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ORIGINAL ARTICLE

Recovery college dropout: A qualitative study of external, relational and course-related dropout drivers in co-produced mental health care

Ditte Andersen[1] | **Anna Kristine Waldemar**[2] | **Sine Kirkegaard**[1]

[1]VIVE – The Danish Center for Social Science Research, Copenhagen, Denmark

[2]Competence Centre for Rehabilitation and Recovery, Mental Health Centre Ballerup, Ballerup, Denmark

Correspondence
Ditte Andersen, Herluf Trollesgade 11, 1052 Copenhagen, Denmark.
Email: den@vive.dk

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Abstract

Recovery colleges (RCs) are rapidly spreading across Western countries, and research indicates beneficial outcomes of this co-produced model of mental health care. Meanwhile, risks of adverse outcomes and RC dropout remain understudied. To address this research gap, we conducted qualitative interviews with 14 participants who dropped out of RC courses in Denmark. This article, adhering to the consolidated criteria for reporting qualitative research (COREQ), presents a typology of the main dropout drivers identified in our sample: external, relational and course-related. *External drivers* involve practical obstacles, for example some participants feared taking public transportation and lacked access to alternative means of travelling to the courses. *Relational drivers* entail distressing interactions with educators or peer students, for example some participants felt stigmatized or intimidated. *Course-related drivers* concern the content of the courses, for example some students considered the academic level too basic as their design did not take prior learning into account, while others experienced a sense of alienation because they were unable or unwilling to share the kind of personal experiences course assignments envisaged. In the discussion of our findings, we consider how different types of drivers call for different modes of responses. We discuss dilemmas related to the proposed responses for reducing or accepting RC dropout.

KEYWORDS
co-production, dropout, mental health, qualitative research, recovery college

INTRODUCTION AND BACKGROUND

Recovery colleges (RCs) are formal learning institutions that offer educational courses to people with lived experience of mental illness, their relatives and mental health care staff. The concept of recovery colleges originally emerged in the United States in the 1990's as an innovative way to support personal recovery (Whitley et al., 2019), and was adopted by other countries, including the UK where the first recovery college opened in 2009 (Toney et al., 2018). The model quickly spread to Australia, Canada, Japan, Ireland, Western Europe and Scandinavia (Perkins et al., 2018). In 2020, more than 80 RCs were operating in 22 countries (Thériault et al., 2020, p. 929), and there is a high degree of commonality across RCs in how they operate (Bester et al., 2021, p. 1755). Co-production is a defining feature of RCs, meaning that courses are always co-designed and co-facilitated by health professionals (experts by training) and people with experiential knowledge of mental health difficulties (experts by lived experience).

Research indicates positive outcomes of RC participation such as increased hopefulness, well-being and

[Correction added on 22 August 2023 after first publication: The citation "Kristensen, C.J. (2023)" and the corresponding reference have been added.]

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self-management skills (Ebrahim et al., 2018; MgGregor et al., 2014; Meddings et al., 2015; Newman-Taylor et al., 2016; Perkins et al., 2018; Windsor et al., 2017) as well as reduced mental health service use and reduced stigmatization (Bourne et al., 2018; Kay & Edgley, 2019; Whish et al., 2022). In a systematic review of RC research, Toney et al. (2018) found that the mechanisms that promote these positive outcomes are an empowering environment; the enablement of relationships between peers; the shift of power balance; and facilitation of personal growth. However, they also concluded that RC evaluations with strong research designs remain few (Toney et al., 2018). In 2022, a new review stated that the lack of comprehensive, robust research is 'a significant concern given the rapid global expansion of RCs' (Lin et al., 2022, p. 2). A third review stated that evaluations of RCs tend to 'suffer from self-selecting samples leading to an overwhelmingly positive experience' and concludes that: 'Evaluation by independent researchers is paramount'. (Whish et al., 2022, p. 443). This article responds to this need by presenting a study on RC dropout carried out by independent researchers.

