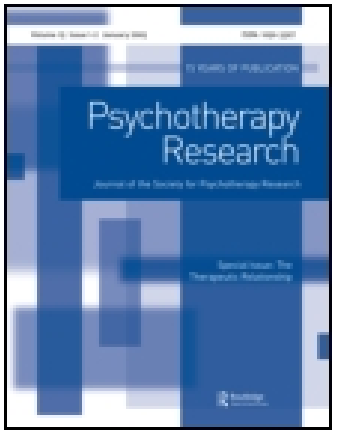

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Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review

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Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review

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Abstract
Among potential predictors of dropout, client variables are most thoroughly examined. This qualitative literature review examines the current state of knowledge about therapist, relationship and process factors influencing dropout. Databases searches identified 44 relevant studies published January 2000–June 2011. Dropout rates varied widely with a weighted rate of 35%. Fewer than half of the studies directly addressed questions of dropout rates in relation to therapist, relationship or process factors. Therapists' experience, training and skills, together with providing concrete support and being emotionally supportive, had an impact on dropout rates. Furthermore, the quality of therapeutic alliance, client dissatisfaction and pre-therapy preparation influenced dropout. To reduce dropout rates, therapists need enhanced skills in building and repairing the therapeutic relationship.

Keywords: individual psychotherapy; dropout; premature termination; therapist variables; relationship variables; process variables

This qualitative literature review aims to examine the current state of knowledge about therapist, relationship and process factors influencing adult outpatient dropout from individual psychotherapy. Below, we describe the rationale for the review in the context of what is already known.

Rates, Definitions and Study Methods

Premature termination of psychotherapy or dropout is a widespread clinical phenomenon. Dropout rates vary widely across studies and are usually reported to be 30–50%. The probably most cited comprehensive meta-analysis of the field by Wierzbicki and Pekarik was published 1993 and reported a mean dropout rate across 125 studies of 47%. Despite these discrepancies, most studies consistently report that the majority of dropouts occur within the first sessions (Baekeland & Lundwall, 1975; Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; Chiesa, Wright, & Neeld, 2003; Kazdin & Mazurick, 1994; McMuran, Huband, & Overton, 2010; Swift & Greenberg, 2012; Wierzbicki & Pekarik, 1993).

Early dropouts are especially problematic, since 12 sessions are often considered a minimum for a good outcome (Hansen, Lambert, & Forman, 2002). If factors associated with therapy dropout are identified, we might be able to better adjust clinical practice to the unique client in order to achieve continuation in a potentially productive treatment that will decrease their distress (Kendall, Holmbeck, & Verduin, 2004; McMuran et al., 2010). The phenomenon has a considerable and complex impact on healthcare organization; resources are wasted and therapists are negatively affected, while research shows that many dropouts are content with their contact or return within a year (Baekeland & Lundwall, 1975; Clarkin & Levy, 2004; Klein, Stone, Hicks & Pritchard, 2003; Murdoch, Edwards, & Murdoch, 2010; Piselli, Halgin, & McEwan, 2011; Reis & Brown, 1999; Wierzbicki & Pekarik, 1993).

At least two distinct problems arise when studying dropouts. The first is definitional. A recent meta-analysis indicated that the definition of dropout moderates the overall dropout rate (Swift & Greenberg, 2012). Previously, Hatchett and Park (2003) found four operational definitions of premature termination represented in the literature:

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therapists' judgment, termination by failure to attend the last scheduled appointment, not attending a predetermined number of sessions (i.e., participants were divided into premature and appropriate terminators on the basis of the median number of sessions completed by the sample), and failure to return after the intake appointment. The authors found that "the therapists' judgment" and "termination by failure to attend the last scheduled appointment" seem to describe the same phenomenon accurately, having the same rate of 40%, but a "not attending a predetermined number of sessions" and "failure to return after the intake appointment" do not, with rates of 53% and 18%, respectively. They suggested that future researchers use termination by failure to attend the last scheduled appointment in combination with an outcome assessment, and they dissuaded from using the duration-based index, since clients and therapists may agree to terminate therapy prematurely due to symptom relief. In our view, the failure to return after the intake appointment represents yet another clinical phenomenon of not starting treatment, deserving separate studies.

The second problem is how to understand and analyze the dropout phenomenon. Harris (1998) noted lack of replication studies and studies with a more complex approach, beyond the simplistic and atheoretical analyses in the numerous studies of dropout predictors on a simple client level. The complex connections between client characteristics, method and practice, and therapist and relational factors, need further investigation as well as a comprehensive understanding (Norcross & Lambert, 2011; Norcross & Wampold, 2011).

Client Factors

Among potential predictors of dropout, client factors are the most thoroughly examined in empirical studies to date. The best-established finding from this body of research is the level of client's socioeconomic status (SES). Those most likely to discontinue psychotherapy are individuals with low SES, which is associated with a low level of education and income, lack of power in society and socially strained residential areas and family conditions (Baekeland & Lundwall, 1975; Hollingshead & Redlich, 1958; Marmot, 2004; McCabe, 2002; Pekarik, 1985a; Richmond, 1992; Wierzbicki & Pekarik, 1993). Low SES is also associated with other correlates of dropout, such as substance abuse, criminality and severe psychiatric disorders, including personality disorder cluster B and psychosis. These individuals frequently produce external explanations to personal problems, thus counteracting the therapeutic process (Baekeland & Lundwall, 1975; Clarkin & Levy, 2004; Hollingshead & Redlich, 1958; McNair & Corazzini, 1994; Paivio & Bahr, 1998; Pekarik 1985a; Richmond, 1992). It is however 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 (Greenspan & Mann Kulish, 1985; Magnusson & Marecec, 2010; McNair & Corazzini, 1994; Richmond, 1992). Individuals with high SES are thus most likely to possess qualities associated with psychotherapeutic continuation and success (Clarkin & Levy, 2004; Marmot, 2004; Paivio & Bahr, 1998). High levels of education, income and social status are associated with persons who have a strong efficacy over their own life and options of social participation (Marmot, 2004).

Therapist, Relationship and Process Factors

In the clinical practice, the therapists' ability to engage different kinds of clients in the therapeutic undertaking may be decisive. Thus, we badly need more knowledge about the potential for therapist, relationship and process variables to predict and prevent client dropout. Unfortunately, the therapist factors are underinvestigated. Previous research reports significant differences among therapists with regard to therapeutic outcome (Baldwin, Wampold, & Imel, 2007; Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Crits-Christoph et al., 1991; Luborsky, McLellan, Digeur, Woody, & Seligman, 1997; Okiishi, Lambert, Nielsen, & Ogles, 2003). Better outcomes as well as lower dropout rates are related to more experience, flexibility in relation to treatment manuals, accommodation to the clients' specific problems, training and own psychotherapy (Blatt et.al., 1996; Crits-Christoph et al., 1991; Greenspan & Mann Kulish, 1985; Luborsky, McLellan, Digeur, Woody, & Seligman, 1997; Messer & Wampold, 2002; Norcross & Wampold, 2011; Richmond, 1992; Roth & Fonagy, 2004).

Two recent studies investigated therapists' own explanations of their dropouts (Murdoch et al., 2010; Piselli et al., 2011). The therapists tend to focus on external reasons, simple causalities and client, rather than their own, contributions. Dropout affected therapists in an almost exclusively negative way, and this kind of attribution to the client might serve as a protector of the own person and professional identity.

On the other hand, clients often explain their discontinuation of treatment with dissatisfaction with the therapist or therapy. Therapists using extensive and early interpretations and confrontations are perceived as unsympathetic and

hostile (Crits-Cristoph & Connolly Gibbons, 2001; Hilsenroth & Cromer, 2007; Norcross & Wampold, 2011). Dropout clients express disappointment about not receiving enough information, validation and support (Lambert & Ogles, 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, Martinez, Ticknor, Huang, & Cordell, 1991; Reis & Brown, 1999). The clients started psychotherapy with expectations that were not fulfilled and not shared with the therapists, who, on their part, described the clients as not understanding what being in psychotherapy involves (Cartwright, Lloyd, & Wicklund, 1980; Pekarik 1985b; Reis & Brown, 1999; Tryon, 1999). Dissatisfaction might be associated with dropout, but there is a complex causality: dissatisfied clients may stay in therapy and satisfied clients may drop out (Beckham, 1992; Garfield, 1963; Lambert & Ogles, 2004; Pollak, Mordecai, & Gumpert, 1992). Furthermore, clients' dissatisfaction with the therapist or therapy may be related to therapeutic alliance, as it affects not only the maintenance of the emotional bond, but also the agreement on goals and tasks.

