

ARTICLE

Dropout and Related Factors in Therapy

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Any review of the literature on clients who choose to access therapeutic services and then dropout must firstly state that the findings are based on information retrieved from a very small percentage of those who actually need an intervention. Epidemiological surveys suggest that only approximately 13 percent of individuals who receive a diagnosis/assessment based on structured interviews or instruments that warrant specialist intervention actually seek the therapeutic service they require (Clarkin and Levy, 2004).

In addition, even though most psychological therapies have been shown to be very effective (Hubble, Duncan & Miller, 1999; Lambert, 2004), approximately 8 percent of clients are worse off after attending at least 12 sessions of therapy. Some evidence suggests that the more training a therapist has, the lower the dropout rate of clients (Stein & Lambert, 1995). In addition more experienced therapists appear to be able to hold on to their clients better than less experienced.

Lambert, Harmon and Nielson (2005) reported that clinicians are historically poor at identifying which clients will not successfully complete therapy. They constructed a measure which correctly identified 85 percent of those likely to dropout when the measure was used over the first three sessions of client contact. They could successfully identify 100 percent of clients whose condition had deteriorated by end of therapy when using the measure.

“Patient deterioration can be reduced if therapists are alerted to the possibility early in treatment” (Lambert & Ogles, 2004, p. 179).

Dropout rates have been comprehensively addressed in a meta-analysis of *125 outpatient therapy studies* which examined factors related to attrition. This meta-analysis found that on average, one should expect that approximately 47 percent of clients will dropout of therapy (Wierzbicki & Pekarik, 1993). Even in a comprehensive research study which was carried out by the National Institute of Mental Health (NIMH) in the U.S. where 249 clients took part in the intake process, only 169 of these completed 12 sessions of therapy! This meant that one third of the initial participants had dropped out. Research has consistently found that community studies have significantly higher dropout than better funded, more standardised and high initial contact with clients NIMH studies (Lambert and Ogle, 2004).

Some clinicians are better at keeping clients engaged in therapy and they tend to have better outcomes than those who do not. Clients who present with significant and complex difficulties may benefit from being referred to these therapists who have a skill in engaging with difficult clients (Brown & Jones, 2005).

The following section will address an A-Z of factors related to a client staying in or dropping out from individual or group therapy early. Interestingly, two factors which in general were not found in

the research to be related to therapeutic outcomes were a client's sex and age (Clarkin & Levy, 2004).

The A-Z of factors related to attrition and dropout:

- (A) Clients with a lower SES and who are from a minority culture have higher rates of dropout (Hubble, Duncan & Miller, 1999; Lambert, 2004).
- (B) Severity of symptoms at presentation predict dropout (Clarkin & Levy, 2004)
- (C) Negative attitudes toward therapy is related to early dropout (Lambert, 2004). The converse is also true; clients who state at the end of first session that they think that therapy is going to be helpful will have predicted 20 percent of their outcome in that initial session (Wampold, 2001).
- (D) Incongruent therapy expectations are related to early client dropout. For example, a client who is treated with prolonged exposure and relapse prevention techniques is more likely to dropout from therapy if they had expected an analytic approach for their treatment of their obsessive-compulsive symptoms. (Hubble, Duncan & Miler, 1999; Clarkin & Levy, 2004; Wampold, 2001).
- (E) Initial negative evaluation of the therapist by the client results in early termination (Bachelor & Horvath, 1999; Clarkin & Levy, 2004).
- (F) Clients' expectations of therapy and more importantly, the strength of the therapeutic alliance as rated by the client predicts their level of attrition and treatment outcome (Beutler, Malik, Alimohamed, Harwood, Talebi, Noble, & Wong, 2004).
- (G) Prochaska (1999) found that 93 percent of clients could be correctly classified into three groups; (a) premature terminators, (b) early but appropriate terminators and (c) continuers in therapy. This correct classification of clients was based on the stage of change that they identified themselves in. Those in the precontemplation phase of change, quickly and prematurely dropped out (40 percent). 20 percent of clients were in the in the action stage when entering therapy, these clients tended to finish quickly but appropriately. Finally, a mixed, larger group of clients, most of whom (40 percent) were in the contemplation stage continued in longer-term therapy.
- (H) Clients with personality disorders, particularly narcissistic issues and young hostile clients with a diagnosis of borderline personality disorder have higher dropout rates. Clients with a dependent or histrionic personality tend to have better outcomes and stay in therapy longer than those with borderline, schizoid, narcissistic, schizotypal, paranoid and antisocial personality disorders (Clarkin & Levy, 2004; Hubble, Duncan & Miller, 1999).