The general attendance rates at RCs are 67 pct. (Dunn et al., 2016, p. 239). Hence, around a third of participants dropout, yet very few studies have examined RC dropout. One study, drawing on a survey of 16 respondents, reported that the most common reasons for non-attendance were personal factors such as illness, competing life commitments and anxiety/worries about other students (Dunn et al., 2016). Another study, drawing on four focus group interviews, found that the most common barriers to attendance were unsuitable venues, being too unwell, imbalanced group composition and inappropriate use of clinical language (Zabel et al., 2016). A third study on motivations for engagement used qualitative interviews with four participants and found that a key obstacle to attendance was being unwell (Harper & McKeown, 2018). With the exception of the first study (Dunn et al., 2016), none of the studies specifically addresses the issue of dropout. Even in the first study, the topic in focus is not dropout per se but barriers to attendance and the self-selecting survey respondents only needed to have missed one class to qualify for study recruitment (Dunn et al., 2016, p. 240). No study to our knowledge has previously systematically recruited RC dropouts to investigate drivers of dropout. Hence, this article represents a valuable contribution to the literature as it identifies drivers of dropout and increase our understanding of how some participants struggle to benefit from the RC model.

METHODS

This is a qualitative study drawing on semi-structured interviews collected as part of a larger ethnographic study of RCs. Participants were recruited from an RC organized in conjunction with the free, universal public psychiatric system in Denmark (Kirkegaard & Andersen, 2018, 2022; Kirkegaard, 2022). Danish psychiatry is inspired by peer programmes in the United States, the United Kingdom, the Netherlands and Australia, reflecting the wide-ranging turn towards a strength- and recovery-oriented approach to mental health care (Thériault et al., 2020). The educators delivering RC courses in our study are paid employees regardless of whether they are experts by lived experiences and/or professional training. The educators with lived experience have a psychiatric diagnosis and experiences with receiving mental health care. The educators with professional backgrounds are trained, for example nurses, physiotherapists or teachers.

Data collection

We obtained contact information from RC staff on 15 students who had dropped out of courses but accepted an invitation to hear more about our research project. Ditte Andersen and Sine Kirkegaard phoned them (one student did not respond), we presented ourselves with names and institutional affiliation and told them about the research project on co-produced mental health care in RCs funded by Independent Research Fund Denmark. We stressed that participation was voluntary, and that they would be anonymized in publications. Fourteen students verbally consented to participate, and we scheduled interviews in the winter of 2020–2021.

The interviews were carried out by Ditte Andersen and Sine Kirkegaard during a time with COVID-19 restrictions and we used telephone interviewing as a form of 'methodological pragmatism' (Lamont & Swidler, 2014). This methodology has drawbacks linked to the loss of visual cues such as body language but offers participants an opportunity to be interviewed in a private, comfortable setting (Block & Erskine, 2012). While in-person interviews tend to facilitate conversational turn-taking that produces detailed material, telephone interviews reduce power imbalances and tension, which make it easier to voice criticism (Jenner & Myers, 2019; Novick, 2008; Vogl, 2013). [Correction added on 22 August 2023 after first publication: "AUTHOR 1" and "AUTHOR 3" in this paragraph have been replaced with "Ditte Andersen" and "Sine Kirkegaard" respectively.]

The interviews were semi-structured by a guide that invited participants to talk about themselves, their everyday lives, their motivation to enrol in an RC, various aspects of their experience of participating in the RC, such as the atmosphere and course assignments as well as their views on good/bad/challenging features of the courses and their motives for dropping out. All participants consented to audio recording, and the audiotaped parts vary from 12 to 52 min with an average of 33 min (excluding opening dialogue and subsequent debriefing). As the data collection proceeded, we began to hear

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similar motives for dropouts indicating data saturation. All interviews were transcribed verbatim.

Seven of the participants had lived experiences of mental illness and enrolment in mental health care. We refer to these participants as service users. Four participants were relatives of service users, and three participants were mental healthcare staff. This distribution reflects the general student population in RCs, where service users represent the majority while relatives and staff comprise smaller groups (Zabel et al., 2016). Two of the participants identified as males, while 12 identified as females, reflecting the general RC population (Thériault et al., 2020, p. 938).