The relationship and process factors associated with dropout were only exceptionally studied. In a qualitative study of former clients' experiences of successful psychotherapy, the most prominent theme was being in relationship with a "wise, warm and competent professional" (Binder, Holgersen, & Høstmark Nielsen, 2009). Alliance, defined as the client and therapist sharing common tasks and goals, with the client's sense of safety and trust in the therapy process and in the therapist, is a well-established predictor of continuation and good outcome of psychotherapy (Hilsenroth & Cromer, 2007; Messer & Wampold, 2002; Norcross & Lambert, 2011; Norcross & Wampold, 2011). An early established and strong alliance predicts continuation, but the contrary does not obstruct the therapy, since the therapist's skills in strengthening the early therapeutic alliance (Hilsenroth & Cromer, 2007) may remediate the situation by reversing a poor initial alliance (Puschner, Bauer, Horowitz, & Kordy, 2005) or repairing ruptures in the therapeutic collaboration (Safran, 2003). Therapists who accomplish early symptom relief also accomplish a strong alliance (Baldwin et al., 2007), thus decreasing risk of dropout.

To sum up, the one-sided research focus on client factors obviously tends to restrict our understanding of the dropout phenomenon in a problematic way and may result in adjustments of treatment procedures that are inadequate for more efficiently addressing the dropout problem. The dyadic nature of the therapeutic relationship is seldom acknowledged in research on dropout, and there is a scarcity of studies including therapist, relationship and process factors. The present study tries to address this limitation. As the importance of therapist and relational factors for the effectiveness of psychotherapy is increasingly acknowledged in psychotherapy research during the last decade, this literature review is limited to publications after the turn of the millennium.

Objectives

To examine the current state of knowledge about therapist, relationship and process factors influencing dropout from individual psychotherapy with adults we reviewed empirical studies with a wide range of methodological approaches, both those directly addressing questions of dropout rates in relation to therapist, relationship or process factors, and those including some of these variables in the analysis. The general PRISMA guidelines (Liberati et al., 2009; Moher, Liberati, Tetzlaff, Altman, & the PRISMA Group, 2009), aimed at enhancing the transparent and complete reporting of systematic reviews and meta-analyses, when applicable to a qualitative literature review, have served as an overall model for this study.

Method

Literature Search Procedure

This literature review is limited to articles published from January 2000 to June 2011. The searches were made in January through November 2011. Studies were included if they (1) were abstracted in English, (2) reported at least some information on dropout, (3) included adult clients who started individual psychotherapy, and (4) related dropout to therapist and process variables. Studies were excluded if they were limited only to (5) forensic care, (6) psychiatric in-patient treatment or compulsory care, (7) substance abuse or addiction treatment, (8) clients with specific somatic illness (mostly diabetes, cancer or coronary disease), (9) child and adolescent psychotherapy, and finally (10) comparisons of pharmacotherapy with or without psychotherapy. This was done to maximize the homogeneity of the sample, as each of the excluded client groups is treated in a highly specific treatment context with unique therapeutic boundaries, requires specialized therapeutic competence, and has unique problems with dropout. Despite these delimitations, we can still expect a great variability in the treatment

context, therapeutic boundaries and required therapeutic competence between the included studies. However, we found these criteria helpful when focusing on therapist and relational factors influencing premature discontinuation in the most common forms of individual psychotherapy. In order to extract factors influencing dropout, we included studies based on comparisons between dropouts and therapy continuers, as well as studies limited exclusively to dropout cases.

The databases electronically searched were PsycINFO, PubMed and the Cochrane Library. Using multiple combinations of the terms attrition, dropout, discontinuation, premature termination or noncompletion, individual psychotherapy, therapist variables, therapeutic relationship, process, and predictors, 1409 citations were electronically identified. Further searches in MEDLINE (OVID) gave no additional hits. After excluding duplicates 1397 remaining studies were screened by the first author by reading titles, abstracts and keywords. Another 1189 studies were removed following the exclusion criteria and after consensus discussion in doubtful cases, and the number of studies was gradually reduced to 208. These studies were reviewed by both authors at the full text level. Closer reading excluded another 164 studies that examined dropout, but did not meet the criterion of relating dropout rates to therapist, relationship or process factors. The remaining 44 studies were included in the review (see flowchart in Figure 1). As the included studies comprised four reviews and two meta-analyses, an additional check was made for duplicates. None of these six publications covered any of the 38 individual studies reviewed. Thus, the information presented in this review does not contain overlap potentially inflating the findings.

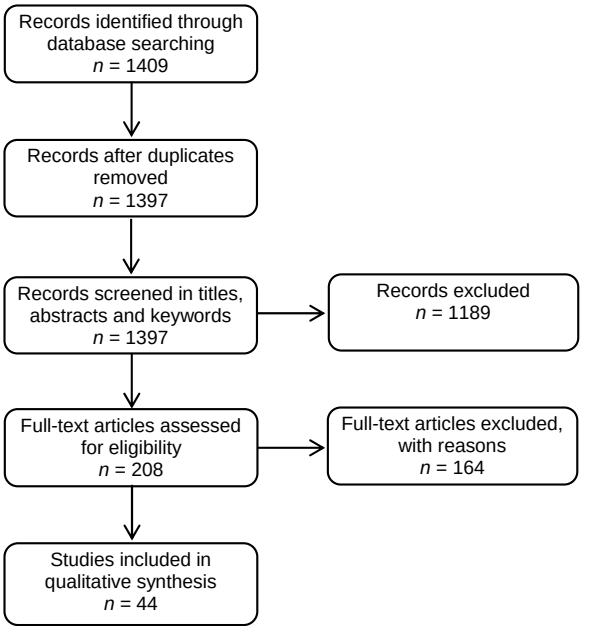

Figure 1. Flowchart for identification of studies to be included in the literature review.

Definitions and Coding Procedure

We define "therapist factors" as the therapist's unilateral contributions, such as the therapist characteristics (who the therapist is in terms of age, gender, ethnicity, experience, training and education, etc.) or therapeutic activities (what the therapist does). "Relationship and process factors" are defined as mutual contributions depending on and emerging within the therapeutic dyad. While all therapeutic relationship variables can be regarded as process categories, process factors are not limited to therapeutic relationship variables. The same single factor can be counted as belonging to different clusters, depending on context. For example, the therapist's gender and ethnicity are considered as therapist factors until the question of client-therapist match becomes problematic in therapy, and thus are counted as a relationship and process factor. During the coding process some factors found in the literature stood out as describing professional boundaries surrounding the therapy, even if they were connected with both the therapist's actions and the therapeutic relationship. Thus, a third cluster was set up, "the therapeutic boundaries," including such factors as limit setting in time and space (contract-making and negotiating the goals and procedures of treatment, the schedule, frequency, duration and place for therapeutic sessions), handling of missed and cancelled appointments, the degree of flexibility in maintaining the boundaries, etc. The distinction between the three clusters of factors related to dropout has to be seen as having heuristic value only. Relevant factors within each cluster were categorized using inductive thematic analysis (Boyatzis, 1998; Braun & Clarke, 2006), a method also called 'inductive clustering' (Miles & Huberman, 1994). The thematic categorization of identified factors was performed jointly by the authors, who discussed all cases until consensus was reached.

The following characteristics of the included studies were coded: type of study (meta-analysis, review, RCT, naturalistic, client survey, qualitative, case studies), country where the study was conducted (ISO 3166 alpha-3 codes), diagnoses (when specified), clients' gender (percent women), treatment type and duration, definition of attrition and attrition rates. This coding was performed by the first author and reviewed by the second author. All cases of disagreement were discussed until consensus

could be reached. In order to secure a correct reading of all studies, both authors reread them in full approximately 3 months later.