- (I) Clients who present with initial hostility dropout quicker than those who present as open and agreeable (Clarkin & Levy, 2004; Tallman & Bohart, 1999). Clients with high levels of resistance in the therapeutic relationship benefit more from non-directive therapy and those who have a non-defensive stance have better outcomes from a more directive therapeutic approach (Beutler et al., 2004).
- (J) Clients with abnormal sleep profiles have poorer outcomes than those with normal sleep profiles (Thase et al., 1997).
- (K) The mismatch between therapist and client result in early termination; this is especially true when there is an ethnic mismatch (Hubble, Duncan & Miller, 1999; Lambert, 2004).
- (L) A psychological formulation of a client's treatment by the therapist results in a higher treatment effect over a medicalised formulation of the clients problems (Hubble, Duncan & Miller, 1999; Lambert, 2004: moderate effect size difference).
- (M) The 'light-bulb' analogy holds true: clients who are ready for change appear to have better outcomes and reported levels of engagement in the therapy process than those who do not report that they are ready to change (Clarkin & Levy, 2004).
- (N) Psychological mindedness is more important for clients in short-term therapy but this factor is not related to outcome in medium to long-term therapy (Clarkin & Levy, 2004; Prochaska, 1999).
- (O) Better ego strength in a client, their capacity to hold onto their identity despite psychic pain, distress, turmoil and conflict between opposing internal forces as well as the demands of their reality has been found to be related to better treatment outcomes (Clarkin & Levy, 2004).
- (P) Introjective clients, those who are perfectionistic and self-critical have better outcomes when attending a psychoanalytic approach versus psychotherapy. Anaclitic clients, those who have fears of abandonment and concerns about loss have better outcomes when attending psychotherapy rather than psychoanalytic therapy (Blatt, Ford, Berman, Cook, Cramer, & Robins, 1994).
- (Q) Object Relations: 'a person's life long pattern of relationships and their characteristic way of interpreting social information' (Clarkin & Levy, 2004, p. 208). Clients with less maturely developed object relations can only utilise therapy as a supportive adjunct to life, the more maturely integrated object relations of a client, the more the effects of the therapeutic relationship can be generalised to other relationships.
- (R) Attachment Patterns: Clients with a secure attachment style fare better than those with insecure attachment styles: "They perceive themselves as competent in relationships and expect a positive response from others" (Clarkin & Levy, 2004, p. 209). There is some evidence that a therapist's attachment style interacts with that of their clients and this influences the quality of the therapeutic relationship (Bachelor & Horvath, 1999).
- (S) Situation specific versus chronic, recurrent problems are more responsive to behavioural interventions (Hubble, Duncan, & Miller, 1999; Lambert, 2004).
- (T) Clients with better interpersonal styles have higher outcome results in group therapy than those with poor interpersonal ability (Burlingame, MacKenzie & Strauss, 2004).
- (U) Anxiety disorders respond better to therapies that use in-vitro and in-vivo exposure techniques (Ogles, Anderson, & Lunnen, 1999).
- (V) Group therapy has a higher level of attrition of clients who have started therapy than those clients who have started individual therapy (Hubble, Duncan & Miller, 1999). Dies (1993) suggested that certain clients should not be selected for group therapy because of this high level of drop-out. Dies (1993) suggested that clients who are in an acute crisis, who have a history of broken attendance in therapy, who have major problems of self-disclosure, who express difficulties with intimacy, who mistrust close relationships, who use denial excessively, who have impulsive behaviour patterns, and who have expressed that they don't want to attend group therapy should not be selected.
- (W) Groups with around ten to eleven members have been found to have more attrition than groups with around eight members. In addition, clients who were invited to attend an extant group were more likely to dropout. Importantly, *clients who were waiting for more than a year on a waiting list were also found to dropout early compared to those on a waiting list for less than a year* (Burlingame et al., 2004 reporting on Kordy & Senf, 1992, a German Study of 445 clients who had attended in-patient group therapy. Original article in German).
- (X) Piper, Ogrodniczuk, Joyce, McCallum, Rosie, O'Kelly, & Steinberg (1999) found that clients in interpretive individual therapy were five times more likely to dropout than those in supportive psychotherapy. They found that when the sessions previous to a client's dropout were analysed that early in the final session the client had made their feelings with regard to dropping out obvious. The clients had expressed frustration about their therapy sessions, that their expectations had not been met, and they complained of the therapist's repeated focus on painful feelings. Therapists had addressed this by focusing on the client-therapist relationship and they had tended to make transference interpretations. The clients resisted this focus on transference by remaining silent or disagreeing with their therapist. The therapists then tended to persist with their interpretations. An argument usually had ensued which appeared similar to a power struggle: At times therapists were rated as sharp, blunt, sarcastic, insistent, impatient, or condescending. The session would then tend to end with encouragement by the therapist for the client to continue therapy (these clients then dropped out of therapy after this session).
- (Y) An eclectic approach appears to meet a client's needs better than a rigid adherence to a specific model. Most experienced therapists are reflecting this finding and are now reporting that they draw on multiple training experiences to inform their clinical practice (Lambert, Bergin, & Garfield, 2004).
- (Z) 40 percent of clients spontaneously remit and leave therapy prematurely, often without explaining the reason to the therapist. This is similar to the 'placebo effect' in waiting list control groups. The improvement may be due to factors outside of the therapy environment. So, on occasion the dropout from therapy might not mean that a client is doing poorly, it may be that the client