Ethics

Our study was approved by the VIVE Research ethical committee (approval no. 2022/3). We took ethical considerations into account at three levels. At the level of *microethics*, our considerations concerned the research participants. We gave participants oral and written information about our research project, stressed that participation was voluntary and ensured verbal consent. In this article, all names are pseudonyms and we have not shared what individual participants said in interviews or other interactions during the ethnographic fieldwork with RC staff.

At the level of *mesoethics*, defined as ethical considerations in relation to the participating organization (Kristensen, 2023), reflections concerned our position in relation to the RC. Some RC studies adopt 'the RC ethos' to create entirely co-produced research where academic scholars and recovery staff design, manage and disseminate research in partnerships (Yoeli et al., 2022, p. 1). A recent review argued that co-creation should always be part of RC evaluations (Lin et al., 2022). While our study is not co-produced in this sense, we recognize the merits, strengths and transformative capacities of the co-production approach in mental health care research (Gordon & O'Brien, 2018). Given our focus on the experiences of students who dropped out of RCs, we have prioritized a preservation of our independence through a formal distance to the organization we studied by not making ourselves financially or otherwise dependent on the RC. Independence has been important in many ways, for example in interviews with the participants who were critical about RCs. Most RC students find themselves in vulnerable positions and criticizing one of the few organizations that may offer the help they need is not easy if the interviewer is affiliated with the organization.

At the level of *macroethics*, we have reflected upon the ethical aspects of our research in relation to the national and international context. The rapid spread of RCs makes it important to understand how and why some participants drop out and thereby fail to benefit from the programmes. Students who drop out may experience severe difficulties and it is important to understand dropouts in terms of reducing human suffering.

Analysis

We identified patterns of meaning in the data set through a thematic analysis (TA). TA is 'a powerful tool for casting light on non-use of mental health services' (Joffe, 2012, p. 214) enabling researchers to 'tap the manifest and latent drivers concerning an issue such as uptake of mental health services' (Joffe, 2012, p. 209). We were guided by the reflexive tradition of TA (Braun & Clarke, 2019), where themes are developed as analytic outputs. Ditte Andersen initially read and re-read transcripts, grouped themes of experiences through an inductive coding in the software program NVivo and conceptualized a typology with three main categories of drivers. Anna Kristine Waldemar and Sine Kirkegaard participated in a collaborative and reflexive process of developing and revising the categorization and conceptualization of drivers that we finalized as a code tree with three subtypes in each category (see Figure 1).

The interviews were conducted in Danish, and quotes chosen as illustrative examples were translated into English. In Danish, those delivering the RC courses are referred to as 'undervisere' which we translate to educators. Those receiving the RC courses are called 'kursister', which we have translated to students. We report the findings in accordance with the consolidated criteria for reporting qualitative research (Tong et al., 2007).

RESULTS

External drivers

The first category of drivers denotes hindrances experienced by participants who were motivated to attend the courses but deterred by external factors. We identified three prominent forms of external drivers, which were transportation, lack of time and illness.

Transportation was a challenge primarily described by participants who were service users. One such participant, Joan, recounted in the interview how she had tried various strategies:

> I have tried to go by bike [to the course] but have realized that it is not viable […] When I went there by bike, I had anxiety for the 45 minutes I managed to stay […] The second time, I took public transport but I cannot cope with that […]. It becomes too much for me.

