Left behind

A review of therapist and process variables influencing dropout from individual psychotherapy

Johanna Roos

Handledare Andrzej Werbart

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Dropping out from psychotherapy is a complex phenomenon that has impact on the mental health of the dropout patients primarily and the mental health care secondarily and needs to be understood from many different angles. Among potential predictors, patient variables are so far most thoroughly examined. This tends to simplify the causal explanations that may result in adjustment of treatment procedures that are inadequate for addressing the problem. The aim of this review is to examine the current state of knowledge about therapist and process factors influencing dropout from individual psychotherapy. After electronic searches in databases 40 relevant studies published 2000–2011 were identified. The results show that the therapist skills and degree of education and experience has a great impact on dropout rates, psychotherapeutic progress and outcome, and the quality of alliance and relationship. The conclusions are that the therapists need training, peer and organisational support for accomplishment and enhancement.

Dropout or premature termination of psychotherapy is an important clinical phenomenon. The frequencies for dropouts vary strongly among studies with frequencies between 30-50 % (Baekeland & Lundwall, 1975; Barrett et al. 2008; Chiesa, Wright & Neeld, 2003; Kazdin & Mazurick, 1994; McMuran, Huband & Overton, 2010; Wierzbicki & Pekarik, 1993). Most dropouts occur within the first sessions, which is problematic, since twelve sessions is considered a minimum for a good outcome (Hansen, Lambert & Forman, 2002). Psychotherapy is an effective treatment for psychological distress and dropouts take no advantage of this. If predictors of therapy dropout are identified, we might be able to better adjust clinical practice to the specific patient in order to motivate the patient to stay in a potentially productive treatment (Lambert, 2004; McMuran et al., 2010). The phenomenon has a great impact on the health care organisation in many complex ways. Resources are wasted, weary therapists are left behind and to even more complicate things studies show that many dropouts are contented with their contact or return within a year (Baekeland & Lundwall, 1975; Klein, Stone, Hicks & Pritchard, 2003; Lambert, 2004; Reis & Brown, 1999; Wierzbicki & Pekarik, 1993).

Thus, dropping out of psychotherapy is a complex phenomenon with varying occurring rates, impacts and predicting factors. The predicting factors can be divided into three

clusters: those concerning the patient, the therapist and finally the process. Most thoroughly examined in empirical studies so far are the patient factors. The most important patient factor predicting dropout is the level of socioeconomic status (SES). Persons with high SES are most likely to possess the qualities that predict psychotherapeutic success. High level of education, income and social status are associated with persons who have a strong efficacy over their own life and options of social participation which together seems to constitute the complex structure of completion respectively dropout from psychotherapy (Baekeland & Lundwall, 1975; Marmot, 2004).

More likely to drop out of psychotherapy are thus individuals with low SES, which is associated with a low level of education, income, lack of power in society and socially strained residential areas and family conditions (Baekeland & Lundwall, 1975; Hollingshead & Redlich, 1958; McCabe, 2002; Pekarik, 1985a, Richmond, 1992; Wierzbicki & Pekarik, 1993). Low SES is also associated with other factors that predict dropout, such as substance abuse, criminality, and certain personality traits such as overall defensive patterns dominated by denial, avoidance and projection but also hostility, aggressiveness, suspiciousness, grandiosity and violent tendencies (Baekeland & Lundwall, 1975; Lambert 2004; McNair & Corazzini, 1994; Paivio & Bahr, 1998; Pekarik 1985a; Richmond, 1992). This is reflected in the therapeutic relationship and makes it difficult for a therapist to form a therapeutic alliance with a patient who has problems coping with issues of dependency, intimacy, trust, distance and autonomy (Lambert 2004; Thormählen et al., 2003). It is more common that these individuals produce external explanations to personal problems but it is also important to acknowledge that persons with low SES actually have less control and influence over their strained life situations, a precondition known to produce psychological distress especially among women (Greenspan & Mann Kulish, 1985; Magnusson & Marecec, 2010; McNair & Corazzini, 1994; Richmond, 1992).

Other common explanations that more represent the relationship and process factors concern dissatisfaction with the therapy or therapist. These are not as thoroughly studied but it is obvious that dropout and dissatisfaction should not be confused since these are different phenomena: dissatisfied patients may stay in therapy as well as satisfied patients may drop out (Beckham, 1992; Garfield, 1963; Lambert, 2004; Pollak, Mordecai, & Gumpert, 1992). Satisfied and symptom relieved patients experience emotional and relational improvement, enhanced self-understanding and compensatory skills, as well as an overall feeling of life and one's life patterns being more meaningful (Binder, Holgersen & Nielsen, 2009; Connolly Gibbons, M.B., Crits-Cristoph, Barber, Wiltzey Stirman, Gallop, Goldstein, Temes, & Ring-Kurtz, 2009). Dropout patients express disappointment about not receiving enough information, validation and support (Lambert, 2004; Reis & Brown, 1999). They describe their therapists as unsympathetic, passive and indifferent which gives rise to shame and embarrassment (Kolb, Beutler, Davis, Crago, & Shanfield, 1985; Mohl et al., 1991; Reis & Brown, 1999). The patients started psychotherapy with expectations that was not fulfilled and not shared with the therapists who, on their part, describe the clients as not understanding what being in psychotherapy involves (Cartwright, Lloyd & Wicklund, 1980; Pekarik 1985b; Reis & Brown, 1999; Tryon, 1999).