With the aim of simplifying the reading, understanding and comparison of the results, all numbers concerning dropout rates, gender distribution and diagnoses were recalculated when needed. Calculations of a weighted average dropout rate and gender distribution (number of clients out of the total number of clients for those studies reporting such data) were conducted using the statistical package Comprehensive Meta-Analysis (Version 2.2), developed by Borenstein, Hedges, Higgins, and Rothstein (2011). Confidence intervals at the 95% levels were calculated. Homogeneity in study dropout rates was examined, following Swift and Greenberg (2012), using the Q statistic. A significant Q value indicates heterogeneity in the dropout rates reported among the studies. The degree of heterogeneity using a percentage was calculated applying the I^2 statistic.

Results

Characteristics of Studies Identified

Findings concerning therapist and relationship factors influencing dropout were presented in studies with markedly varying designs, participants, therapeutic approaches, definitions of dropout and methods of data analysis. Thus, rather than conducting a meta-analysis, we focused on describing the studies and on qualitative synthesis of their results. The included studies are presented in detail in Table I. The 44 studies were carried out in 13 Western countries: USA (22), Great Britain (4), Austria (3), Canada (2), Germany (2), Israel (2), Italy (2), Sweden (2), and one study each in Brazil, Greece, the Netherlands, Norway and Spain. No studies were found from Australia, Asia or Africa. One study was published in German, one in Portuguese and the remainder in English. There were two meta-analyses, four review studies, and 38 individual studies (five randomized controlled trials, 28 naturalistic effectiveness studies, three client surveys, one case study and one qualitative study). One of the RCTs did not differentiate between therapy types (Gabbay et al., 2003) and another included only one treatment condition (Thormählen et al., 2003). One of the naturalistic studies included case comparison pairs matched on the same therapist (Charnas, Hilsenroth, Zodan, & Blais, 2010) and a further two were based on random assignment to different conditions (Reis & Brown, 2006; Shoffner, Staudt; Marcus, & Kapp, 2007). The recently published meta-analysis by Swift and Greenberg (2012) is not included in the literature review, as it was published after the publication deadline of 30 June 2011.

The number of participants was specified in 40 studies, comprising a total of 35,381 participants, ranging from six in one qualitative study to 22,095 in a meta-analysis, with a median of 120 (IQR = 69–387; M = 885; SD = 3484). Diagnoses were specified in 28 studies. Mood Disorders, Anxiety Disorders and Personality Disorders dominate. The clients' gender was specified in 34 studies (comprising 10,454 clients). Women dominate, ranging from 46% to 100%, with a mean of 70.0% (SD = 0.134).

The type of individual psychotherapy was specified in 26 of the studies. Psychodynamic psychotherapy and cognitive behavioral therapy dominated, but other types were represented as well. Duration or frequency was specified in 14 studies in terms of number of sessions, estimates, mean, or minimum number of sessions or treatment length. Two of these concerned therapy models with fixed duration and frequency (Horwitz et al.'s [1996] psychodynamic model and Luborsky's [1984] supportive-expressive psychotherapy), two studies specified treatment duration, four studies stated mean number of sessions, and a further four stated a minimum number of sessions related to the definition of dropout, while two studies specified only the frequency.

Dropout was defined in 31 studies and rated in 30. In three studies dropout was the inclusion criterion and not otherwise specified, and a further 11 did not indicate the dropout rate. The four reviews and one meta-analysis neither specified nor rated the concept, while the second meta-analysis only indicated mean dropout rate for all included studies. A further six studies did not define dropout, yet four of these nonetheless rated dropout. Two studies defined dropout without rating.

Across the 30 studies (comprising 10,452 clients), the weighted dropout rate was 35.0%; 95%CI [29.2%, 41.3%]. The studies were highly heterogeneous in their dropout estimates, $Q(29)$ = 1044.89, p = .000, I^2 = 97.23, with dropout rates ranging from 13% to 69% (the three studies with only dropouts not included). Recalling Hatchett and Park's (2003) distinction among four operational definitions, three studies used therapists' judgment, 10 studies used not showing up (including unilateral termination), and 15 defined dropout as the clients discontinuing before a certain number of sessions or time-limit. Only one study specified the number of nonstarters after the initial appointment (Reitzel et al., 2006). The variation was stronger using the predetermined number of sessions or time-limit (12–69%) than termination by failure to attend the last scheduled appointment (15–53%), but the mean was 36% in both cases. Just under half of the studies

Table I. Characteristics of studies and factors associated with dropout (44 studies)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Bados et al. (2007) **Naturalistic**	ESP	203	72% female	n.s.	CBT; 14 sessions	Dropping out of treatment before 14 sessions without the therapist's consent	44% (37%, 51%)	Clients who attributed dropout to having improved were fewer than in other studies, perhaps due to less experienced therapists.	n.s.	The majority of the attritioners dropped out after session 1, 28%, and by session 5, 52% had dropped out. Their explanations were dissatisfaction with the therapist or treatment (47%) and improvement (13%). Dropouts had more severe disorders that might be difficult for less experienced therapist to handle.
Barrett et al. (2008) **Review**	USA	n.s.	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	Therapist giving the client feedback on the progress had fewer dropouts.	Pretherapy preparation sessions reduce attrition	Initial perceptions and expectations influence dropout rates. Dropouts perceived their therapists as less expert, competent or trustworthy. Perceptions about competence affected alliance. Dropout correlated with dissatisfaction.
Baruch et al. (2009) **Naturalistic**	GBR	882	71% female	MD 47%, AD 23%, PD 8%, Other 17%	Individual PT once weekly for more than 20 sessions	Decision to stop treatment before session 21	69% (66%, 72%)	Continuers had more experienced therapists than dropouts.	n.s.	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**	AUT	111	59% female	AD 54%, MD 10%, PD 10%, Other 39%	PT n.o.s.; duration n.s.	Clients who discontinued on their own initiative by failing to attend appointments	36% (28%, 45%)	Therapists tend to overestimate the severity of symptoms and need for treatment length.	n.s.	Dropouts returned within 12–18 months and often reported symptom relief as a reason for dropping out. Disagreements about symptom severity did not predict dropout. Dissatisfaction with competence of staff increased risk of dropout.

Table I (*Continued*)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Charnas et al. (2010) **Naturalistic**	USA	101	70% female	MD 54%, AD 13%, PD 53%, Other 33%	PDT; twice weekly	Clients who completed first assessment, attended fewer than eight sessions and explicitly indicated that they did not want to continue	22% (15%, 31%)	n.s.	n.s.	Early alliance predicts continuation.
Corning & Malofeeva (2004) **Naturalistic;** comparison pairs matched on the same therapist	USA	739	60% female	n.s.	PT n.o.s., ST and LT. H/E 29%, CBT 29%, IPT 25%, PDT 17%, SYT 17%; duration n.s.	Clients who discontinued on their own initiative by failing to attend appointments	35% (32%, 39%)	n.s.	Cancellations increased risk of dropout. Waiting-list placement did not increase the risk of dropping out.	Highest risk early in treatment, increased risk at session 8 and almost no remaining risk at session 28.
Defife at al. (2010) **Naturalistic**	USA	542	n.s.	n.s.	n.s.	Missed appointments (MAs)	15% (12%, 18%)	Therapists cancelling appointments increase risk of ruptures and clients later MAs.	5% of MAs were explained by practical misunderstandings, registration difficulties, and reschedules.	13% of MAs were motivated by dissatisfaction with therapy or the therapist, negative therapy process reactions and alliance ruptures, but almost as many (11%) were for reasons unknown to therapists.
Derlega et al. (2001) **Client survey**	USA	168	83% female	MD 21%	PT n.o.s. with a median of 10 sessions; duration n.s.	n.s.	n.s.	n.s.	n.s.	Strong alliance predicts continuation. The level of commitment in therapy and alliance is influenced negatively by perceived neglect and positively by loyalty. Problems in the therapeutic relationship and dissatisfaction with therapy or therapist predict dropout.
Falkenström (2010) **Naturalistic**	SWE	101	82% female	MD 30%, AD 24%, PD 15%	Mostly PDT; duration n.s.	Patients who suddenly stopped coming for therapy without discussing this with their therapist	16% (10%, 24%)	n.s.	n.s.	Dropouts tend to return later with more motivation. PDT leads to more sessions and higher improvement than current psychiatric contact.

