The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 6, Issue 2,DIP: 18.01.014/20180602
DOI: 10.25215/0602.014
http://www.ijip.in | April - June, 2018

The International Journal of INDIAN PSYCHOLOGY

Research Paper

Reasons for Dropout of Clients from Therapy

Kashish Behl[1]*, Mahalakshmi Rajagopal[2]

ABSTRACT

A successful prognosis from a psychotherapy can be predicted by the client's compliance to the treatment and therapy. Dropout of clients from therapy results in an incomplete treatment and less efficient outcomes from the therapy. This paper attempts to explore reasons for such a dropout by clients from therapy. Findings revealed interesting intrinsic as well as extrinsic factors. Environmental cues like distance or time paucity can constraint a person to seek therapy. Intrinsic reasons like low motivation, stigma attached to therapy, or defenses such as denial of a problem can result in a person withdrawing from therapy prematurely. For a successfully therapeutic treatment and efficient outcomes it's essential for a therapist to be aware of such factors playing a role. Successful resolution of these apprehensions and obstacles during course of treatment can open doors to recovery from a full-fledged therapy process.

Keywords: *Client Dropout, Therapy, Premature termination*

Psychotherapy is typically a treatment session between the client and the therapist drawn on the psychological principles and aimed at bringing positive changes in feelings, thoughts and behaviors of the client seeking help. Frank & Frank (1991, p.1) stated "Certain types of therapy rely primarily on the healer's ability to mobilize forces in the sufferer by psychological means. These forms of treatment may be generally termed psychotherapy". Hence according to this definition, mobilization of energy in the patient for a change is an essential feature in psychotherapy.

Dropout from therapies remain a major cause for inefficiency in improving the mental health status of the society and thus leads to low clinical improvements for the clients (Pekarik, 1985). In a meta-analytical study by Greenberg and Swift (2012), it was found out that one in five clients drop out of psychotherapy before completing the treatment. In various articles this is also referred to as attrition, premature termination or discontinuation. This is different from the situation where clients refused to take the therapy at all (Garfield, 1994).

[1]Msc Clinical Psychology, Christ University, Hosur Road, Bengaluru-560029, India
[2]Director, Sahayam Intervention Centre, Dwarka, New Delhi- 110075, India
*Responding Author

Received: March 30, 2018; Revision Received: April 5, 2018; Accepted: May 20, 2018

2018 © Behl K &Rajagopal M; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (www.creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Dropout is failing to return to the therapy after few initial sessions with the therapist. Attrition or premature termination/discontinuation from psychotherapy acts as an obstacle to serving and improving mental health status. As a result, clients do not receive adequate treatment leading to low relief from their illness. Attrition, also known as unilateral termination refers to client withdrawing from the therapy against the will/consent of the therapist. This discontinuation from the therapy can result from various factors which have been explored further in this paper.

Hatchett et al. (2002) defined dropout as the failure to attend the last scheduled session of the therapy. Frayn (1992) explains dropout as the termination of therapy any time within the first 9 months. Dropout has also been explained as the consumer-initiated termination without therapist agreement regardless of the number of sessions completed (Pekarik, 1992; Richmond, 1992; Tutin, 1987).

Factors associated with dropouts

Andersen (1968, 1995) gave a model of health services utilization which suggests four broad categories to decide the pattern of patients' utilization of health care services.

1. Patient characteristics- are general factors which are related to the person seeking therapy, for instance: the age, gender, religion etc. of the client.
2. Enabling factors- are any kind of barriers or problems which makes the client unable to seek aid and complete the therapeutic treatment.
3. Need factors- include the factors which are related to the client's need for treatment such as duration/length of treatment, diagnosis etc.
4. Environmental factors- are factors around the client which limits his ability to utilize the health care services such as the cost, feasibility, therapeutic set up etc.

Owens et al. (2002) provides an extension to Anderson's model and include three more factors associated with the drop out from a therapy. These include: client perceptions, his/her attitudes and assumptions of psychological problems and its treatment.

