPACT study (Goodyer et al., 2011, Goodyer et al., 2017), which was a randomised control trial to assess the clinical and cost effectiveness of three psychological treatments: Brief Psychosocial Intervention (BPI), Cognitive Behavioural Therapy (CBT), Short-Term Psychoanalytic Psychotherapy (STPP). Four hundred and sixty-five participants aged 11-17 were randomly assigned to one of the three treatment arms. Participants were recruited from three regions in England (East Anglia, the North West, and North London). Recruitment and randomisation have previously been reported elsewhere (Goodyer et al., 2017). All treatments were offered within a Child and Adolescent Mental Health Services (CAMHS) setting. Linked to the IMPACT trial was the qualitative sub-study, the IMPACT-My Experience study (IMPACT-ME; Midgley, Ansaldo, & Target, 2014). This study explored the personal experiences of the participants through semi-structured interviews with adolescents, parents, and therapists at three time points, before the start of the treatment (Time 1), at the end of the treatment (Time 2) and one year after the end of the treatment (Time 3).

Participants and data collection

For this study, we sought to explore parents' perspectives of the reasons for treatment dropout. Parents were purposively sampled from the IMPACT-ME study whose

children were classified as having dropped out of therapy in the IMPACT trial and where the parent had been interviewed about their experience of their child's therapy. Time 2 and Time 3 interviews from the IMPACT-ME study were both included, as both explored parents' experiences of therapy, including how therapy ended.

Thirty-two adolescents were classified as having dropped out of therapy, resulting in 33 parents identified as being eligible for inclusion in the present study. Eleven parents had no interview data available. Therefore, interview data was available for 22 parents, across Time 2 and Time 3 (21 mothers, 1father). As the focus of this project was to understand dropout from treatment, transcripts were required to include the parent's explicit reference to, or knowledge of, the adolescent ending treatment early in order to be included, although explicit use of the term 'dropout' was not necessary. This process excluded 10 parents from the present study.

The final sample consisted of 12 parents (11 mothers, one father) of 11 adolescents. Ages ranged between 39-52 years (M=44.2, SD=4.84). Of the 11 children, there were 7 females and 4 males, whose ages ranged between 11-17 years (M=14.72, SD=2.12). Six received STPP, two received CBT and three received BPI (see Table 1). For the 11 cases included in this study, six mothers were interviewed at both Time 2 and Time 3, and the rest were interviewed once only (either at Time 2 or Time 3). One father was interviewed in addition to the mother at Time 3, providing two perspectives on the same treatment. All of these interviews were included in the present study as they were relevant to the research aim.

TABLE 1 HERE

Data analysis

Thematic analysis (Braun & Clarke, 2006) was conducted by HL and an inductive approach, in which the researcher approached the transcripts with no pre-defined sets of codes, enabled the research to remain data-focused, generating themes which provided a basis for future research and theory. Transcripts were read in full and relevant excerpts were selected as per the aforementioned process. The process of line-by-line coding was employed, whilst the researcher made simultaneous memos of points for consideration during analysis and for discussion. Following this, focused coding established which codes fit together to create potential superordinate themes, and all codes and relevant quotes relating to a theme were grouped together. To ensure as many codes as possible were generated from the data, the researcher moved between the processes of initial and focused coding. Once no further codes could be generated from the data, the potential themes were studied for subthemes. All themes were discussed among the authors and reviewed to ensure that they accurately reflected the transcripts.

Ethical considerations

Ethical approval was obtained for the IMPACT and IMPACT-ME studies from the Cambridgeshire 2 Research Ethics Committee, Addenbrookes Hospital Cambridge, UK (Reference: 09/H038/137).

Results

Data analysis led to the development of five themes, presented in a narrative form, with data extracts from interviews included. Some details have been changed or removed, to ensure anonymity, and all names changed. Where relevant, it is made clear whether the theme was a common one across most/all participants, or was more specific to one or only a few participants.

Theme 1. Practical barriers

Parents often reported practical barriers as a reason for their child stopping therapy, due to issues fitting the sessions around other parts of their lives:

[therapy] was at a bit of a strange time, he had to go at like quarter past four so also you've got to fit it in around school (Georgia).