The therapist factors, finally, are studied even less. The few studies concerning this factor found significant differences among therapists with regard to frequency of patient dropout and therapeutic outcome (Blatt, Sanislow III, Zuroff & Pilkonis, 1996; Crits-Christoph, Baranackie, Kurcias, Beck, Carroll, Perry, Luborsky, McLellan, Woody, Thompson, Gallagher & Zitrin, 1991; Luborsky, McLellan, Digeur, Woody & Seligman, 1997). Lower rates of dropout are related to more experience, flexibility in relation to treatment manuals which correlates with accommodation to the specific problems of the patients, training and own psychotherapy and this also accounts for the level of psychotherapy outcome (Blatt et.al., 1996; Crits-Christoph et.al., 1991; Greenspan & Mann Kulish, 1985; Luborsky et.al., 1997; Messer & Wampold, 2002; Norcross & Wampold, 2011; Richmond, 1992; Roth & Fonagy, 1996). Therapists using interventions as extensive and early interpretations and confrontations are perceived as unsympathetic and hostile which is a dropout predictor (Crits-Cristoph & Connolly-Gibbons, 2001; Hilsenroth & Cromer, 2007; Norcross & Wampold, 2011).

All together these findings converge into the concept of alliance which is surrounded by the more elusive concept of being together – a common factor within psychotherapy largely independent of theory or technique, whose complex importance for therapeutic relationship, process and outcome cannot be overestimated (Norcross & Wampold, 2011; Messer & Wampold, 2002). Binder et al. (2009) gave room for patients' own expressions of successful psychotherapy experiences of change. Different aspects of symptom relief were expressed but the superior factor as well as the underlying explanation was the relationship with a "wise, warm and competent professional". Alliance is defined as the patient and therapist sharing common goals or purpose with the therapy, with the patient's sense of safety and trust in the therapy process and in the therapist, while the relational concept of being together describes the many layers of the moment-to-moment intermodal exchange, affect attunement and the matrix of intermodal equivalence in the relationship between patient and therapist. Being together holds the paradox of individuation growing out of symbiosis within the earliest and most basic modes of communication far beyond words (Daniel, 2006; Crits-Cristoph & Connolly-Gibbons, 2001; Hilsenroth & Cromer, 2007; Jørgensen, 2004; Kolden et al., 2005; Kumin, 1996; Lambert, 2004; Norcross & Wampold, 2011; Puchner et al., 2005; Stern, 1985; Stern, 2004). An early established and strong alliance predicts continuation but the contrary does not doom the therapy since the therapist's skill may remedy (Puchner et al., 2005). The skill of the therapist often means an adaptation of interventions, attitude and an overall approach according to the patients' specific needs and difficulties caught within the alliance but even more within the matrix or thickly woven fabric of being together (Crits-Cristoph & Connolly-Gibbons, 2001; Daniel, 2006; Hilsenroth & Cromer, 2007; Kolden et al., 2005; Lindgren, Werbart & Philips, 2010; Kumin, 1996; Norcross & Wampold, 2011; Stern, 2004). Psychotherapy outcome can be enhanced by matching patient characteristics and therapist qualities (Norcross & Wampold, 2011).

The dropout phenomenon not only raises problem for the clinical practice. At least a two-folded problem also arises in research. The first considers the definition. Hatchett and Park (2003) summarize this by subdividing the term dropout into four operational definitions represented in the literature to evaluate their concordance with premature terminations. The definitions are (a) therapists judgement, (b) termination by failure to

attend the last scheduled appointment, (c) median-split procedure, and (d) failure to return after the intake appointment. When examining them the authors find that (a) and (b) both seem to describe the same phenomenon accurately having the same rate of 40%, but (c) and (d) are not, with rates at 53% and 18% respectively. No unequivocal recommendation is made but they suggest future researchers to use (b) – the no-show in combination with an outcome evaluation and dissuade from using (c) – not attending enough sessions. These recommendations are made since patients and therapists can agree upon terminate therapy prematurely because of symptom relief. The second fold considers the problem of how to understand the dropout phenomenon. Harris' (1998) summary of this problem consist of three parts: the lack of consensus regarding the definition (which was outlined above), the lack of replication-studies and the problem of simplistic and atheoretical analyses, exemplified by the numerous studies of dropout predictors on a simple client level and the lack of studies with a more complex approach. Norcross and Lambert (2011) confirm this in their review and of evidence-based therapy relationship elements that underlie treatment outcome and effectiveness. Their conclusion is that the many complex connections between patient characteristics, method and practice, and therapist and relational factors need further investigation as well as a comprehensive understanding (Norcross and Lambert, 2011; Norcross & Wampold, 2011).