Table I (*Continued*)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Gabbay et al. (2003) Part of a **RCT**	GBR	464	75% female	MD 100%	Brief PT: CBT 30%, NDC 28%, GP's usual approach 42%; duration n.s.	Failing to complete therapy as agreed	14% (11%, 17%)	n.s.	n.s.	Better outcome and satisfaction if there is full agreement with therapist beforehand that the core problem is psychological. Small dropout differences between dyads with agreement and dyads without.
Goldenberg (2002) **Naturalistic**	USA	2,889	61% female	MD 34.6%, AD 30.8%	PT n.o.s.; duration n.s.	n.s.	59% (57%, 61%)	Completion depended on therapist factors mostly; the most experienced therapists had the most completers and most visits. Enhancing therapist's training and skill seems to be the best way to reduce dropout rates.	n.s.	Completers improved but not dropouts. No leading predictor for the dropout group was found. However, the dropout group consisted predominantly of nonimproved clients.
Goldman & Anderson, (2007) **Naturalistic**	USA	55	89% female	n.s.	EPT 55%, CBT 18%, Other 27%; mean length of therapy five sessions; duration n.s.	Failure to attend one session followed by failure to schedule for any further session	44% (31%, 57%)	Possibility of comparing dropout rates between therapists was not used.	n.s.	Initial strong alliance correlated with clients' stabile object relations and secure attachment, but it did not correlate with dropout rates.
Hamilton et al. (2009) **Naturalistic**	USA	145	57% female	n.s.	PSA training cases; 3–102 months	Clients discontinuing prematurely	40% (32%, 48%)	Dropouts were evenly distributed among candidates and their supervisors. No difference in the dropout rate between first and third training cases.	n.s.	Clients converted from psychotherapy to psychoanalysis hade lower dropout rates. The majority of dropouts occurred in the first month of treatment, mostly after one or two sessions.
Hatchett & Park, (2004) **Naturalistic**	USA	245	68% female	n.s.	PT n.o.s.; duration n.s.	Premature termination when client missed schedules appointment without rescheduling	40% (34%, 46%)	The therapist's sex does not matter.	n.s.	Matching sex in the therapist-client dyad does not influence dropout rate. The therapist's sex influences the perception of the client's sex-related experiences.

Table I (*Continued*)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Hauck et al. (2007) **Naturalistic**	BRA	56	84% female	n.s.	PAT; duration n.s.	Interruption (communicated or not) before 3 months of treatment	13% (6%, 24%)	n.s.	n.s.	Dropouts reported to be satisfied with their health, despite psychopathological severity. Low therapeutic alliance is a risk of dropout.
Hoyer et al. (2006) **Client survey**	DEU	461	81% female	MD 48%	CBT 34%, CCT 35%, PDT 16%, Other 14%; duration n.s.	Premature termination	42% (38%, 47%)	Therapeutic malpractice was seldom reported; most adverse experiences were described by clients as unreasonable therapist behavior or unpleasant therapeutic action.	n.s.	Most frequent reasons presented by dropouts were lack of improvement and poor therapeutic relationship. Satisfaction and improvement were lower when adverse events were reported.
Junkert-Tress et al. (2000) **Case studies**	DEU	12	n.s.	n.s.	ST PDT; duration n.s.	n.s.	100%; only dropouts	Therapists' hostile countertransference affects alliance negatively.	n.s.	Difficulty in forming an alliance with narcissistic clients due to their relating problems and enacting idealization and devaluation.
Kaplowitz et al. (2011) **Naturalistic**	ISR	23	65% female	MD and AD 87%, PD 57%; large comorbidity	CBT 26%, PD 74%; duration n.s.	n.s.	30% (15%, 52%)	Therapists with high Emotional Intelligence (EI) achieved better therapist-rated outcome results and lower drop-out rates.	n.s.	Working alliance did not predict dropout. High therapist EI did not affect alliance.
Lampropoulos (2010) **Naturalistic** (archival study)	GRC	112	59% female	MD 48%, AD 16%; large comorbidity	Counseling; duration n.s.	Defined by therapists as dropouts	38% (30%, 48%)	n.s.	n.s.	Larger client-student therapist agreement about positive changes for completers than dropouts. Completers had somewhat better treatment gains than dropouts.

Table I (*Continued*)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Lingiardi et al. (2005) **Naturalistic**	ITA	47	66% female	PD	PT, Horwitz et al.'s model	Discontinuation of psychotherapy by the client without communication or discussion with the therapist	21% (12%, 35%)	Therapists evaluate clients in cluster B more negatively than cluster A, and clients in cluster C most positive and optimistic on development of alliance. Therapist rate alliance lower than clients.	n.s.	Early therapeutic alliance evaluations are good predictors of dropout. Cluster A clients have difficulty establishing alliance with the therapist and vice versa.
Löffler-Statska et al. (2010) (sample 1 + 2) **Naturalistic**	AUT	224 (129 + 95)	71% female (sample 1 + 2)	MD, AD; PD	Mostly PAT/PDT; 83% at least 10 sessions for all samples	Clients who never started therapy or attended less than 10 sessions	n.s. (no distinction between treatment rejecters and early dropouts)	n.s.	n.s.	Difficulty in forming an alliance with externalizing clients due to their problems with relating and self-reflecting when the therapists perceive them as cold and dismissive.
Mahon et al. (2001) **Naturalistic**	GBR	114	100% female	Eating disorder	Open-ended individual psychotherapy with dietary advice and monitoring, IPT or CBT; duration n.s.	Premature termination without therapist's consent before session 10	55% (46%, 64%)	An ability to form a warm and trusting relationship where other issues than those in clinical focus can be talked about (e.g., childhood traumas) influenced continuation.	n.s.	Attachment patterns correlate with dropout rates; unsafe attachment predicts dropout.
Maramba & Nagayama Hall (2002) **Meta-analysis**	USA	22,095	n.s.	Two of 7 studies of Vietnam veterans with PTSD; other n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	Therapists have specific ethnic and cultural competence that influences their therapeutic ability with different clients; however, this does not necessarily influence dropout rates.	n.s.	Ethnic match between therapist and client influences outcome and dropout rates. Ethnicity and cultural competence probably hard to differentiate under certain circumstances.
Morlino et al. (2007) **Naturalistic**	ITA	100	100% female	Eating disorder	n.s.	Premature termination without therapist's consent	53% (43%, 63%)	n.s.	n.s.	Alliance between client and therapist plays a key role for a stable and continuous therapeutic program.

Table I (*Continued*)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Mueller & Pekarik (2000) **Naturalistic**	USA	230	46% female	MD 25%, AD 15%, Other 55%.	CBT 32%, EPT 30%, SYT 19%, PDT 19%; duration n.s.	Attending fewer sessions than anticipated	n.s.	Therapists underestimate the possibility of attrition, and they are more negatively affected by them than necessary, since they overestimate client dissatisfaction and underestimate client improvement at dropout.	The fewer sessions, the higher the dissatisfaction, but no connection was found between fewer sessions and less improvement.	Clients' prediction of treatment duration was the best predictor of actual duration, satisfaction and positive outcome.
Nysaeter et al. (2010) **Naturalistic**	NOR	32	81% female	BPD	Non-manualized PDT; mean 68 sessions; 1–3 years of treatment	n.s.	28% (15%, 46%)	n.s.	n.s.	Opposite sex of therapist predicted drop-out. Open-ended therapy and termination when client and therapist had agreed reduced dropout. No impact of the working alliance on attrition.
O'Brien et al. (2009) **Review**	GBR	854	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	33% (30%, 36%)	Therapists perceived as unsympathetic and less experienced therapists had more dropouts. Clinical psychologists have lowest dropout rates.	Change of therapist doubles risk of dropout.	Dropout correlates with overall dissatisfaction with the care, including being detained, previous coercive experiences, experiencing adverse events, and being rejected.
Ogrodniczuk et al. (2005) **Review**	USA	n.s.	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	Therapist showing warmth, regard, empathy and genuineness and giving room for negative feelings had fewer dropouts.	Therapist reminding their clients about appointments had fewer dropouts. Clients prepared by the therapist or someone else on what therapy might involve and what might be expected were less likely to drop out.	Clients who made negotiations with their therapist etc., were less likely to drop out.