This was compounded by the suggestion from another parent, who explained her daughter's age at the time of the treatment meant she had to accompany her child to appointments and wait for her daughter:

I used to have to go all the way over to [town] and you know and sit and wait for the hour, because I couldn't get home in that hour… cause she was also incapable of getting on a bus and doing it herself, it was far too far away for her at the time she was much younger than she is now. (Iris)

One parent described that her daughter had a misconception about how CAMHS worked, believing it to operate like a "drop-in service to get support as and when needed" (Lily). Together these findings reflect practical obstacles to adolescents fitting therapy into their lives.

Theme 2. Adolescent's readiness to work with the therapist

Parents described one of the barriers to therapy being the emotional toll of therapy and whether their children were able to work with the therapist.

Parents described therapy as "intrusive", "awkward" (Lily), "exhausting", "scary", "overwhelming" (Kelly), and "nerve-racking" (Hannah) for their child. Additionally, parents spoke about adolescents' difficulty to talk about their thoughts/thoughts and feelings. Kelly explained that her daughter did not like sharing her thoughts in therapy as she felt like she had to "let her armour down… I sort of get the sense that her armour's in place to protect her". Similarly, Hannah explained:

He's a very quiet boy it takes a lot for him to open [up]. (Hannah)

Parents often described the child's stubbornness in engaging in treatment:

She was just determined she wasn't gonna talk to him, absolutely determined, and that's where this sort of stubbornness comes in and she just decided she wasn't going to engage and so she didn't (…) and even if she maybe has an inkling that maybe she could do it differently she would never, she'd never go down there, you know, 'no, I've said this is no good therefore I can't possibly go back on that'. (Kelly)

This 'stubbornness' may reflect the child not being ready to work with the therapist at that stage. Other parents explained their children were "lazy" (Georgia) about committing to therapy, and "couldn't be bothered" (Jackie). Fred commented that his daughter "didn't seem willing to stick with it", suggesting later, therapy "may have been beneficial had it gone further". This highlights how parents view their child as having

an active role in deciding whether they continued in therapy, but that this hinged on whether they had a positive attitude about attending and engaging whilst there.

Parents reported they could not make their child go to therapy if they did not want to and respected their child's decisions to end treatment:

I'll do what I can to get you there but nobody can make you talk in a therapy session, can they? If she didn't wanna do it it's her choice, it's absolutely her choice. (Iris).

Overall, this theme illustrates how parents understood their children's decisions to end therapy as being unprepared, unready, or reluctant to work with their therapist.

Theme 3. Relational difficulties between adolescent and therapist

This theme refers to relational difficulties between adolescent and therapist, which parents expressed as potential reasons for dropout.

For some parents, this was related to characteristics of the therapist. A frequently cited example was the therapist's gender. Parents explained how adolescents found it hard to open up as a result of a mismatch between their gender and the gender of the therapist.

I wonder if [he] might have had a man to talk to that might have been better. I'm thinking he might have related to a man. If it had been a man he might have felt more comfortable about things. (Georgia)

Kelly supported this idea, explaining that her daughter refused to engage with her therapist, because he was male. In answer to a question from the interviewer about what was unhelpful about the therapy for her daughter, one parent stated:

She didn't like him I think. If it was a lady from the beginning, but because it was a man - I think that's why she didn't want to open [up], the one thing, cos I know so little about it, but one thing it was because it was a man. (Bella).

The age of the therapist was also mentioned as a barrier. Iris explained how her daughter was expecting her therapist to be younger: "the girls that interviewed her [for the IMPACT study] was what she was expecting as well and the girls that interviewed her were a bit younger". Another parent explained his daughter had to:

Sit with a middle-aged woman who was more like closer to her grandmother than even her parents. I think that was probably all a bit off-putting for her. (Fred)

Similarly, Fred recalled his daughter describing her therapist as a "teacher-type kind of character who sat there with a book and a pen and took notes". This suggests therapists were seen as authority figures, and parents suggested this may have made their child uncomfortable. Kelly explained her daughter had previously responded well to therapists who were "very kind and very sympathetic and very gentle, but in a very no-nonsense sort of way". This is supported by Claire who explained her daughter responded well to doctors who her daughter perceived as being "just kind of a normal person", rather than like a stereotypical doctor. This suggests that adolescents expect certain qualities in their therapists and perceived failure to meet these expectations could be linked to dropout.