Dropping out from psychotherapy is a complex phenomenon indeed, not least in light of the fact that the therapeutic relationship is a dyad with all that implies and where a great importance, but seldom acknowledged, is directed towards the therapist. Regarding this the research focus on preferably client predictors obviously tends to simplify the causal explanations in a problematic way that may result in adjustments of treatment procedures that are inadequate for really addressing the dropout problem. This study tries to address this limitation. The aim is therefore a literature review of the current state of knowledge about therapist, relationship and process factors influencing the dropout phenomenon in individual psychotherapy.

Method

Databases used for electronic searches in this study were PsychINFO, Pubmed and Cochrane Library. The inclusion criteria were (a) individual psychotherapy, (b) attrition or dropout or discontinuation, (c) predictors, (d) adults and (e) publication between 2000 and 2011. Searches were then performed in titles, abstracts and keywords. An extensive reading process started. By reading titles, abstracts and keywords several studies were excluded according to the following principles: studies concerning forensic care, in-care or compulsory care, addiction, and finally medication treatment with or without psychotherapy. The remaining studies were then read in full and those not meeting the criterion of relating dropout rates to therapist or process factors were excluded. McMuran et al.'s (2010) systematic review of non-completion in personality disorder treatments has served as an overall model for this study.

Being a review the study methodically aims to gather and overview existing information and knowledge about a certain phenomenon.

Results

The last searches were made by January 2011 in all three databases and by then 1153 studies were electronically identified using the inclusion criterions. By using the exclusion criterions when reading titles and abstracts the number of studies could be gradually reduced to 201. Closer reading of these studies excluded further 161 studies. The remaining 40 studies are included in the review and reported in Table 1 and below.

The 40 studies were carried out in twelve countries in the Western world: USA (22), Britain (3), Austria (3), Germany (2), Sweden (2), Italy (2), and 1 study each in Brazil, Canada, Spain, Greece, Norway and Israel. No study was found from Australia, Asia or Africa. One study was published in German, one in Portuguese and the rest in English. Of the 40 studies four were reviews, two were meta-analyses, 33 were quantitative studies and one was qualitative. The number of participants was specified in 35 of the studies and all together they amount 34,972 participants, ranging from 6 to 22,095 with a mean of a thousand participants in each study.

Diagnoses were specified in 22 studies. Mood Disorders, Anxiety Disorders and Personality Disorders dominate. The proportion of women was specified in 30 of the included studies. Women dominate, ranging from 51 to 100 percent with a mean of 68 percent. All studies concerned individual psychotherapy since this was one of the inclusion criterions. The type of psychotherapy was specified in half of the studies. Psychodynamic psychotherapy and cognitive behavioural therapy dominated but other types were represented as well. Duration was specified in seven studies. Two of these concerned specific therapy models (Horwitz' psychodynamic model and Luborsky's supportive-expressive psychotherapy), three of them stated a mean number of sessions, and two stated a minimum number of sessions that was also related to the definition of dropout.

Dropout was defined and rated in 26 of the studies. The four reviews left both these concepts unspecified, the two meta-analyses as well, in three of the studies dropout was the inclusion criterion and was not otherwise specified and in further five studies they were simply not specified for different reasons. The rates of dropout varied strongly between 12 and 69 percent with a mean of 39 percent. Recalling Hatchett and Park's (2003) distinction between four operational definitions the 27 studies used either (b) not showing up (16) or (c) a median-split procedure with the patient ending before a certain number of sessions or time-limit (10). The variation was stronger using the median-split procedure, between 12 and 69 percent, than using termination by failure to attend the last scheduled appointment, 15-53 percent, but the mean was 39 percent in both cases.

Therapist factors behind dropouts were specified in 22 of the studies. Within this factor twelve subordinated factors emerged. The therapist's education, experience and age influenced dropout in six studies. The therapist showing empathy, warmth and regard predicted continuation in five studies. Reminding about appointments, calling when missed and being supportive in a concrete manner predicted continuation in four studies. Gender and ethnicity of the therapist was a focused factor in four studies. They showed that this factor did not influence dropout rates in itself but still demonstrating that gender and ethnicity of the therapist gave specific competence that affected their ability as therapist with different patients which in the long run could influence dropout.

Table 1. Characteristics of studies and predictors of dropout (40 studies).