Following are few variables explained in detail, some borrowed from above models and some otherwise to explain the factors associated with drop out from psychotherapy better.

a. *Education and Perception of mental health*: Prevailing social stigma in society still makes people perceive mental illness in a negative way. Low awareness about mental illnesses and their treatment leads to the inefficiency of the mental care services. Studies have shown how perceptions of mental health likely influence the utilization of services. (Kouyoumdjian, Zamboanga & Hanse, 2003)

b. *Weak Therapeutic alliance* (Therapist-Patient congruence): In a study by Edward (1992), it was concluded that early levels of rapport between patient and therapist is related to patients' decision of staying in the treatment. Connelly et al. (1986) concluded from their study that people who dropped out from their therapies were more antagonistic towards their therapists compared to the other clients who continued to stay.

c. *"We got recovered"*: Often clients after achieving a significant amount of improvement from the therapy, they unilaterally decide to terminate it. Cahill et al. (2003) found out in their study that 70% of people who achieved good level of improvement dropped out from the therapy, however only 13% of these had acquired a clinically significant change.

d. *Income/Unemployment*: Low socioeconomic status/unemployment is a factor which increases the rate of dropout since the demand of the treatment, which is, to attend regular therapy session becomes unaffordable for such people. Low socioeconomic status has consistently been found to be related to psychotherapy dropout (Baekeland &Lundwall, 1975; Garfield, 1994).

e. *Racial status*: Race still continues to be a discriminating factor in society leading to differential behavior towards minorities. Wierzbicki and Pekarik (1993) in their study found that 47% of the dropout rates were affected by racial status bring one of the factors.

f. *Other reasons*: Greenberg (2012), in his study mentioned few other possible causal variables for dropout from psychotherapy. This includes number of *external constraints* like transportation or cost or child care. Also, according to him another major factor could be the anxiety about disclosing one's feelings and personal experiences.

In a study by Pekarik and Stephenson (2010), it was concluded that adult and children dropout should be analyzed separately in a research and hence more research needs to highlight the *role of parent* variables in influencing continuation of their children's treatment as largely parents decided for the termination of the their child's therapy sessions. Swift (2012) points how it can be frustrating for the therapists after building rapport with the children, suddenly their parents decide to not get their kids to the therapy anymore.

Attrition and motivation

Attrition can also be explained by its relation with motivation. Clients high on motivation to change presumably have higher chances of completing their treatment. However, clients with superficial motivation are less likely to have autonomy for a change. As a result of poor motivation to change, many clients fail to continue and are more likely to terminate the therapeutic treatment before its completion (Ogrodniczuk, Joyce, & Piper, 2005; Rappaport, 1997). Wierbicki and Pekarik (1993) did a meta-analysis of 125 studies and found out that due to lack of motivation in the clients, around 50% of the clients dropped out and nearly 80% of them didn't even stay for 10 sessions. Hence, this highlights the importance of client motivation as a factor in the therapeutic treatment.

Researchers have also noted that dropout by clients can also differ with the difference in the type of problems. For few issues, certain people are more resistant to seek therapy compared to other issues. In a study by Rounsaville (1978), it was found that half of the battered women who had appointments to seek available help failed to appear. Lindsay, Ouellet, and St-Jacques (1992) also reported high rates of dropouts for violent spouses.

Yalom (2015) also presents list of few factors which play a role in unilateral termination in a therapy. These include deviant position in a group, conflicts in intimacy and disclosure, stress amongst few others. Farber (1983) identified most stressful patient behaviors for therapists. After suicidal statements by clients and aggression and hostility, premature termination was rated highest as the most stressful patient behavior.

Consequences of dropouts from psychotherapy

Though dropout of clients from the therapy is a voluntary decision taken by the clients themselves, however it has adverse repercussions at times. Starting from the effect on the therapists, therapists tend to get demotivated and demoralized seeing clients discontinue the therapy prematurely (Barrett, Chua, Crits Christoph, Gibbons, Casiano, & Thompson, 2008; Ogrodniczuk, Joyce, & Piper, 2005; Piselli, Halgin, & Macewan, 2011)

Apart from the effect on therapists, the limited mental health resources also tend to be wasted by such premature termination of therapy by the clients. Joshi, Maisami, & coyle (1986) noted how failure of clients to turn up for the therapy wastes time and blocked appointments denies help to the one's in need. But the larger impact of the dropout is on the clients themselves. Premature termination results in the incomplete treatment and hence they do not receive an "adequate dose" of therapy. It leads to the client's failure in recovery which can also imply that they continue to suffer or even face adverse symptoms.