Table I (*Continued*)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Perry et al. (2007) **Naturalistic**	CAN	53	77% female	AD 75%, MD 64%, PD 75%, Other 7%	LT PDT; median duration 110 sessions	Premature termination on client's initiative for intrinsic reasons or extrinsic reasons	28% (18%, 42%)	n.s.	Clients dropping out for intrinsic reasons had fewer weekly sessions than continuers. Therapist availability correlated with their clients' dropout rates. Sparse contact correlated with clients' reluctance and troubled alliance. Switching therapist if the client felt the match was not good enough could prevent dropout.	n.s.
Reis et al. (2006) **Naturalistic** with random assignment to four preparatory conditions	AUT	125	66% female	MD, AD or other 80%	10 therapists of which 5 PDT, 2 CBT, 3 SPT and 1 ET; duration n.s.	Client failure to attend and failing to schedule a new appointment within 30 days of the last event	31% (24%, 40%)	n.s.	Clients who were prepared by the therapist on what the therapy might involve, what might be expected etc., were less likely to dropout.	n.s.
Reitzel et al. (2006) **Naturalistic**	USA	313	55% female	MD 46%, PD 19%, 19% AD 19%, Other 56%	PT n.o.s.; duration n.s.	1. Failure to attend therapy at all; 2. Unilateral termination by the client after contact with assigned therapist	22% (18%, 27%)	n.s.	Delay in case assignment predicts nonattendance to the first therapy session but not premature termination from therapy.	n.s.
Ruiz et al. (2004) **Naturalistic**	USA	220	65% female	MD or AD 39%, PD 9%, other n.s.	CT 34%, PDT 20%, BT 19%, Systemic 10%, Experiential 9%, Others 8%; duration n.s.	Not completing the first seven sessions	n.s.	n.s.	n.s.	High generalized interpersonal distress according to IIP gives poorer outcome but lower dropout. It is hard to form an alliance with high idealization, narcissism and hostile submissiveness.

Table I (*Continued*)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Samstag et al. (2008) **RCT**	USA	48	56% female	MD 63%, AD 25%, PD 79%, other 17%	PDT I +II 23% + 25%, SUT 10%, CBT 21%, IPT 21%; duration n.s.	Premature termination before attending one-third of agreed-upon treatments	33% (22%, 48%)	n.s.	n.s.	Lower degrees of cohesion in patient-therapist dialogue and of alliance were found in drop-out dyads than in completer dyads.
Shamir et al. (2010) **Client survey**	ISR	82	65% female	Psychotic disorders 36%	PDT, CBT, SUT and other; commonly weekly sessions; duration n.s.	Clients attending at least one session but not returning for scheduled revisits	100%; only dropouts	Therapist "reaching out," "holding" and encouraging client to stay in therapy reduces dropout.	All dropouts noted that had the clinic reached out to contact them, they may have reconsidered and continued treatment.	Many dropouts reported satisfaction, symptom relief and receiving all the treatment the clinic could offer, while therapist considered the dropout as a treatment failure. Most dropouts occurred before session 10.
Sharf et al. (2010) **Meta-analysis**	USA	1301	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	Mean 11 studies: 56% (53%, 59%)	n.s.	n.s.	Weak alliance correlates with higher dropout rates; the longer the treatment, the stronger correlation. Completers report stronger alliance.
Shoffner et al. (2007) **Naturalistic** with random assignment to three conditions	USA	n.s.	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	n.s.	Therapists in direct contact with client before session or assessment either to remind them of the appointment or to encourage attendance reduce dropout.	n.s.
Spinhoven et al. (2007) **RCT**	NLD	78	92% female	BPD	SFT, TFP; 50 sessions every other week	n.s.	33% (24%, 44%)	n.s.	n.s.	Low early alliance predicts dropout but not outcome. Low alliance was predicted by dissimilarity in the dyad regarding pathological personality characteristics. Lower alliance and higher dropout in TFP.

Table I (*Continued*)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Swift & Callahan (2011) **RCT**	USA	60 (31 + 29)	62% female (sample 1 + 2)	Mostly MD and AD	Individual therapy n.s.; pretherapy duration education group and controls; duration n.s.	Premature termination as defined by therapist	55% (42%, 67%) (sample 1: 77%; sample 2: 31%)	n.s.	Dropouts had fewer sessions. Clients informed about the dose-effect model stayed in treatment longer and were more likely to be completers.	n.s.
Thormählen et al. (2003) Part of a larger **RCT**	SWE	80	69% female	Only PD included	SE (Luborsky)	Clients not attending or discontinuing on own initiative	35% (25%, 46%)	n.s.	n.s.	Degree of focus on one defined interpersonal problem predicted dropout.
Todd et al. (2003) **Naturalistic**	USA	123	n.s.	n.s.	PT n.o.s.; duration n.s.	Ending therapy before date agreed-upon by both therapist and client	n.s.	Therapists mostly explained dropout by one single and often external reason.	Dissatisfied clients had fewer sessions than satisfied clients. Improved clients had more sessions than nonimproved clients.	Clients reported more dissatisfaction with therapy than therapists. Both clients and therapist reported multiple reasons for termination.
Vasquez (2007) **Review**	USA	n.s.	n.s.	n.s.	PT n.o.s.; duration n.s.	n.s.	n.s.	Therapists perceived as unsympathetic, biased, and discriminating had more dropouts among ethnic minorities.	n.s.	Reality comes in to the room, even discrimination. Clients describe even facial expressions and other subordinate expressions.
Westmacott et.al. (2010) **Naturalistic**	CAN	118	77% female	AD 30%: MD 26%, Other 41%	CBT 59%, EXP 13%, IPT 12%; duration n.s.	Unilateral termination of therapy	35% (27%, 44%)	Therapists underscore dropouts' improvement and dissatisfaction.	n.s.	Dropouts reported mismatch; therapists and dropouts had incongruent views of presenting problems, goals and procedures.
Wilson & Sperlinger (2004) **Qualitative**	USA	6	50% female	n.s.	LT PAT for more than 2 years	Discontinuing before the minimum of 2 years	100%; only dropouts.	Therapists are highly and negatively affected by the dropout. Inexperience enhances this negative feeling, while experience reduces self-blame and enhances a more adaptive curiosity about the event.	n.s.	Clients reported mismatch between them and therapists, therapy giving rise to too much painful feelings and strong ambivalence. Clients overreport positive feedback to therapist and underreport experiences of conflict and pain.

Table I (*Continued*)

Author Type of study	Country	*N*	Gender	Diagnoses	Treatment type and duration	Definition of attrition	% attrition (95% CI)	Therapist characteristics and therapeutic activities	Therapeutic boundaries	Relationship and process factors
Young et al. (2000) **Naturalistic**	USA	1769	51% female	MD 30%, AD 5%, Other 54%	PT n.o.s.; duration n.s.	Clients who discontinued on their own initiative failing to attend appointments	n.s.	n.s.	Calling clients when they do not show up tends to reduce dropout.	Dropouts tend to report more improvement than continuers.

Note. Country names according to ISO 3166 alpha-3 codes.

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. BT = Behavioral Therapy; CBT = Cognitive-Behavioral Therapy; CCT = Client-Centered Therapy; CT = Cognitive Therapy; EPT = Eclectic Psychotherapy; EXP = Experiential Psychotherapy; GP = General Practitioner's usual approach; H/E = Humanistic-Existential Psychotherapy; IPT = Interpersonal/Relational Psychotherapy; LT = Long-Term; NDC = Non-Directive Counselling; PAT = Psychoanalytic Psychotherapy; PDT = Psychodynamic Psychotherapy; PT = Psychotherapy; PSA = Psychoanalysis; SE = Supportive-Expressive Therapy; SFT = Schema-Focused Therapy; ST = Short-Term; SUT = Supportive Psychotherapy; SYT = Systemic Psychotherapy; TFP = Transference-Focused Therapy.

identified, 19 of 44, directly addressed questions of dropout rates in relation to therapist, relationship or process factors: the two meta-analyses (Maramba & Nagayama Hall, 2002; Sharf, Primavera, & Diener, 2010), one review (Vasquez, 2007), five RCTs (Gabbay et al., 2003; Samstag et al., 2008; Spinhoven, van Dyck, Giesen-Bloo, Kooiman, & Arntz, 2007; Swift & Callahan, 2011; Thormählen et al., 2003), nine naturalistic studies (Kaplowitz, Safran, & Muran, 2011; Lampropoulos, 2010; Lingiardi, Filipucci, & Baiocco, 2005; Morlino et al., 2007; Reis & Brown, 2006; Reitzel et al., 2006; Shoffner et al., 2007; Todd, Deane, & Bragdon, 2003; Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010), one case study (Junkert-Tress et al., 2000) and one qualitative study (Wilson & Sperlinger, 2004). Most of the remaining studies focused on client variables, but included some therapist or relationship variables in the analyses. Most studies, 33 out of 38 individual studies (including two studies that were part of a RCT), did not include matched control group or random assignment to different conditions. Furthermore, the definitions of the included concepts varied extensively.