Author Type of study	Country	N	Diagnoses	% women	Treatment type and duration	Definition of attrition	% attrition	Therapist factors	Relationship and process factors
Bados et al. (2007) **Naturalistic**	ES	203	n.s.	72%	CBT; 14 sessions	Dropping out of treatment before 14 sessions without the therapists consent	44%	n.s.	The majority of the attritioners dropped out already after session 1, 28.1%, and by session 5 51.7 % had dropped out. They had dissatisfaction with therapist or treatment (46.7%) and improvement (13.3%) as explanations
Barrett et al. (2008) **Review**	US	n.s.	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	Therapist giving the patient feedback on the progress had fewer dropouts	Initial perceptions and expectations influence dropout rates. Dropouts perceived their therapists as less expert, competent or trustworthy. Dropout correlates with dissatisfaction
Baruch et al. (2009) **Naturalistic**	GB	882	MD 47%; AD 23%; PD 8%; Other 17%	71%	Individual PT once weekly for more than 20 sessions.	Decision to stop treatment before session 21	69%	Continuing patients have therapist with longer experience than dropouts	A generally higher level of emotional and cognitive functioning and of other external circumstances predicts continuation and quality of alliance
Berghofer et al. (2002) **Naturalistic, interviews**	AT	111	AD 54%; MD 10%; PD 10%; Other 39%	59%	PT n.o.s.; duration n.s.	Patients who discontinued on their own initiative failing to attend appointments	36%	Therapists tend to overestimate the severity of symptoms and need for treatment length	Dropouts come back within 12-18 months and often reports symptom relief as a reason for dropping out
Charnas et al. (2010) **Naturalistic**	US	101	MD 54%; AD 13%, PD 53%; Other 33%	70%	PDT; twice weekly	Patients completing first assessment, attended fewer than 8 sessions and explicitly indicated that they did not want to continue	22%	Differences between therapist (age, gender, education, experience) have greater impact on dropout and outcome rates than differences between patients. SES and other factors of the therapists have impact and need to be acknowledged	Early alliance predicts continuation

Corning & Malofeeva (2004) **Naturalistic**	US	739	n.s.	60%	PT n.o.s., ST and LT. H/E 29%, CBT 29%, IPT 25%, PDT 17%, SYT 17%.	Patients who discontinued on their own initiative failing to attend appointments	35%	n.s.	Patients initially placed on waiting-lists are at higher risk of dropping out. Highest risk early in treatment, increased risk session 8 and almost no remaining risk at session 28
Defife at al. (2010) **Naturalistic**	US	2338 appointments	n.s.	n.s.	n.s.	MA= Missed Appointment	15%	Therapists cancelling appointments increase risk for ruptures and patients later MA:s	13 % of MA were motivated with dissatisfaction with therapy or therapist and other alliance ruptures. 5 % of MA were explained with practical misunderstandings
Derlega et al. (2001) **Patient survey**	US	168	MD 21%	83%	PT n.o.s. with a median of 10 sessions; duration n.s.	n.s.	n.s.	n.s.	The level of commitment in therapy is influenced by perceived neglect, loyalty, voice and exit and has an impact on alliance. Strong alliance predicts continuation
Falkenström (2010) **Naturalistic**	SE	101	MD 30%; AD 24%; PD 15%	82%	Mostly PDT; duration n.s.	n.s.	16%	n.s.	Dropouts tend to return later with more motivation. PDT leads to more sessions and higher improvement than current psychiatric contact
Goldenberg (2002) **Naturalistic**	US	2889	MD 34.6%; AD 30.8%	61%	PT n.o.s.	n.s.	59%	Completers improved but not dropouts. Completion depended on therapist-factor mostly, the most experienced therapists had the most completers and most visits. Enhancing therapists education and skill seems to be the best way to reduce dropout rates	n.s.
Goldman & Anderson, (2007) **Naturalistic**	US	55	n.s.	89%	PT, EPT 54.7%; CBT 18.2; Other 27.3%, mean length of therapy 5.35 sessions; duration n.s.	Failure to attend one session followed by failure to schedule for any further session.	44%	Possibility of comparing dropout rates between therapists was not used	Initial strong alliance correlated with patients' stabile object relations and secure attachment but it did not correlate with dropout rates.
Hamilton et al. (2009) **Naturalistic**	US	145	n.s.	57%	PAT	Patients discontinuing prematurely	40%	Tendency that candidates have higher dropout rates than supervisors as a consequence of inexperience. Some therapist seem to have higher dropout rates	Patients converted from psychotherapy to psychoanalysis hade lower dropout rates than patients in evaluation

Hatchett & Park, (2004) **Naturalistic**	US	245	n.s.	68%	PT n.o.s.; duration n.s.	Premature termination when patient missed schedules appointment without rescheduling	40%	The therapist's sex does not matter	Matching sex in the therapist-patient dyad does not influence dropout rate. The therapist's sex influences the perception of the patient's sex-related experiences
Hauck et al. (2007) **Naturalistic**	BR	56	n.s.	84%	PAT	Interruption (communicated or not) before 3 months of treatment.	13%	Higher degree of education and experience tend to reduce dropout	Low degree of alliance is a risk for dropout. Initial agreements between therapist and patient reduce dropout
Hoyer et al. (2006) **Patient survey**	DE	461	MD 48%	81%	PT: CBT 34%; CCT 35%; PDT 16%; Other 14%; duration n.s.	Premature termination	42%	n.s.	Satisfaction with and improvement after PT do not necessarily correlate. Patients are more satisfied if the treatment includes information about their diagnosis, making agreements and evaluations with the therapist and educational contributions
Junkert-Tress et al. (2000) **Case studies**	DE	12	n.s.	n.s.	ST PDT	n.s.	100%; only dropouts	n.s.	Difficult to form an alliance with narcissistic patients due to their relating problems and therapists hostile countertransference
Lazaratou et al. (2006) **Epidemiologic**	GR	A: 455; B: 476	n.s.	n.s.	PT n.o.s.; duration n.s.	Premature termination without therapist's consent	A: 59%; B: 32%	Other teamwork modifications that enhance therapists ability to form alliances reduce dropouts	Shorter period between diagnostic assessment and starting therapy reduces dropout. Fewer diagnostic appointments reduce dropout. Focused therapies have less dropout
Lingiardi et al. (2005) **Naturalistic**	IT	47	PD	66%	PT, Horwitz et al.'s model.	Discontinuation of psychotherapy by the patient without communication or discussion with the therapist	21%	Therapists evaluate patients in cluster B more negatively than cluster A and C. They evaluate cluster C most positive and optimistic. Therapist rate alliance lower than patients	Early evaluation of alliance, depending on both relational and pedagogical components, predicts dropout well. Cluster A-patients seem to have most difficult to form alliance with the therapist and vice versa