Hence, this research paper aims to better understand the reasons as to why clients' dropout from therapies after some time of joining.

LITERATURE REVIEW

Pre-mature dropout of clients from therapy can be attributed to various causes. To begin with, low income and education has been found to affect one's decision to continue the therapeutic treatment. Wierzbicki & Pekarik (1993) did a meta-analysis of 125 psychotherapy dropout studies. Result showed significant effect sizes for three variables (client demographic) which were: racial status, education and income. It was also seen that the number of dropouts increased for minorities, less educated and lower income groups. Similarly, Daly & Susan (2000) in their study found out that men who dropped out from the psychotherapy were more likely to be unmarried, belong to lower income groups or unemployed and less educated than men who remained and continued the therapy.

Apart from income and educational concerns, the dropout rates can also be hypothesized to be associated with parental decisions. Since children seeking mental health treatment are accompanied by their parents to the therapy, it's their parents who make decisions of continuation or termination of the therapy. Kazdin, Holland & Crowley (1997) in their study recruited 242 families in which children were seeking treatments. Findings of the study suggest that main reasons associated with the dropouts from therapy were perceived barriers by the parents like stressors and obstacles in going for treatment, perception of treatment not being successful or relevant and a poor relationship with the therapist.

Perceptions of mental health treatment and continued stigma in the society has a large role to play in dropout of clients from their therapies. Britt, Jennings, Cheung, Pury & Zinzow (2015) in their study tried to understand the role of different stigma perceptions in treatment seeking and dropout among active duty military personnel. 1324 active duty soldiers were administered a self-report survey measuring 4 different stigma perceptions. Results revealed that the participants having higher mental health problem reported higher on all 4 stigma perceptions and showed reduced chances of treatment seeking when considered individually. This self-stigma was the only unique predictor of dropouts.

Next, linked to this stigma a common belief of “I have recovered” is a factor leading for many clients to self-decide resulting in unilateral termination of the therapy. Infact unmatched levels of expectations from the therapy and hence dissatisfaction can also be the factor. In a study by Shamir, Szor & Melamed (2010) sample with 82 dropped out clients from therapy sessions were recruited and administered a questionnaire that evaluated their satisfaction with the therapy and explored other reasons for termination. Results revealed that the participants (65 clients) decided to terminate the therapy on their own either due to dissatisfaction with the therapist or kind of therapy or many felt that their condition had improved and thus no longer required the therapy.

Thus rising dropout from the therapy today is a growing concern in the area of mental health. It results in incomplete treatment of clients and termination of therapies before clients have fully recovered. This leaves the patients still suffering and trying to cope up with the unrecovered condition. Existing literature largely looks at one specific factors associated with dropouts in their study or tend to magnify on the dropout condition for a particular mental health condition and fails to give an overall amalgamated picture of possible interplay of factors leading to early termination of clients in the therapy. This paper tends to cover the client sample with flexible and broad age group from children to adults and look at the overall broad combination of factors associated with reasons of their dropouts and thus have a broad in-depth look at all possible combinations of factors. This will also allow the therapists to adopt appropriate techniques to control these factors to influence the clients, for instance: motivational interviewing as a technique might help the therapists deal with the various factors that emerge to play a role in influencing the clients to dropout. They can carefully plan their sessions and keep a track of growth and be warned of emergence of any possible factor which might influence a client to prematurely terminate the therapy sessions.

METHODOLOGY

Research problem

To explore the possible factors that contributes towards an increase in dropout rates from therapeutic treatments.

Sampling

For the purpose of the study, purposeful random sampling was used to select the dropped-out clients from the therapy. Nastasi (2004) believes that purposeful random sampling adds

credibility to the small sample of qualitative research study. On the basis of the case reports from Sahayam Intervention Centre, New Delhi, clients who discontinued from the therapy sessions were identified and randomly chosen for the interview. Sample size of four was employed for the purpose of the study. Sample included any dropped-out client, whether a child or an adult. Mothers were interviewed for a dropped-out case of a child. Demographic area was settled in for: New Delhi.