The therapeutic relationship, or perceived lack of, was frequently referred to:

I think she just felt like she was a stranger, you know, she didn't really have a relationship with her particularly. (Lily)

Parents also explained how their child did not feel understood by their therapist, and

that although therapists frequently tried different ways to engage with the adolescent, these were ultimately futile. Iris explained that, if her daughter was to have therapy again, they would "choose the therapist and someone that she gets on with, rather than being just allocated whoever's available".

'Liking' the therapist seemed to be a preconception held by a few of the adolescents, and parents referenced this as potential a reason why their child stopped attending. Georgia explained "I think if it'd been someone different, [her son] might have continued going" but "he really didn't like her" and therefore he found it hard to keep going, "especially when you go there and it's someone you don't like".

Some parents described feeling that their child had been 'let down', feeling frustrated, annoyed, or irritated by their therapist, or the therapy.

I think she kept asking him weird questions. She kept bringing the subject up which annoyed him and it frustrated him. (Georgia)

Linked to this is the misconception for some adolescents around the confidential nature of the therapy setting. Lily explained that her daughter thought her therapist was "sort of being nosey about her private stuff", explaining further:

I don't know if she thought that it would be shared beyond, you know, that space necessarily. It's more, um, reluctance to just open up to somebody who, who doesn't know you, that maybe that they're going to form an opinion based on a conversation in this little window and it's not really going to be based on an understanding of who you are from knowing you over a long period of time or in different contexts, she didn't understand that in that neutral space it's, it's like a blank canvas. (Lily)

In summary, this theme reflects how difficulties in the therapeutic relationship explain

adolescent's decision to end therapy.

Theme 4. Perceived helpfulness of therapy

Parents reported understanding that therapy was not a quick route to recovery:

I've sort of said to [Child], 'look all I can tell you is that talking therapy works for most people, it is a long process, it doesn't happen overnight and you just have to stick with it and hope that it will benefit you. (Claire).

However, some parents reported that their child expected to see results quickly, hence being disappointed when there was no immediate improvement, concluding it was not working, and they would stop attending. Fred explains: "at some points [it] actually led to some frustration with it because she was seeking some guidance and it wasn't moving fast enough for her in terms of seeking a solution."

Similarly, parents reported how their child found therapy unhelpful, which ultimately led to them disengaging from treatment. Georgia stated her son found the therapy unhelpful at alleviating his depression: "if it was helping [the depression], then he would've kept going, but that wasn't helping him", and that this was his reason for discontinuing. Bella explained her daughter "doesn't like to talk about things, about her feelings" therefore suggesting that talking therapy was an unhelpful treatment choice and was not of benefit to her daughter.

Parents also suggested that the therapist focused on the wrong topics in therapy, or that the approach taken was incorrect. Iris believed her daughter's therapist did not ask the right type of questions, referring to her own experience of counselling as a basis for what 'good' therapy looked like – "the best counsellors I've had have asked me very prompting questions to get me talking, but [daughter] wasn't getting any of that".

This theme highlights that the reality of therapy was different to what adolescents expected, and this discrepancy could be one reason why adolescents drop out of therapy early, in addition to not perceiving it as helpful.

Theme 5. Parents unaware of why their children ended therapy

There were aspects of the child's therapeutic journey that parents were not aware of. Jackie reported she was not aware her child had not been attending sessions until the therapist phoned to inform her. Her son had "just stopped going" to his treatment, and when asked how long he had attended before he stopped going, she replied "I couldn't tell you". This shows that the adolescents did not necessarily communicate directly with their parents about how they found therapy, and their reasons for not going. One parent said:

[My son] didn't really talk about it, yeah I tried to talk to him but just 'I don't wanna go', he'd say that was his answer. (Hannah)

This highlights how parents are sometimes on the periphery of the therapeutic journey, thus making it challenging to know exactly why their child stopped therapy.