Löffler-Statska et al. (2010) **Naturalistic**	AT	1: 129; 2: 95	MD 41% resp. 28%; AD 19% resp. 22%; Other 40% resp 46%; PDA 17% resp. 21%; PDB 54% resp. 55%; PDC: 22% resp. 19%	1: 74%; 2: 68%	Mostly PAT/PDT; 83% at least 10 sessions for all samples	n.s.	n.s.	n.s.	Difficult to form an alliance with externalizing patients due to their problems with relating and self-reflecting when the therapists perceive them as cold and dismissive
Mahon et al. (2001) **Naturalistic**	GB	114	Eating disorder	100%	n.s.	Premature termination without therapists consent before session 10	55%	Ability to form a warm and trusting relationship where other issues than those in clinical focus can be talked about, such as childhood traumas	Attachment patterns correlate with dropout rates – unsafe attachment predicts dropout
Maramba & Nagyama Hall (2002) **Meta-analysis**	US	22095	2 of 7 studies of Vietnam veterans with PTSD; other n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	Therapists have specific ethnic and cultural competence according to their own background which influences their therapeutic ability with different patients	Ethnic match between therapist and patient influences outcome and dropout rates. Ethnicity and cultural competence probably hard to differentiate under certain circumstances
Morlino et al. (2007) **Naturalistic**	IT	100	Eating disorder	100%	n.s.	Premature termination without therapists consent	53%	n.s.	Alliance between patient and therapist plays a key role for a stable and continuous therapeutic program
Mueller & Pekarik (2000) **Naturalistic**	US	230	MD 25%; AD 15%; Other 55%.	46%	CBT 32%; EPT 30%; SYT 19%; PDT 19%	1. A lower percentage of accurate (37%) than fewer-visits (72%); 2. A lower percentage (33%) of more than fewer-visits (72%)	1. 37% 2. 33%	Therapists underestimate the possibility of attrition and they are more negatively affected by them than necessary since the overestimate client dissatisfaction and underestimate client improvement at dropouts	Clients' prediction of treatment duration was the best predictor of actual duration, satisfaction and positive outcome. The fewer the sessions the higher the dissatisfaction, but no connection between fewer sessions and lower improvement
Nysaeter et al. (2010) **Naturalistic**	NO	32	BPD	81%	Non-manualized PDT; mean 68 sessions, 1-3 years of treatment	n.s.	28%	n.s.	Opposite sex of therapist predicted drop-out. Open-ended psychotherapy reduced dropout. Ending therapy when agreed-upon goals were obtained reduced dropout

O'Brien et al. (2009) **Review**	GB	Total n. 854	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	33%	Therapists perceived as unsympathetic had more dropouts	Dropout correlates with overall dissatisfaction with the care
Ogrodniczuk et al. (2007) **Review**	US	n.s.	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	Therapist reminding their patients about appointments, showing warmth, regard, empathy and genuineness and giving room for negative feelings had fewer dropouts	Patients prepared by the therapist or someone else on what therapy might involve, what might be expected, and who made negotiations with their therapist etc were less likely to drop out
Perry et al. (2007) **Naturalistic**	CA	53	AD 75%; MD 64%; PD 75%; Other 7%	77%	LT PDT; median duration 110 sessions	Premature termination om patients initiative for intrinsic reasons or extrinsic reasons	28%	Therapists availability correlates with their patients dropout rates	Patients dropping out for intrinsic reasons had fewer weekly sessions than continuers. Sparse contact correlates with patients' reluctance and troubled alliance
Pinsker-Aspen et al. (2007) **Naturalistic**	US	57	MD 65%; AD 11%; PD 18%; Others 18%	70%	PDT; Duration n.s.	Premature termination	12-18%	n.s.	Strong alliances gave lower dropout rates. Strong alliances correlates with patients complex, differentiated and well integrated object relations and higher relational capacity according to therapists assessments
Reis et al. (2006) **Naturalistic**	AT	125	MD, AD or other 80%	66.4%	10 therapist of which 5 PDT, 2 CBT, 3 SPT and 1 ET; Duration n.s.	Patient not coming and failing to schedule a new appointment within 30 days of the last event	31%	n.s.	Patients that were prepared by the therapist on what the therapy might involve, what might be expected etc were less likely to dropout
Reitzel et al. (2006) **Naturalistic**	US	313	MD 46%; PD 19%; 19% AD 19%; Other 56%	55%	PT n.o.s.. Duration n.s.	1. Failure to attend therapy at all; 2. Unilateral termination by the patient after contact with assigned therapist.	22%	n.s.	Experiencing timeliness of treatment predicts attendance. Long time between assessment and therapy predicts dropout.
Ruiz et al. (2004) **Naturalistic**	US	220	MD or AD 39%; PD 9%, others n.s.	65%	CT 34%; PDT 20%; BT 19%; Systemic 10%; Experiential 9%; Others 8%. Duration n.s.	Not completing the first 7 sessions	n.s.	n.s.	High generalized interpersonal distress according to IIP gives poorer outcome but lower dropout. Hard to form alliance with high idealization, narcissism and hostile submissiveness