Lack of time was a dropout driver primarily described by participants who were relatives of service users or mental health care professionals. The participant Anne

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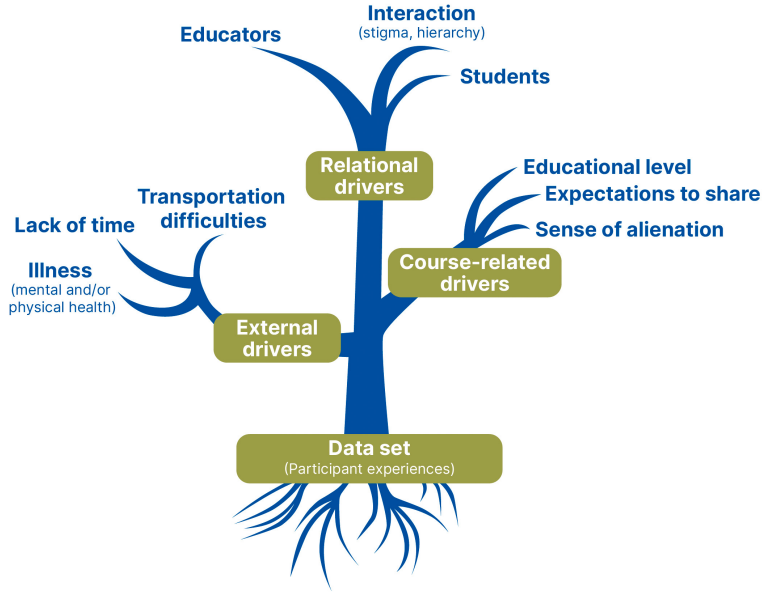

FIGURE 1 Code tree with an overview of categories and subtypes of dropout drivers identified in the data set.

explained that even though her employer encouraged her to participate in RC courses, her work obligations could clash with participation:

> I have had to drop out of courses because we are busy and we have to [sentence unfinished]. If I must prioritize—of course—I have to attend to my work obligations first.

Illness—either in the form of a physical ailment or a lack of mental well-being—was a challenge described by participants who were service users or relatives of service users. Lisbeth explained how her daughter's mental illness made it impossible for her to attend the course: 'I was really frustrated, but it meant I simply couldn't make it'. Another participant, Susan (service user) explained:

> It's a lot of ups and downs. That's why my attendance is unstable. Sometimes I also get caught up by alcohol […] I went to one session, and I just felt – I don't know – there's nothing wrong, I mean, people are nice in the courses. It's just upsetting to be around people [when you're unwell]. So, I have dropped out twice.

Dropouts spurred by external drivers did not reflect a dissatisfaction with the courses, and some participants were quite frustrated about dropping out.

Relational drivers

The second category of drivers concerned relational dynamics in the courses. We identified three main forms of relational dropout drivers linked to educators, student peers and interaction experienced as either hierarchical or stigmatizing.

Poor relations to educators made it difficult for some students to benefit from the courses. For example, Sandra, a service user, conveyed how her motivation to participate crumbled in an encounter with an educator she felt was patronizing:

> She [the educator] asked how long ago it was that I was on sick leave due to stress, and I told her […] She did some math [and stated] "Oh, there's no problem", I can just go ahead on exposing my body to stress or anxiety. Then I responded; "Do you have any evidence to back that or is it just your personal opinion?" […] It was not a constructive conversation. Actually, I think she was acting rather 'know-it-all'. […] I could feel it had a real impact. I noticed how I began doodling in my papers instead of paying attention […]. She didn't really have anything to offer […] Well, she has 'been there' herself, and she has recovered completely. Well, that's just great! But you cannot say something like that, because we're all different.

Relations to student peers are also important. Some participants reported that they had dropped out after feeling intimidated by other students. For example, Vivian (relative), who participated in a course with her daughter, shared the following experience:

> This group was fraught with very taxing anxiety patients […] One of them talked a

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> lot about his horrific story, what he has been through and he was extremely outspoken. […] It did more harm than good. […] It was as if we were lacking some resolute educators in charge that could say "That's enough". […] It was awfully disheartening to hear about these experiences. It fueled my daughter's fear and anxiety because "Is this what my future will be like?" […]. So it [dropping out] is more for the sake of our daughter. I don't think she should be exposed to more of that.