Data Collection

Data was collected using telephonic interview method. The interview was semi- structured in nature by which an attempt was made to get an insight into the possible causes of the dropout of clients from the therapy. The questions were open ended in style and probing was used along with the interview questions. Open ended questions helped the clients to flexibly answer the questions. Using in-depth interviews has been acknowledged as being a large chunk of information about the participants (Cross, 1981).

The interview guide included questions varying from general rapport building questions to their experience at the therapy Centre and with the therapist. Gradually, questions about their reasons for dropouts were explored and it was noted to include questions regarding their coping pattern and status after their discontinuation from the therapy. Experts were also consulted for reviewing the interview guide to improve its validity and reliability. Running notes were taken through-out the interview and the exact statements of the clients were also noted down. All the interviews lasted around 20-30 minutes.

Procedure

The client's information and details were ethically taken from Sahayam Intervention Centre's records and accordingly the prematurely dropped out clients from the therapy were approached via an email. The email conveyed the details of the study as well as a consent form attached. The consent clearly stated the clauses for confidentiality and other ethical guidelines. After getting the consents signed by the clients, the telephonic interviews were arranged as per the suitability and convenience of the client. The initial few questions aimed at rapport building which was in important step to achieve in a non-face to face kind of interview. According to Chermack (1979) a proper rapport will constitute of empathy, genuineness and unconditional positive regard. The informal rapport building questions included, client's daily routine; relationship with the family, and general enquiry about their hobbies.

Once the clients got comfortable, the interview was proceeded to get further information about their therapeutic treatments and reasons of dropping out. Running notes were taken through the interview in clients' own statements. Once the interview was completed, clients were reassured about the confidentiality and anonymity of their interview. Afterwards, the results were analyzed and interpreted using thematic analysis.

Analysis

Thematic analysis was employed for the purpose of this study. Thematic analysis is a popular qualitative analysis method that requires to work on the presenting themes or patterns and classification in the data collected by a researcher. It helps to look the entire data in great detail and to run through it multiple times in order to select the dominant reoccurring ideas and themes. The responses of each client was reviewed individually first and then all the possible themes were clubbed and identified across the interviews. Lastly, the themes were reviewed, identified and organized in a comprehensive pattern and cross checked with the data to check answer to each research question and form an elaborative story. Finally, the themes were interpreted and discussed.

RESULTS

This section presents the results of the present study. Table 1 summarizes the demographic details of the participants.

Table 1 Demographic Table

Client no.	Age	Gender	Reason for therapy	Number of sessions attended
1	12 years	Male	Bed wetting	Three sessions
2	50 years	Male	Depression	Two sessions
3	34 years	Female	Stress & tension	Four sessions
4	8 years	Male	Emotional control	More than 10

Case Description

Following are brief descriptions of the 4 participants who were interviewed as a part of this study:

Case 1: The client is a 12 year old boy who received therapy at the age of 11. The key area of concern was bed wetting however, the case report revealed further that the client also had an issue of being aversive towards female gender and especially for the word “sister”. The client continued his therapy over three Sessions and then withdrew from the therapy thereafter. Client’s mother was interviewed who came across as quite defensive and protective about certain information.

Case 2: Second client is a 50 year old male suffering from depression. He underwent therapy around couple of years back and dropped out of the therapy after two sessions. The client came across as extremely demotivated to undergo therapies for his treatment. Infect he is aversive to any kind of external help, be it medications or therapies. He solely believes in self-help and thus one’s own motivation and efforts towards wellbeing.

Case 3: The third client is a working young female. She discontinued the therapy after four sessions. The client took therapeutic help for personal stresses. She was protective about the information and didn't reveal much about the stressors. She came across as a quite positive person who is overwhelmed by alternative kind of therapies and lifestyle changes. She is a believer in therapeutic kind of help and was seen to be an independent person.

Case 4: A six year old boy was the fourth client whose primary concern for seeking therapeutic help was to control emotional outburst in his cerebral palsy. The client along his parents continued the therapy for over more than 10 sessions. Mother of the client was interviewed who came across as quite optimistic however she had other priorities on mind for her son other than emotional therapy like special education, walking classes etc.