Samstag et al. (2008) **RCT**	US	48	MD 63%; AD 25%; PD 79%; Other 17%	56%	PDT I +II 23%+25%; SUT 10%; CBT 21%; IPT 21%. Duration n.s.	Premature ending before one-third of agreed-upon treatment	33%	n.s.	A lower degree of narrative coherence and of alliance were found in drop-out dyads than in completer dyads
Shamir et al. (2010) **Patient survey**	IL	82	Psychotic disorders 36%	65%	PDT, CBT, SUT and other; commonly weekly sessions. Duration n.s.	Patients attending at least one session but not returning for sheduled revisits	100%; only dropouts	Therapist "reaching out", "holding" and encouraging patient to stay in therapy reduces dropout.	Many dropouts reported satisfaction and symptom relief while therapist considered the dropout as a treatment failure. Most dropouts before session 10.
Sharf et al. (2010) **Meta-analysis**	US	1301	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	Mean 11 studies: 56%	n.s.	Weak alliances correlates with higher dropout-rates, the longer the treatment the stronger the correlation
Shoffner et al. (2007) **Clinical trial**	USA	n.s.	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	Therapist in direct contact with patient before session or assessment either to remind them of the appointment or to encourage to come reduce dropout	n.s.
Thormälen et al. (2003) **RCT**	SE	80	PD	69%	SUT (Luborsky)	Patients not attending or discontinuing on own behalf	35%	n.s.	A distinct focus on defined problems seems to reduce dropout
Todd et al. (2003) **Naturalistic**	USA	123	n.s.	n.s.	PT n.o.s.; duration n.s.	Ending therapy before agreed-upon both by therapist and patient	n.s.	n.s.	Dissatisfied patients had fewer sessions than satisfied. Improved patients had more sessions than not improved. Patients reported more dissatisfaction with therapy than therapists. Both patients and therapist reported multiple reasons for termination
Vasquez (2007) **Review**	US	n.s.	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	Therapists perceived as unsympathetic, biased, discriminating had more dropouts among ethnic minorities	Reality comes in to the room, even discrimination. Patients describe even facial expressions and other subordinate expressions.

Wilson & Sperlinger (2004) **Qualitative**	US	6	n.s.	50%	LT PAT for more than 2 years	Discontinuing before the 2-year minimum	100%; only dropouts	Therapists are highly and negatively affected by the dropout. Experience lower the self-blame and enhance the curiosity about the event which is more adaptive	Clients reported mismatch between them and therapists, therapy giving rise to too much painful feelings and strong ambivalence. Clients over-report positive feedback to therapist and underreport experiences of conflict and pain
Young et al. (2000) **Naturalistic**	US	1769	MD 30%; AD 5%; Other 54%	51%	PT n.o.s.; duration n.s.	Patients who discontinued on their own initiative failing to attend appointments	n.s.	n.s.	Dropouts tend to report more improvement than continuers. Calling patients when they do not show up tends to reduce dropout

Key for diagnoses: AD - Anxiety Disorder; MD - Mood Disorder; PD - Personality Disorder; PDA - Cluster A (Paranoid, Schizoid, Schizotypal) Personality Disorder; PDB - Cluster B (Antisocial, Borderline, Histrionic, Narcissistic) Personality Disorder; PDC - Cluster C (Obsessive-Compulsive, Avoidant, Dependent) Personality Disorder.

Key for treatment type and duration: BT - Behavioural therapy; CBT - Cognitive Behavioural therapy; CCT - Client centred therapy; CT - Cognitive therapy; EPT - Eclectic psychotherapy; H/E - Humanistic-existential psychotherapy; IPT - Interpersonal/relational psychotherapy; LT - Long-term; PAT - Psychoanalytic psychotherapy; PDT - Psychodynamic psychotherapy; PT - Psychotherapy; ST - Short-term; SUT - Supportive psychotherapy; SYT - Systemic psychotherapy.