Relations to student peers could also be strained by more mundane feelings. For example, some participants experienced wearisome peers. Nanna (service user) explained;

> What you gain from a course is critically dependent on what kind of people happen to make up the group. Of course, you can say that is just how it is, but what I experienced that day was that the group included some student nurses, some patients, and then one relative who took up a lot of time and space with long, meticulous accounts […]. One started thinking, oh well, time can be better spent than this.

Educators may apply various ways of regulating contributions from over-talkative or disruptive participants. However, regulating strategies risk changing the relational dynamics in the course. Eva (service user) stated:

> I just saw how one of the relatives [in the course] offered some inputs, and I feel they [the educators] shut the person down very quickly. Maybe what the person said was not so relevant, but one could have provided her more space […] They [the educators] moved on very quickly.

When educators regulate students' contributions they exercise a control enabled by the authority vested in them as educators. This gave some participants a sense of hierarchy in the course interaction. Thomas (service user) stated:

> It was like, how can you describe it, 'them and us'. Them, who are educators, and us, clients. There is a hierarchy […]. They are the ones in charge – the educators. And then we are the ones who must listen. I mean, it is obvious actually. It is an educational course we are enrolled in […] But sometimes it's too rigid. It is more strict or constraining than is sensible.

Some participants who dropped out experienced some interaction as stigmatizing. Miriam (service user) shared the followed experience:

> I just felt like she [a student peer] looked at me with a very interrogating, condemning gaze. And it's a gaze I get quite often in my everyday life because I don't have a job. So, the fact that I show up to a course offered in the context of the mental health care system, and then have to face it here too – I simply couldn't take it.

In the sample, no participants reported feeling stigmatized by educators, but some participants felt stigmatized by student peers, and as conveyed by Miriam, this can be quite upsetting.

Course-related drivers

The third category of drivers related to the content of the courses. We identified three main forms of dropout drivers related to course content: the educational level, the expectation to share experiences, and a sense of alienation.

The educational level was criticized for being too academically low by some of the participants who dropped out. The participant Kasper (relative) explained:

> It's a bit of the same "lalala" you get everywhere else, and if you've been to more than one course, you hear things repeated. You can tell it's directly imported from the same manuscript. So I feel there's too much information that is too – well, just a plate of "lalala" that almost seemed like it was looking up something on Google.

Some participants wondered whether their long record of experience may explain their lack of benefit from the courses. Mona (relative) deliberated:

> I could tell that I might be misplaced, because the other participants were new to the mental health care system – most of the others [the other relatives] had younger children. In that sense, my record is longer, and I have previously attended courses in [name place]. So, I probably knew too much [to benefit].

Thomas (service user) had a similar deliberation as he found the educational level too basic to benefit him after many years of experience. However, he also accepted the RC principle that courses must be accessible for all:

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> Their [educators'] teaching – it is pretty basic and simplistic […]. However, it [the courses] has to be for all, so I need to put up with things the way they are.

Expectations to share personal matters on the RC courses were criticized by some participants who experienced them as too demanding. A participant, Anne (staff), explained 'It's the atmosphere created, and maybe when the others do it [share], you don't want to fail or something. It is peer pressure, I believe'. The participant Miriam (service user) offered an example of how the expectations to share felt demanding:

> In fact, I just came for the teaching […] I actually felt this was very personal, and we were not really asked whether we felt like doing it [share personal drawings], it was just something we were expected to do. I mean, at first, I thought we were making the drawing for ourselves, like a reminder, and I didn't mind that. But then we were told "Now team up and show it to your group". That I really did not like […]. But then again, I felt, well, it was part of the course plan and I kind of felt we had to do it […] So I just felt really out-of-place.

The third subtype of course-related drivers was a feeling that we have conceptualized as a sense of alienation. In recovery courses, all participants are encouraged to engage with exercises by using their own experiences with recovery. Some participants felt they did not have experiences that qualified them to do this, as they did not have lived experiences with mental illness. Samira (staff) explained:

> I didn't say much when the educators asked us about matters […] I didn't really feel I could make a contribution because I don't have much personal experience […] I don't have much to offer.