The three clusters of factors associated with dropout are presented in Table II in an order following the number of publications per factor and specifying the kind of empirical support.

Therapist Characteristics and Therapeutic Activities

Therapist characteristics and therapeutic activities contributing to dropout were specified in 14 studies and were categorized in seven factors. *The therapist experience* was seen to influence dropout in one review (O'Brien, Fahmy, & Singh, 2009), three naturalistic studies (Bados, Balaguer, & Saldaña, 2007; Baruch, Vrouva, & Fearon, 2009; Goldenberg, 2002) and one qualitative study (Wilson & Sperlinger,

Table II. Therapist, boundary and relationship factors contributing to dropout: kind of empirical support and numbers of studies

	Empirical support						
Factor	Meta-analyses	Reviews	RCTs	Naturalistic studies	Client surveys	Qualitative/Case studies	Total
Therapist characteristics and therapeutic activities		**2**		**10**	**1**	**1**	**14**
Experience		1		3		1	5
Training and education		1		2		1	4
Overestimation of client's needs and underestimation of improvement				3			3
Showing empathy, warmth and regard; being emotionally supportive		1		1	1		3
Negative responses		1		1			2
Emotional intelligence				1			1
Improving skills and educating therapists				1			1
Therapeutic boundaries		**3**	**1**	**9**	**1**		**14**
Sparse contact or few appointments; delay in case assignment			1	4			5
Providing concrete support, reminding about appointments, being available		1		2	1		4
Preparation, information or treatment negotiation		2	1	1			4
Cancellations by therapists, frame disruptions				2			2
Change of therapist		1		1			2
Relationship and process factors	**2**	**3**	**5**	**22**	**3**	**2**	**37**
Quality of therapeutic alliance	1	1	2	13	1	1	19
Client dissatisfaction		1	2	7			10
Agreement on core problems, goals, procedures and changes			3	2		1	6
Negative processes, conflicts, hostility, neglect, rejection, adverse events		2		1	2		5
Mismatch of gender, ethnicity and cultural background	1	1		2			4
Early symptom relief				3	1		4
Lack of improvement				3	1		4
Mismatch of pathological personality characteristics			1				1

Note. Number of publications per factor (several factors might appear in each study).

2004). To sum up, the more experience, the less dropout. Baruch et al. (2009) found the experience factor to be more decisive for dropout than any client factor, with the conclusion that continuing clients have more experienced therapists than do dropouts. Goldenberg (2002) made the same finding, adding that experienced therapists also offered more sessions to their clients. Bados et al. (2007) assumed that dropouts from therapy with more experienced therapists attribute their discontinuation to symptom relief and show more improvement than dropouts with less experienced therapists. Experienced therapists were also found to react to their clients' premature termination with lower levels of anxiety and less self-blame than less experienced (Wilson & Sperlinger, 2004). One further study (Hamilton, Wininger, & Roose, 2009) found no difference between experienced and less experienced therapists at a clinic offering long-term psychodynamic therapy or psychoanalysis with both candidates in training and their supervisors who also functioned as therapist.

The therapists' training and education was found to be interconnected with experience in four studies. The review (O'Brien et al., 2009) showed that clinical psychologists, largely regardless of experience, had the lowest dropout rates and achieved better improvement with their clients than all other professions. Training, together with organizational support and teamwork, was found to reduce dropout in two naturalistic studies (Falkenström, 2010; Goldenberg, 2002) and one qualitative study (Wilson & Sperlinger, 2004). Taken together, these findings indicate that the therapist experience and training factors have a complex relationship to both dropout and outcome.

Three naturalistic studies demonstrated that *therapist overestimation of symptom severity and duration of needed treatment* as well as underestimation of symptom relief can give rise to premature termination or misunderstanding. When clients describe faster improvement than the therapist expected, dropout in that respect is to be considered as completed treatment (Berghofer, Schmidl, Rudas, Steiner, & Schmitz, 2002). Mueller and Pekarik (2000) found a combination of improvement underestimation and dissatisfaction overestimation by the therapists in dropout cases. When clients unilaterally ended therapy, therapists were only partially aware of either the extent of clients' perceived improvements or their dissatisfaction (Westmacott et al., 2010).

The therapist's empathy, warmth and regard contributed to continuation in one review, one naturalistic study and one client survey. Unlike being supportive in a concrete manner, this factor focuses on the therapist's emotional support. The therapists' contributions included an overall genuineness and openness to negative feelings (Ogrodniczuk, Joyce, & Piper, 2005), an openness to such areas of painful emotions as childhood traumas not initially in the therapeutic scope (Mahon, Bradley, Harvey, Winston, & Palmer, 2001), and the therapist's initiative in "recruiting," "holding" and encouraging the client to stay in treatment (Shamir, Szor, & Melamed, 2010).

Conversely, one review (Ogrodniczuk et al., 2005) and one naturalistic study (Mahon et al., 2001) found that *therapists who responded negatively*, did not give room for negative affects, rejected their clients or who were hostile, especially towards clients with personality disorders cluster B, had more dropouts. This is in accord with clients' reports of adverse experiences, while regular therapeutic malpractices, such as sexual abuse, extratherapeutic interactions or other serious incidents are very seldom reported (Hoyer, Helbig, & Wittchen, 2006).

Two further factors associated with discontinuation were found in one naturalistic study each. Higher levels of *therapist's emotional intelligence* were related to better therapist-rated outcome results and lower drop-out rates (Kaplowitz et al., 2011). *Improving therapeutic skills and training counselors* when to end therapy may be an effective way to reduce dropout (Goldenberg, 2002).

Therapeutic Boundaries

Specific characteristics of therapeutic boundaries contributing to dropout were specified in 14 studies and were categorized in five factors. *Sparse contact or few appointments* weakened alliance and increased risk of dropout in one RCT (Swift & Callahan, 2011) and three naturalistic studies (Mueller & Pekarik, 2000; Perry, Bond, & Roy, 2007; Todd et al., 2003). One further naturalistic study indicated that *delay in case assignment* between the screening appointment and therapy start predicted nonattendance at the first therapy session but not premature termination from therapy (Reitzel et al., 2006). These time factors can be regarded as an aspect of administration and organization of the work at clinic (Todd et al., 2003).

Therapists who provided *support in a concrete manner*, gave reminders about appointments, were available between sessions, and provided feedback and encouragement were shown to reduce dropout rates in one review (Ogrodniczuk et al., 2005), two naturalistic studies (Shoffner et al., 2007; Young, Grusky, Jordan, & Belin, 2000) and one client survey (Shamir et al., 2010). No attempts have been made in these studies to distinguish between the clients'

need for concrete support and more complex emotional needs.

Preparation, information about therapy or negotiation of agreement, as well as discussion of expectations and preferences beforehand, significantly reduced discontinuation in four studies. These studies examined preparations concerning the length of therapy or number of sessions, the duration and frequency and, more broadly, what it might involve and require from the client in more practical areas such as taking time off work, scheduling, etc. The specific lack of such preparation was associated with dropout in one review (Ogrodniczuk et al., 2005), one RCT (Swift & Callahan, 2011) and one naturalistic study (Reis & Brown, 2006),while the presence predicted continuation in one RCT (Swift & Callahan, 2011) and two reviews (Barrett et al., 2008; Ogrodniczuk et al., 2005). One important factor in this context is how the clinical work is organized. As shown by Defife, Conklin, Smith, and Poole (2010), as many as 5% of the missed appointments could in fact be explained by missed communication between clinician and client, registration difficulties, and reschedules.

Two further factors predicting discontinuation were found in the studies. *Cancellations made by therapists* and other frame disruptions strongly increased this risk in two naturalistic studies (Corning & Malofeeva, 2004; Defife et al., 2010). *Change of the therapist* doubled the risk of dropout in one review (O'Brien et al., 2009), while switching the therapist if the client felt the match was not good enough could prevent dropout according to one naturalistic study (Perry et al., 2007).