Discussion

This study aimed to qualitatively investigate parental perspectives on why their child dropped out of treatment for adolescent depression. We found that, in some instances, parents did not know, or were unsure of, the reasons behind their children's termination of therapy, yet they trusted their decisions to end therapy. Nevertheless,

most parents gave important insights into the range of factors that played into their children's treatment endings. These included practical barriers associated with attending sessions, adolescent's readiness to work with a therapist, relational difficulties between adolescent and therapist, and perceived helpfulness of therapy.

Parents are often facilitators of a child attending appointments (Costello, Pescosolido, Angold, & Burns, 1998; Nock & Ferriter, 2005), although this is usually thought for younger children than adolescents. Parents in this study highlighted practical barriers to getting their adolescent to engage with therapy, such as the time of appointments. Increasing accessibility to therapy is a key point of consideration, something which the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) project in the UK is aimed at (Ludlow, Hurn, & Lansdell, 2020). Use of digital therapies, allowing for more flexible appointments, as well as placing practitioners within school and community settings, for example, could lead to improved treatment attendance.

Parents spoke about their child not being ready or able to open up to their therapist, which suggests that some adolescents were ultimately unprepared for what would happen in therapy and the emotional journey they would go on whilst in therapy. This finding echoes a similar finding of Midgley et al. (2016), who qualitatively investigated adolescents' expectations prior to starting therapy for depression and found that adolescents were often unable to articulate any concrete expectations about therapy, instead answering "I don't know"; when they did express views, it was often based on stereotypes of therapy drawn from the media, or based on a comparison to going for a medical consultation. Early discussion around what treatment may involve – with both young people and their parents - could help develop more accurate expectations, which may, in turn, influence whether an adolescent will remain in therapy for the duration of

the treatment.

Many of the reasons for dropout identified in this study were related to relational issues with the therapist. Parents described needing a therapist their child felt a connection to, whom they liked, and felt understood by. Frustrations with therapists, such as feeling they were asking the wrong questions, were commonly reported by parents. This fits with research based on analysis of transcripts of therapy sessions in the IMPACT study, where observer ratings of therapy session records showed that unresolved ruptures in the therapeutic relationship were more common in sessions with young people prior to dropout due to dissatisfaction (O'Keeffe et al., 2020). These findings emphasise the importance of therapists paying attention to interactions in the moment with young people – to identify warning signs that a young people may have frustrations with aspects of the therapy. Addressing it in the moment means ruptures are more likely to be resolved and this may lead to favourable outcomes.

Other parents spoke about their child not feeling comfortable with the therapist due to personal attributes. The age and gender of the therapist, as well as the therapist persona were all given as examples of things adolescents 'did not like' about their therapist. This finding conflicts with recent research by Pfeiffer et al (2020), who found no interaction between therapist and adolescent client gender and clinical outcomes. Clinical services might consider asking young people if they have preferences about their therapist (e.g. gender), and where possible meeting these requests as this may improve treatment attendance.

Educating adolescents and their parents about the different types of therapy available is also important; and providing opportunities for choice of therapy to be reviewed when there are indications that things are not progressing well. The current study highlighted

that some parents felt their child was not receiving the 'right' type of therapy, or that the therapy was unhelpful and did not work for their child, based on aspects of their child's personality, for example, not finding it easy to talk about their feelings. This suggests talking therapies may not be suitable for all depressed adolescents, and consideration needs to be given to how to engage clients who find talking challenging. Involving parents early in the therapy choice would give parents a chance to highlight their child's struggles and – where appropriate - help identify a therapy that relies less heavily on talking (e.g. more strategies-focused). Alternatively, it provides the therapist with an awareness that this client may find articulating their feelings hard, allowing them to potentially adapt the approach they use. Parents are uniquely positioned by being key caregivers to the adolescent undergoing therapy, thus, are well placed to provide insight to what may be most helpful for their child. Understanding parental ideas about what they think would best help their child could reduce the likelihood of their child dropping out of treatment prematurely. This is supported by previous research which found parents' feelings about therapy impacted on the duration of time that their children spend in treatment (Garcia & Weisz, 2002), and that matching parental preference to a child's treatment relates significantly to how many sessions a child attends (Bannon & McKay, 2005). Moreover, in this study, only two of the 12 parents commented on meeting their child's therapist directly, suggesting that the remaining parents' opinions of the therapist were based on what they had been told by their child. A relationship should be formed with the parent where possible, as well as the adolescent, to improve communication between the home and therapeutic environments.