Therapists perceived as biased or unsympathetic had more dropouts in three studies. These factors obviously influence the therapeutic relationship. For example, patients in one study described sublime therapist reactions as tone of voice, glance in eyes as important for feelings of being understood and accepted. Therapist with access to team of colleagues or tutorials, education and organisational support had fewer dropouts in two studies. Therapist not giving room for negative affects or perceptions of the therapeutic relationship or of the process increased risk for dropout in two studies. In one study each three further factors influenced the dropout rates. Therapists cancelling appointments, not giving feedback on the progress, and responding more negatively to patients with cluster B personality disorders had more dropouts. Finally, two additional factors were found though not immediately related to dropout but still important for understanding the phenomenon. In two studies therapists were showed to overestimate the length of the contact and severity of symptoms, thereby giving rise to premature endings or misunderstandings. In another study the authors found extensive individual differences in dropout rates between therapists and had material for lining out these but explicitly chose not to while concluding that all the therapists in the study had dropouts anyway.

Relationship and process factors behind dropout were specified in 38 of the studies and ten subordinated factors emerged. The quality of the alliance influenced dropout rates in sixteen studies. Strong alliance early in the process predicted continuation in the studies. Dropouts occur in over half of the cases before session five. Sparse contact, lack of timeliness between the first contact and starting therapy or few appointments increased risk for dropout in seven studies. Preparation and information about therapy, expectations and preferences beforehand predicted continuation in six studies. A general dissatisfaction about the therapist or the therapy predicted dropout in five studies. In five studies gender or ethnic mismatch between therapist and patient predicted dropout. Focusing after agreeing upon central problems predicted continuation in two studies. Attachment patterns were examined in one study showing that counter-matching of patterns between therapist and patient worked out better than matching when comparing dropout rates. Three final subordinated factors emerged in eight studies that cannot directly be classified as influencing factors but they are still important parts of the phenomenon. Patients dropping out from treatment are not necessarily patients that have experienced lack of improvement, but rather the opposite, which is clearly shown in four studies. Patients dropping out gave rise to misunderstandings in two studies: therapist considered the occurrences failures while the patients turned out being satisfied and relieved of symptoms which is concordant with above. Dropouts returned within less than 18 months to treatment in two studies.

Discussion

The common knowledge

Previously well known facts about psychiatric outpatients in general and dropout especially were confirmed in this review. The most common diagnoses were Mood Disorders, Anxiety Disorders and Personality Disorders which is concordant with findings from psychiatric outpatient services. Women's domination is also falling into the category of well known facts, especially since forensic care settings and substance abuse clinics, where men dominate among patients, were excluded from this review.

The dropout rates varied strongly but were constantly high with a mean of almost 40 percent, some percentages higher than in previous reviews of dropout. This could be an effect of the focus in the included studies on dropouts specifically. When defining a patient not showing up to an appointment as a dropout the phenomenon is probably more exactly caught than defining dropout as the patient not attending enough number of sessions. The rates varied less for no-shows and the rates where not at the same risk of being biased by the fact that many therapists and patients agree upon earlier endings because of symptom relief. One study defined dropout as attending fewer than 21 sessions and that could be considered as almost asking for an unfairly high dropout rate (69%). The high dropout rates produced by the median-split procedure probably reflect other phenomena within the psychotherapy field especially the fact that therapy, as all other relationships in life, consists of constant renewals of agreements such as abridged length of therapy because of symptom relief. These are at least as important but in the periphery of the dropout phenomenon.

As well known, or even as expected, these findings may be they are of no less importance. Confirmed over and over again they convincingly describe the psychiatric reality when it comes to these fundamental conditions.

Another well known fact confirmed here and probably more reflecting the research reality than the clinical practice is the sparse focus on therapist factors especially but also on relationship and process factors behind dropouts in comparison with the extensiveness of studies focusing on patient factors. The importance of SES and the difficulties produced by patients with personality disorders, especially cluster B, is confirmed over and over again. Living under social and economical strains could be considered as a vicious circle. Such life circumstances in themselves produce psychological distress and suffering expressed both by women, dominating among psychiatric patients, and men, dominating in forensic care and substance abuse clinics. Especially women and patients from ethnic minorities express in the studies a wish to match the therapist's gender or ethnicity to one's own. This reflects probably an experience of being different or deviant, not understood, misunderstood or even worse discriminated, maybe with feelings of shame and embarrassment. The effect of such distress, the hopelessness and powerlessness, the stigma left by a history of forensic care might aggravate the strained life conditions as well as the perceptions of unsympathetic and unsupportive therapists give rise to dropout and actually not being helped. Again, patients factors in general and the SES-factor especially are of no less importance in describing the fundamental conditions of the psychiatric reality but important angles of the dropout phenomenon are still left in darkness, such as the therapist and the relationship and process factors.

The common factors

This review distinguishes between therapist and relationship and process factors, each of them divided into several subordinated factors (summarized in Table 2). There are differences between those factors but, after all, almost all of them could be converged into therapeutic alliance and definitely all of them into the relational and common factor of being together. Building a strong alliance early in the process predicts continuation.