Relationship and Process Factors

Relationship and process variables contributing to dropout were specified in 37 studies and were categorized in eight factors. *The quality of the therapeutic alliance* (in terms of its level) influenced dropout rates in 13 studies. Strong alliance early in the process predicted continuation in one meta-analysis (Sharf et al., 2010), four naturalistic studies (Baruch et al., 2009; Charnas et al., 2010; Lingiardi et al., 2005; Morlino et al., 2007) and one client survey (Derlega, McIntyre, Winstead, & Morrow, 2001). Low early alliance predicted dropout in one meta-analysis (Sharf et al., 2010), one review (Barett et al., 2008), two RCTs (Samstag et al., 2008; Spinhoven et al., 2007) and three naturalistic studies (Defife et al., 2010; Hauck et al., 2007; Perry et al., 2007). Furthermore, Corning and Malofeeva (2004) marked session eight as particularly at risk of dropout.

It has also to be noticed that the difficulties in establishing and maintaining therapeutic alliance are often connected in the literature to the client's pathological relational patterns or interpersonal problems. Five studies examined alliance related to the level of personality development. Three naturalistic studies (Goldman & Anderson, 2007; Mahon et al., 2001; Ruiz et al., 2004), as well as case studies (Junkert-Tress et al., 2000), found that basic stability of personality, such as stable inner object relations and secure attachment patterns, was associated with strong alliance and continuation. According to one naturalistic study (Baruch et al., 2009), the higher the level of emotional and cognitive functioning and the lower the external burdens, the easier alliance building was. The presence of personality disorders and more severe symptoms complicated building of alliance in five studies. Such personality traits as narcissism and externalization, typical for personality disorders cluster B, were found to affect alliance negatively in three of these naturalistic studies and one case study, which could be attributed to the clients' relational difficulties (Junkert-Tress et al., 2000; Löffler-Statska, Blueml, & Boes, 2010; Ruiz et al., 2004) or to the client's therapeutic inexperience (Bados et al., 2007). The fifth, naturalistic, study (Lingiardi et al., 2005) found instead that clients with traits within personality disorders cluster A, such as avoidance and depression, were harder to form alliance with and clients with traits of cluster B easier, due to their tendency for idealization.

Another related factor frequently associated with dropout was *client dissatisfaction*, with widely shifting content across the studies (one review, two RCTs and the seven naturalistic studies). One naturalistic study found client dissatisfaction to correlate with symptom severity (Bados et al., 2007), while another naturalistic study showed that satisfied clients could have comparable distress but still report being content with their health (Hauck et al., 2007). Two further naturalistic studies found a correlation between dissatisfaction and fewer sessions but not necessarily reduced outcome (Mueller & Pekarik, 2000; Perry et al., 2007). One RCT (Swift & Callahan, 2011) and one naturalistic study (Todd et al., 2003) found, on the contrary, connections between continuation, more sessions and better outcome. Dissatisfaction with the therapy and with the therapist's competence, trustworthiness, ways of talking and handling problematic issues were associated with dropout in one review (Barrett et al., 2008), one RCT (Gabbay et al., 2003) and three naturalistic studies (Bados et al., 2007; Berghofer et al., 2002; Defife et al., 2010).

Lack of agreement on definition of core problems, goals and procedures was found to influence dropout and outcome in one RCT (Gabbay et al., 2003) and one naturalistic study (Westmacott et al., 2010), and

narrative incoherence in the first third of treatment had the same consequences in one further RCT (Samstag et al., 2008), while the agreement on one defined interpersonal problem predicted continuation in another RCT (Thormählen et al., 2003). Furthermore, better client–student therapist agreement about positive changes was found for completers than dropouts in one archival study (Lampropoulos, 2010). In a qualitative study of unilaterally terminated long-term psychodynamic therapy, clients expressed strong ambivalence and reported a mismatch with the therapists or the therapy gave rise to painful feelings (Wilson & Sperlinger, 2004). Taken together, these six studies seem to indicate the role played by presence or absence of a shared context of meaning in the dyad for dropping out or continuation of therapy. However, one naturalistic study reported that disagreement about symptom severity did not predict dropout (Berghofer et al., 2002) and one RCT showed only small dropout differences between dyads in agreement that the core problem is psychological compared with those without (Gabbay et al., 2003).

Negative processes in therapy, such as problems and conflicts in the therapeutic relationship, being late, experiencing the therapist's hostility, negative therapy process reactions and other adverse experiences were strongly associated with dropout in two reviews (O'Brien et al., 2009; Vasquez, 2007), one naturalistic study (Defife et al., 2010) and two client surveys (Derlega et al., 2001; Hoyer et al., 2006). This factor seems to be interconnected with the therapist's negative responses.

Mismatching of gender, ethnicity and cultural background affected dropout in complex and diverse ways. When the clients were female or from a cultural minority, gender or ethnicity was associated with dropout in one review (Vasquez, 2007) and two naturalistic studies (Hatchett & Park, 2004; Nysaeter, Nordahl, & Havik, 2010). In such cases of dropout, the clients described both overt discrimination, such as biased remarks or offenses, and more subtle discriminatory behaviors, such as therapists' tone of voice or glance causing feelings of not being understood or accepted. Furthermore, the extensive meta-analysis by Maramba and Nagayama Hall (2002) showed that an increase in the cultural competence of therapists of different ethnicities was associated with lower rates of dropout from psychotherapy after the first session and an increase in the number of sessions attended.

In-treatment change in symptoms may be regarded as a component of the therapeutic process, influencing and influenced by the quality of the therapeutic collaboration (cf., Barber, Connolly, & Crits-Christoph, 2000). *Early symptom relief* was associated with treatment discontinuation in three naturalistic studies and one client survey. Dropout clients often reported improvement or receiving all the treatment the clinic possibly could offer as a reason for dropping out (Bados et al., 2007; Berghofer et al., 2002; Shamir et al., 2010) and could also report more improvement than continuers (Young et al., 2000).

On the other hand, three naturalistic studies and one client survey found that clients dropping out experienced *lack of improvement* or less improvement than did continuers. Goldenberg (2002) found no leading predictor of dropout; however, the dropout group consisted predominantly of non-improved clients. Lampropoulos (2010) demonstrated more treatment gains for continuers than dropouts. In a German client survey, most frequent reasons for dropping out were lack of improvement and a poor therapeutic relationship (Hoyer et al., 2006). In a study of client and therapist reasons for termination at a psychology training clinic, dropouts from treatment were overrepresented among dropouts from data collection, and their treatments were perceived by therapists as less successful. Furthermore, therapists were more likely than clients to endorse success as a reason for termination (Todd et al., 2003).

Finally, dissimilarities between therapist and client maladaptive schemas and *mismatch of pathological personality characteristics* were found in one RCT to have had a direct positive effect on early growth of the therapeutic alliance, thus indirectly influencing treatment continuation, but showed no relationship with clinical improvement (Spinhoven et al., 2007).

Discussion

Main Findings

The contribution of therapist, relationship and process factors to discontinuation of therapy is a relatively new, but expanding research field. At the present state of knowledge, we believe it is important to collect results from a wide range of methodological approaches. Thus, RCTs can test causal hypotheses, naturalistic studies can explore different factors in a real-life setting, while case studies can give us in-depth insight into relationship and process factors contributing to dropout. Strategies for reducing client-initiated premature termination can be tested by applying different research strategies. On the other hand, the strength of evidence for the results presented here varies across the 44 included studies, and the methodological diversity makes it impossible to follow a strict meta-analytic procedure.

Nonetheless, the present review seems to be representative of a larger body of psychotherapy

research. The most common diagnoses were Mood Disorders, Anxiety Disorders and Personality Disorders, i.e., the most frequent diagnoses among psychotherapy clients in psychiatric outpatient services. Women's predominance is marked, especially since forensic care settings and substance abuse clinics were excluded. The dropout rates varied strongly but were constantly high with a weighted dropout rate of 35%, which is concordant with previous findings, but considerably higher than the 20% reported in the recent comprehensive meta-analysis (Swift & Greenberg, 2012). The rates varied less for no-shows, as these cases could include therapists and clients agreeing upon earlier termination. One study defined dropout as attending fewer than 21 sessions (Baruch et al., 2009), which could be considered as almost asking for an unfairly high dropout rate (69%). The high dropout rates produced by the criterion of predetermined number of sessions or time-limit probably reflect the fact that therapy, as in all other relationships in life, consists of constant renegotiation of agreements.

