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Dropping out of psychotherapy

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It's a big problem. Surveys show that nearly half of people who begin psychotherapy — individual, group, or couples — quit, dissatisfied, against the therapist's recommendation. An article in the Harvard Medical School Psychiatry Department's journal, the *Harvard Review of Psychiatry*, discusses why this happens so often and suggests some ways to prevent it.

The authors note some reasons why patients drop out: They are unwilling to open up about themselves; they cannot agree with the therapist about what the problem is; they just don't get along with or feel confidence in the therapist; they believe they are not improving quickly enough; they have unrealistic expectations.

The result, often, is that the patient feels like a failure. His or her problems are likely to get worse, and the symptoms are more likely to become chronic. When a patient drops out of group therapy, other group members may feel abandoned and group cohesion may be damaged. Psychotherapists may be demoralized because they feel rejected, and this feeling may interfere with the treatment of other patients.

What can be done about it? To find answers, the authors reviewed 35 years of scientific literature. They base their recommendations on the several dozen research studies and clinical descriptions they found.

Patient selection. Before starting therapy, it may help to screen patients for a good match to the therapist and the therapy. Plenty of attention has been devoted to this subject but not much controlled research, say the authors. There's some evidence that screening questionnaires for psychodynamic and cognitive behavioral therapy can help to distinguish patients who will complete therapy from those who won't. With reliable screening, patients at high risk for dropping out might be offered a different treatment, or specific preparation for treatment.

Preparation. Before beginning psychotherapy, some patients need to be educated about the process. They can be given an explanation of the rationale, the roles and

obligations of patient and therapist, expected difficulties and realistic hopes. This can be done with audiotaped or videotaped instructions, or by simulated therapy sessions (or videotaped excerpts from actual therapy sessions).
Group therapy, the authors say, requires more preparation because of the greater threat to control, privacy, and emotional safety. One approach is "experiential pretraining" — attending actual group therapy sessions to learn what it is like.

All these approaches have helped to improve attendance and lower dropout rates in some controlled studies, although results are not consistent.

Short-term or time-limited therapy. When the treatment is brief or has a fixed end point, dropout rates tend to be lower — in some studies, as much as 50% lower. As the authors note, that is partly because the less time a patient spends in therapy, the less opportunity there is for premature termination. But knowing when it will end may provide a sense of urgency and purpose that prevents patients from becoming discouraged.

Negotiation. Therapist and patient should agree in advance on the means and ends of therapy — what this person needs to accomplish and how it is to be accomplished. Negotiation is especially important in group therapy because otherwise, patients referred to groups may think that the unique features of their own situation are being ignored.

Case management. This is sometimes necessary to solve problems that make psychotherapy difficult, such as lack of adequate housing or employment or a disastrous family situation. Case management today is used mainly for people suffering from severe mental illness, especially those with low income and little education. One study found that case management for severely depressed patients in group therapy reduced the rate of quitting by 50%.

Motivational enhancement. Sometimes the problem is that the patient is not yet sufficiently willing or ready to change. Motivational enhancement aims to promote confidence in the ability to change and create a climate in which commitment to change becomes possible. It is already common in the treatment of alcoholism, drug addiction, and eating disorders.

Establishing the therapeutic alliance. Many studies have shown that the critical feature of all successful psychotherapy is a strong working relationship between the patient and the therapist. There is no formula for achieving it, although warmth, empathy, respect, and interest are always important. The alliance should be formed quickly; some believe that if it does not develop within the first three sessions, it never will.

Appointment reminders. Reminding patients of their appointments is routine for many health care professionals but sometimes avoided by psychotherapists because they want to promote responsibility in patients, or because they believe it's better to explore the meanings behind cancellations. The authors suggest that encouraging consistent attendance is more important.

Facilitating expression of feelings. The therapist must create an atmosphere in which a patient can safely discuss uncomfortable feelings, doubts, and questions about the therapy and the therapist. Otherwise, the patient may become uneasy and abandon the therapeutic project.

The authors note that there has been far too little research on this subject as of mid-2005 — only 15 studies since 1970, and only 4 since 1985 — possibly because many psychotherapists take a casual attitude toward the problem. They point out that no single strategy will work for all patients and in all situations, and they recommend that clinicians try several approaches. But only more research will make it possible to compare ways of preventing dropouts and to suggest more specific recommendations. They invite others to contribute ideas.

References

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