Table 2. Therapist and relationship/process factors contributing to dropout; number of publications per subordinated factor (several subordinated factors might appear in each study). *Factors in italics represent those not immediately influencing dropout but still important for understanding the phenomenon.*

Factor	Frequency
Therapist factors	22
Education, experience and age	6
Empathy, warmth and regard	5
Concrete support (reminding about appointments for example)	4
Gender and ethnicity	4
Unsympathetic, biased therapists	3
Denying of negative affects	2
Team of colleagues, organisational support	2
Cancellations made by therapists	1
Not giving feedback	1
Negative responses	1
Initial overestimation of treatment length or severity of symptoms	*2*
Not investigating obvious differences between therapists	*1*
Relationship and process factors	38
Quality of alliance	16
Sparse contact or few appointments	7
Patient dissatisfaction	5
Mismatch of gender and/or ethnicity	5
Preparation, information	6
Central focus	2
Counter-matching attachment patterns	1
Misunderstandings	*2*
Returning before 18 months after dropout	*2*
Dropout ≠ lack of improvement	*4*

Preparing and informing about what it takes, dense appointments and a concrete holding by reminding about appointment as a non-evaluative hands-on way of addressing external difficulties is all a way of strengthening the initial alliance. Timeliness between intake and psychotherapy start is a factor mentioned in the studies as influencing dropout rates. However, this factor also contains those in recent studies called the non-starters, i.e. those that not start in agreed-upon therapy at all, and they partly differentiate from dropouts. Showing empathy, being sympathetic and attentive towards the patient, accommodating to the patient's needs, focusing on central issues that are agreed upon, giving feedback on the progress and giving room for negative affects

primarily, all this describes the relational flow of being together which secondarily further strengthen alliance. Dissatisfaction and misunderstandings could then be considered aspects of a weak alliance and ruptures in the relationship. Quality of alliance is therefore an aspect of time passing. Dropout occurs most frequently early within the first sessions, while late dropouts occur somewhere between rarely and never. Alliance is in its turn held by the relationship; the concept of being together which is a thick fabric woven of threads of all colours and materials in many layers.

Although alliance and the concept of being together counts as a relationship and process factors it still weighs heavier on the therapist to form an alliance and build a relationship that holds on for continuation and a psychotherapeutic good outcome. The therapeutic relationship is always unequal and asymmetric and the responsibility for continuation and outcome may never be evenly shared between therapist and patient. Some of the studies clearly show that the therapist factor, consisting of such components as the therapist's skills, degree of education and experience, is a superior factor that in the end rules out every other factor. A skilled therapist handles attachment patterns, difficulties, needs, wishes and character traits of the patient adaptively and accordingly in order to secure continuation and a positive progress in therapy. The very same studies that report patients wishing matching of gender and ethnicity with their therapists also report that mismatching does not need to end with dropout, just as an initially weak alliance does not have to remain weak as long as the therapist is skilled enough. Other studies not included in this review confirm this and also supports the occasional need for matching patient characteristics and therapist qualities.

The context of skill

The skilled therapist rises up from the reviewed studies as a professional person with a contradictory competence at first glance. A skilled therapist builds a strong early alliance by not giving cancellations or sparse appointments and protects the relationship from ruptures, still taking negativity, disappointments and hardly bearable affects into the room. A skilled therapist holds on to psychotherapeutic frames while unorthodoxly going beside them in different ways when it is called for. Previous studies have shown that a flexible relation to treatment manuals for the benefit of accomodation to specific needs of the patients distinguishes skilled therapists - which is considered as another facet of the contradictory spectra of psychotherapy. Skill seems to be the knowledge, handling and endurance of contradictions and paradoxes coming alive when two worlds meet – not to collide, nor repel, nor fuse – simply "the paradox of individuation out of a symbiotic matrix of intermodal equivalence" by using "pre-object modes of communication in the clinical situation" (Kumin, 1996, p. 74). In this way skill demands intuition, a know-how, which could be seen as an exponential effect of education, training and experience working together. Even patients dropping out, which will occur no matter how skilled the therapist might be, add to knowledge provided openness and curiosity about the phenomenon in the therapist, among the peers and colleagues and in the organisation. Skill is not a certain amount of knowledge carried inside the therapist. Skill is also an aspect and a reflection of its context, met and reflected in the peers, supported and enhanced by the organisation offering education, training and support. Everything counts in a world of constant complexity of the psychotherapeutic situation.

Clinical implications

Implications for further clinical practice are briefly summarized in point form below.

- Thorough examination of the patient characteristics, expectations, perceptions and needs with an according treatment adaptation gives the best predictor of psychotherapy continuation and outcome and securing of success.
- Preparation and pedagogical elements beforehand enhance continuation.
- Since the therapists skill, an aspect of education, training and experience, is of overwhelming importance, it needs constant enhancement and development by education and training with a continuous feedback on the progress and development of the therapeutic alliance as well as support by team and organisation.

Advantages and limitations

Meeting problems and searching knowledge from the opposite angle or in the opposite direction is known to be an effective method. What works for whom in psychotherapy can be understood by studying the void a dropout leaves as well as the fabric of the relationship becomes visible through the rip the rupture caused. Just as long the lightning of the phenomenon is broad enough.

This review might be biased in the following way: no additional reader made an objective evaluation of the relevance of the included studies or any objective evaluation of the sorting between therapist and process factors. AW, however, functioned as such, except from being my supervisor, and I am grateful to him for his everlasting pursuit for consensus with me. Furthermore, this study is limited to patient-initiated dropout, as none of the included studies specified therapist-initiated discontinuation of therapy.

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