Therapists' experience, training and skills, together with providing concrete support and being emotionally supportive, had an impact on dropout rates. Among relationship and process factors, the quality of therapeutic alliance, client dissatisfaction and pre-therapy preparation influenced dropout. Disregarding the relative weight of the reviewed factors, client-initiated discontinuation of therapy seems to be more common in dyads characterized by low early therapeutic alliance, less agreement and mutual understanding in matters of concrete arrangements and support, presenting problems, goals and procedures, therapy duration and achieved improvements, greater client dissatisfaction and more negative processes, and with therapists with less experience and training. Therapeutic boundaries emerged in this study as a cluster of factors interconnected with both therapeutic activities and process factors. Low frequency, few appointments and frame ruptures appeared to be connected with higher dropout rates, while being supportive in a concrete manner and preparing the client for therapy could counteract dropout. Together, these studies reflect the dual aspect of boundaries, the importance of stable and reliable frames and of flexible adaptation to clients need.

Client-initiated premature termination due to symptom relief may be an important study object, especially as it is a paradigmatic example of the client's and the therapist's diverging perspectives on the therapeutic process and outcome. According to our review, in some circumstances dropouts seem to report more improvement than continuers, even if they are dissatisfied, have been offered fewer sessions, experienced more adverse events and were assessed with more symptoms and distress. Other studies found that clients dropping out experienced lack of improvement or less improvement than did continuers. Assuming that the need for treatment length correlates with symptom severity, these findings appear to be incongruous. On the other hand, such cases may reflect the complex wave of client, therapist, frame, process and outcome factors, illustrating the need for in-depth studies applying more advanced design and analytical procedures.

The present review demonstrates the need of dropout studies focusing on interaction between client factors and therapist, relationship and process factors. The importance of SES and the difficulties produced by clients with personality disorders, especially cluster B, can be related to such process factors contributing to dropout as attraction barriers and gender, ethnic and cultural mismatch of the therapeutic dyad. Especially women and persons from an ethnic or cultural minority complain about lack of sameness in these matters (Karlson, 2005; Maramba & Nagayama Hall, 2002; McCabe, 2002; Norcross & Wampold, 2011; Vasquez, 2007). Apparently persons with more problems tend to be more problematic clients who bring their disorders and disturbances into the therapy room. Several studies included in the meta-analysis by Maramba and Nagayama Hall (2002) showed that the therapists may have certain competencies in this respect, reflecting their own background. Possibly, the focus on client variables had impeded further development of therapeutic interventions and methods counteracting the potentially negative effects of mismatch. It is also possible that people with low SES are more often seen in psychiatric inpatient settings and outpatient clinics by novice therapists. Accordingly, Swift and Greenberg (2012) found that that experienced therapists attained significantly lower dropout rates than did those in training, while university-based clinics (including training centers and counseling centers) had the highest average rates of premature discontinuation. The authors speculate that therapists become more responsive and focused on the relationship as they move beyond their years of basic training.

Implications for Clinical Practice

One conclusion for dropout prevention may be that therapists can enhance their skills by further training in strategies for strengthening initial alliance, repairing ruptures in collaboration and negotiating treatment frames and principles (Hilsenroth & Cromer, 2007; Ogrodniczuk et al., 2005; Safran, 2003; Swift, Greenberg, Whipple, & Kominiak, 2012). Even if

the therapist's skills in relation to dropout are explicitly elaborated in only one study (Goldenberg, 2002), it is implicit in most of the therapist factors identified in this review. The therapeutic skills often mean an adaptation of interventions, attitude and an overall approach according to the clients' specific needs and difficulties (Crits-Cristoph & Connolly Gibbons, 2001; Daniel, 2006; Hilsenroth & Cromer, 2007; Kolden et al., 2005; Norcross & Wampold, 2011; Swift & Greenberg, 2012). Although alliance counts as both a relationship and a process factor, it still weighs heavier on the therapist to form an alliance and to build a relationship that holds out for continuation and 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 client. The very same studies that report clients 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. After reviewing the 44 studies, we concur with the conclusion made by Goldenberg (2002, p. 212): "given that everything possible is done to prevent attrition, improving counselors' professional skills and educating counselors about when to end therapy may be the most effective way to reduce treatment attrition."

Learning from clients who drop out from therapy may be one way of enhancing our therapeutic skills, providing openness and curiosity about the phenomenon among the therapists, peers and colleagues and in the organization. Modifying team functioning (fewer diagnostic sessions, focused psychotherapy techniques, a shorter time interval between referral and first diagnostic appointment) could result in a significant reduction in the early termination rate in a child and adolescent unit (Lazaratou, Anagnostopoulos, Vlassopoulos, Tzavara, & Zelios, 2006), a conclusion also relevant for adult psychotherapy. Based on the recent comprehensive meta-analysis of premature termination in adult psychotherapy, Swift et al. (2012) presented six practice strategies for reducing dropout: client education prior to therapy about duration and patterns of change, providing role inductions in order to prepare the client for the therapy, incorporating client preferences in the therapy, early strengthening of hope, fostering the therapeutic alliance, and continuous assessing and discussing treatment progress. The authors recommend using these methods in a combination tailored to each client's need and therapist's experience.

The most impressive finding from our literature review is the impact of the therapeutic relationship on premature discontinuation or completion of therapy. The best-explored relational and process factor underlying dropout is the therapeutic alliance, described by Safran (1990, p. 140) as a "continuously oscillating kind of relationship." Such an understanding of the therapeutic alliance as "the relational context in which all other aspects of the therapeutic process unfold" (Safran & Muran, 2006, p. 290) points out a new direction for future dropout research: the interactions between the relationship factors and the therapist's skills in building and repairing the therapeutic relationship.

Limitations

There are several limitations in this review, as well as in the studies reported here. The review might be biased in the following ways: No additional reader made an objective evaluation of the relevance of the studies included. Bias caused by selective publication of studies or results within studies was not assessed. The sorting between therapist, therapeutic boundaries and relationship or process factors was based on the authors' intuition and consensus discussion. Many of the included studies did not directly address questions of dropout rates in relation to therapist, relationship or process factors, but included some of these variables in the analysis. Only few studies included matched control group or random assignment to different conditions. The range of sample sizes varied extensively, as both case studies, RCTs, large-scale naturalistic studies and meta-analyses were included. Definitions of dropout, as well as other variables in focus, differed widely across studies. Many studies looked at several factors, and only those associated with dropout in relation to therapist, relationship and process variables are listed here. Only studies conducted in the Western world could be included. Furthermore, this review is limited to client-initiated dropout, as only one of the included studies (Todd et al., 2003) specified therapist-initiated discontinuation of therapy.

Further Research

The great variation across studies in frequencies of dropouts may indicate that the organizational structure of the included clinics, team functioning, treatment policy and guidelines may influence dropout ratios (Staines, 2008). Among the changes in the practice of psychotherapy in the new millennium, the implementation of managed care, where the number of sessions and types of treatment are regulated by third parties, has presumably the strongest impact on the therapist, frame and process factors related to client dropout. However, organizational factors are

still the least explored. In an up-to-date meta-analysis (Swift & Greenberg, 2012) the intervention setting influenced dropout: university-based clinics (including training centers and counseling centers) had the highest average rates of premature discontinuation. In a recent Swedish study (Werbart & Wang, 2012), significantly more nonstarters and dropouts were found at clinics with lower levels of organizational structure and stability. We currently need extensive research on organizational factors potentially increasing or preventing both client-initiated and therapist-initiated discontinuation of psychotherapy.

The specific interaction effects between the identified variables still need to be explored. There is also a need of better consensus on the definition of dropout (cf., Swift & Greenberg, 2012). In our opinion, the most adequate operationalization in studies of therapist and relational factors may be "unilateral premature discontinuation." Even if future research can contribute to more knowledge and reduced impact of therapist and relationship or process variables on premature terminations, a certain amount of dropout in psychotherapy must probably be not only expected but also accepted, in some cases as an expression of the clients taking over responsibility for their life, in other as an example of the limitations inherent to psychotherapy.

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