Another participant also employed in mental health care, Anne, explained:

> Often, I kind of feel like a wildcard in that setting. I feel different as a staff member participant […]. Sometimes I sit there with a feeling that – maybe also due to the limited number of staff participants – I sit and wonder whether I actually am supposed to attend these courses, whether they really mean it, since so few staff members participate. I begin to doubt […] It's not because I don't want to share […] [but] my role is a different one when I go to work. If I had a problem, I would have gone to a psychologist.

Some service users and relatives also questioned the role of mental healthcare staff in the courses. Eva (service user) deliberated:

> I can imagine that those who are staff, they might think that they might not really need this kind of course. However, at the same time it just [sentence unfinished]. It creates a sense of parity with other people. You are not so stigmatized [as a service user] […] [when] different sorts of people are included in the courses.

Some participants who were mental health care professionals reported that they felt their experiences were not relevant, or that it was inappropriate for them to share personal experiences with past or potentially future patients. For example, a mental health care professional had an ADHD diagnosis that she did not want to share at a course with participants with whom she felt she had to maintain a professional relationship. The reluctance to share personal experiences reflects a traditional professional ideal that emotional distance and neutrality are important components to sustain a professional care relation with patients. However, students who are unable or unwilling to share personal experiences for various reasons may struggle to make sense of their participation, which can lead to a sense of alienation that spurs dropout or reluctance to sign up for courses in the first place.

DISCUSSION

A thematic analysis of 14 qualitative interviews with students who had dropped out of RCs identified three main drivers of dropout. First, external drivers that are practical obstacles such as illness, time constraints or transportation; second, relational drivers reflecting poor relations to educators or student peers; and third, course-related drivers deriving from dissatisfaction or a sense of alienation from the course content.

Different types of dropout drivers may call for different modes of responses. The three subtypes of *external drivers* we identified (transportation, lack of time and illness) represent practical obstacles that could be solved through concrete measures. Participants who lack manageable ways of travelling to the courses might be helped by forms of transportation aid such as taxi vouchers or travel buddy volunteers. Mental health care professionals who lack time to attend courses might be aided if their employers gave them leave to attend the RC courses, and participants who fall ill might be more likely to be retained if RC staff systematically followed up on them to monitor their well-being.

Relational drivers of dropout could be combatted by modifying the interpersonal dynamics in the courses. Many RCs have implemented ongoing evaluation

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practices using student feedback such as standardized questionnaires distributed at the end of courses (Thériault et al., 2020). However, poor relations to educators and student peers remain a sensitive topic to communicate in evaluations, which are often written in the presence of student peers and handed in to the educators themselves. In a study of feedback forms from 40 RC students, only two students criticized educators (Meddings et al., 2014, p. 148), and many colleges report that up to 95 pct. of students are highly satisfied (Bourne et al., 2018, p. 359; Thériault et al., 2020, p. 930). The remarkable statistics might suggest an underreporting of critique. Furthermore, when courses end, some students have dropped out and their voices hence excluded. An informal and easily accessible 'ombudsman' or other contact person may help such students tell someone about their relational concerns before they dropout.

Course-related drivers are linked to organizational principles of the RC courses and therefore require structural responses. Differentiating the academic level of courses and allowing participation without sharing personal experience may accommodate students who felt the educational level was too low or expectations to share too high. However, such measures potentially clash with the organizational principles of RCs. As recounted by Perkins et al. (2018), in RCs 'The ethos is that everyone learns together and from each other' (p. 4), and RCs represent 'a culture of equity and inclusion where everyone's assets, strengths, resources, and networks are celebrated and leveraged' (Lin et al., 2022,p. 2). Differentiating academic levels or expectations to students such that, for example, students who are mental health care professionals are formally expected to engage with course assignments in another way than participants with lived experience might be seen to counter the principle of parity. Consequently, the costs of reducing dropout spurred by course-related drivers must be taken into account.