has improved because of other environmental factors other than therapy; e.g., increased social support from partner, family and friends etc. (Hubble, Duncan & Miller, 1999; Lambert, 2004).

Conclusion and Recommendations

Factors related to a client's initial presentation can determine their length of time in therapy, their treatment outcome and the degree to which they can engage in a therapeutic relationship, as well as whether they prematurely drop out or not. The strength of the alliance between the client and therapist as rated at the beginning of therapy by the client is strongly predictive of outcome. Using a clinician's opinion to predict dropout/engagement is not a reliable method to predict clients who will complete their treatment or drop out prematurely. Rating mechanisms and models of a client's readiness to change which are better at predicting clients who are at risk of dropout have been developed. Identifying these clients who are at risk of attrition during the assessment and early treatment phases of treatment is recommended. The factors which assist in helping these clients continue attending their therapy should also be explored.

Facilitating staff in receiving multiple training experiences should theoretically assist therapists in being better able to meet a client where they are at. This should enhance a client's therapeutic engagement and reduce dropout. It may also be useful for principal and senior psychologists to identify members in their teams who demonstrate an ability to engage and keep clients who would have been rated as a high risk for dropout.

In Ireland, there is a dearth of research in relation to the current baseline rates of dropout, premature termination and the number of clients who complete their therapy contracts. Understanding the degree to which dropout occurs in the community setting and the factors which influence higher and lower levels of this attrition may help normalise this phenomenon for psychologists at the coal face and assist their line managers in service planning.

Finally, there is no doubt that the level of dropout reported in community services is equal to a significant percentage of whole time equivalent (WTE) staff in a regional psychology service. The actual percentage of WTE psychologists' time and the monetary cost of dropout, cancellations and clients who do not fully engage in treatment needs to be assessed.

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