Strengths and limitations

This qualitative study allowed for an in-depth exploration of parental perspectives on why their child dropped out of treatment for depression. This is the first time the IMPACT-ME data have been used to investigate the parental perspective on dropout for adolescent depression, and this research adds to the current knowledge on this topic, by highlighting that parents have key insights, which can explain potential barriers for adolescents to remaining in treatment. Nevertheless, this research has some limitations. The interviews did not focus on dropout, but looked at experiences of therapy more generally. Whether dropout was detected and discussed relied on the skill of the interviewer and what was shared by participants. Therefore, interview content relevant to the research aim varied across the transcripts. Moreover, the researchers decided which parts of the transcripts to use for analysis, meaning a level of subjectivity existed in the data inclusion process. This was controlled for as much as possible through consolidating inclusion criteria and discussion between researchers. Transcripts for this study came from two different time points. Time 3 interviews were conducted roughly one year after treatment had terminated, meaning parents were relying on memory recall to answer questions about their adolescent's experiences in therapy. Despite including transcripts from Time 2 and Time 3 for six parents in this study, the transcripts were not checked for consistency in response across the two time points. This means that any changes in parental response and reasons for these changes in perspective were not noted and therefore, not captured in this research.

Conclusion

The present study highlights the importance of parental perspectives in understanding

dropout from treatment for adolescent depression. Parents identified several reasons for their child ending treatment early: practical barriers to treatment, adolescent's readiness to work with a therapist, relational difficulties between adolescent and therapist, and the perceived helpfulness of the therapy. Some parents were unaware of why their child ended therapy. These themes highlight the importance of educating adolescents (and their parents) on different treatment options and what to expect whilst in treatment; and the importance of reviewing how therapy is progressing. It also suggests there could be some value in therapeutic services asking clients if they have a preference on the practitioner they are allocated (e.g., gender). Therapists should also consider addressing ruptures in the moment, to help reduce frustration and potentially reduce drop out, as well as offering flexible options for therapy (e.g., online sessions). This study suggested that parents of those adolescents who dropped out of therapy rarely had the opportunity to meet with their adolescent child's therapist. It may also be helpful for parents to be involved throughout their child's therapeutic journey, as this study highlights that parents are uniquely positioned to suggest how to best support their child.

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Declarations of interest

The authors declare that they have no competing or potential conflicts of interest.

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Table 1. Demographics

Parent's name	Parent's Age	Parent's Gender	Parent's Employment Status	Childs age	Child's Gender	Treatment Arm	Parent Interviewed at Time 2 and/or Time 3*
Alice	39	Female	Unemployed	11.30	Male	STPP	2
Bella	39	Female	Unemployed	17.76	Female	STPP	2
Claire	44	Female	Part-time	14.60	Female	BPI	2
Debbie	46	Female	Unknown	15.38	Male	STPP	3
Ellie	42	Female	Part-time	13.61	Female	BPI	3
Fred	41	Male	Part-time	13.20	Female	STPP	3
Georgia	Unknown	Female	Unknown	17.30	Male	STPP	2&3
Hannah	52	Female	Full-time	14.10	Male	CBT	2&3
Iris	40	Female	Full-time	13.20	Female	STPP	2&3
Jackie	Unknown	Female	Unknown	17.82	Male	STPP	2&3
Kelly	51	Female	Full-time	13.41	Female	BPI	2&3
Lily	48	Female	Full-time	13.49	Female	CBT	2&3

*Note: Time 2 = end of therapy; Time 3 = one year later.