An advantage of including participants who are mental health care professionals is that it creates a mix of people on the courses that counters stigmatization (Collins et al., 2018; Perkins et al., 2017). Participants in our sample (cf. Eva) also advocated this argument. A recent review found that 89 pct. of RCs include staff participants (Lin et al., 2022, p. 6). However, if the students who participate as mental health care staff do not think they need the courses, or if they do not feel they have any experiences to share, the purpose of participating to counter stigmatization and create parity may not transform into a meaningful engagement with course assignments.

Taking a step back, we may raise the question: to what extent is dropout a phenomenon that RCs should aim to curb? The genre of dropout studies routinely ends with a discussion of how to reduce dropout rates, for example with an aim of improving cost-effectiveness (Dunn et al., 2016). However, for a student that experiences participation in RC courses as a waste of time or even as harmful, dropping out is beneficial. Dropout discussions might benefit from developing a distinction between adverse and pertinent dropout.

Applying this distinction to our study, we argue that most dropout spurred by external drivers appeared adverse in the sense that participants were frustrated that something hindered their attendance. Fighting this kind of dropout to the extent that limited resources and practicalities allow appear desirable because the dropout is unwanted from the student's point of view. Likewise, much dropout spurred by relational drivers appeared adverse in the sense that poor relations prevented participants in our study from benefitting from the courses in the way they had hoped to.

Reducing dropout spurred by course-related drivers, on the other hand, might change foundational principles of the RC and thereby present dilemmas at the organizational level. Designing courses with higher academic levels and lowering expectations to share personal experiences might counter some dropout related to the content of RC courses, but it might simultaneously clash with the principles that make RCs into what they are (Perkins et al., 2018, p. 17 ff.).

Our study indicates that some of the same mechanisms that facilitate positive outcomes for some participants, such as the extensive sharing of personal experiences (Toney et al., 2018), may be the same ingredient that spurs other participants to drop out or experience alienation. Rather than fighting all types of dropout, which may risk changing the features that drive positive outcomes in the process, we should consider RCs as a concept that fits and benefits some, but not all participants, and signpost those who do not benefit from RC to alternative services that accommodate their needs, preferences and circumstances.

CONCLUSION

The rapid spread of RCs calls for solid research on beneficial as well as adverse outcomes. This article presents the first systematic study of RC dropout thereby constituting a valuable contribution to the literature. We conclude external, relational and course-related drivers spur RC dropout. Some drivers are manageable within the RC concept while others require structural changes and therefore call for a principled discussion of what types of dropout to accept. Future research must investigate how drivers of dropout vary with national contexts and illuminate how responses designed to reduce dropout work in practice. This research will enable well-informed decisions on how and when to combat or accept dropout.

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RELEVANCE TO CLINICAL PRACTICE

This study contributes to the existing body of knowledge on RCs by bringing light to potential adverse outcomes of RC participation and drivers that spur dropout. The study proposes ways that adverse dropout may be reduced but also suggests an acceptance of some types of dropout in a recognition of RC as a concept that fits and benefits some, but not all participants.

AUTHOR CONTRIBUTIONS

Ditte Andersen and Sine Kirkegaard contributed to funding acquisition, research project design, data collection and data analysis. Ditte Andersen, Anna Kristine Waldemar and Sine Kirkegaard contributed to review of literature and previous dropout research, interpretation and discussion of results and writing—original draft. Ditte Andersen and Anna Kristine Waldemar contributed to writing—revision. All authors have read and agreed to the revised manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data (qualitative interviews) are not publicly available due to privacy and ethical restrictions.

ANONYMIZED INSTITUTIONAL REVIEW BOARD AND APPROVAL NUMBER

VIVE Research Ethics Committee; approval number 2022/3.

ETHICS STATEMENT

Our study was approved by VIVE Research Ethics Committee (approval no. 2022/3). All participants provided verbal informed consent prior to their participation in the study.

ORCID

Ditte Andersen https://orcid.org/0000-0002-2085-3305
Anna Kristine Waldemar https://orcid.org/0000-0003-2581-1662
Sine Kirkegaard https://orcid.org/0000-0003-0191-1001

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