Table 2 Major themes

Themes	Sub themes	Quotations
External Factors	Familial role	”wife keeps telling to go for treatment”
	Physical Constraints	“far off, consumes lot of time”
Internally displayed characteristics	Defense mechanisms	“I don't think at that level. I didn't agree what they told”
	Satisfaction	“Helped initially, then stagnant growth”
	Motivation	“call it anything, laziness or no motivation”
	Attitudes	“wanted a quick and immediate solution”
	Current coping	“Still coping up. Still phases of depression”

The major themes extracted are external and internal insights revealed in the interviews. This broadly implies to the fact that interviews constantly reflect emotions and views of the clients either attributed to the internal self or putting it onto the external causes. External factors broadly cover two sub themes, one of familial role which refers to the support or no support shared by the families of the clients as it is believed to be a major insight into the exploration of dropouts. Another one is the sub theme of physical constraints refers to all those factors which are externally hindering a client's capacity to seek out for therapeutic help.

Interviews also gave an insight into the internal pattern of thoughts and reasons clients hold. The first sub theme of defense mechanisms stand for all those unconscious ways the interviewee adopted in order to distort reality and come up with defenses to build an effective coping pattern. Next, the sub theme of satisfaction and motivation reveal their levels of

satisfaction with the therapy sessions they underwent and if at all they found it effective. Motivation on the other hand refers to their own intrinsic motivation and how strong is it to drive them towards seeking therapeutic help. Very importantly, the sub theme of attitudes cover a vast array of attitudes, common and unique in all clients. These attitudes vary from their attitudes towards their own illness to attitudes towards therapy and so on. Lastly, current coping theme attempts to highlight the present coping patterns and styles of those clients who have discontinued from the therapy.

DISCUSSION

The study aimed at exploring the various reasons behind the increase in dropout rates of clients from therapy sessions. For this purpose, in-depth interviews were conducted and vast themes were identified to give an insight into this. The interviews lasted for about twenty minutes and more. The clients for the interviews were the dropouts from the therapy after few sessions. After having built a proper and comfortable rapport with them, the interviews were proceeded.

The interviews largely revealed two key factors playing a role in their decisions and thoughts, external and internal factors. External factors refer to all the extrinsic factors, outside an individual's control which were playing a role in influencing the client's mindset. Extrinsic factor controlling a client's motivation to move towards therapeutic help is also familial support which was the first sub theme. Having a strong support and push from family makes a client motivated to seek help whereas a non-supportive family might tend to pull back an individual from seeking therapeutic help. Same was revealed in the interviews. Some cases were seen to be accompanied by both the parents while there was case too where father was unsupportive of the therapies and thud didn't accompany the child to the therapy. Familial role has broader role to play in the therapy sessions of the young children. Since it's the parents who are the key decision makers for young children who are client's often the dropout reasons and decisions can be biased where the client himself/herself might not be willing to withdraw. Pekarik and Stephenson (2010) in their study concluded that role of parent variable is a crucial factor to analyze separately in terms of its role in influencing continuation/discontinuation of treatment since it's the parents who significantly decide termination of their child's therapy.

Physical external constraints present externally also might unknowingly hamper a client's capacity to seek help (Greenberg, 2012). Some factors might play a role environmentally and restrict them to visit for therapies (Andersen, 1995). Few such factors were revealed in the study too which were common to the clients. Few regular clients were seen to be affected with the factor of "distance". As soon as the centre for therapy shifted from one part of the city to another, dropouts were seen to rise and clients have mentioned it too in their interviews stating how distance became one of the constraining factors despite of their will to continue the therapy. Client's response "it's far off and consumes a lot of time" shows their concerns regarding the distance. Apart from distance, time and money were too seen in couple of cases. Time in relation to priorities came across in the interview. Individuals with

other priorities set, find it difficult to manage time for the therapies, despite of the fact that therapy requires commitment of few hours for a day in week. Money was an uncontrollable factor, as the clients who were independently seeking help and could afford the therapies didn't have a choice but to consider dropping out. (Garfield, 1994). One of the female client reported "I wasn't even earning then, money was a big issue". Cantin and Raynor (1993) in their study found out how for women age and employment were significant factors associated with dropouts.

Extrinsic factors are usually uncontrollable and goes against person's will. However, there were intrinsic factors revealed in the interviews which were largely common to the cases and reflect the internal mindset and patterns of the clients seeking therapy. Firstly, unconscious feelings that all individuals go through when they step forward to seek therapy reveal quite an information of their thought patterns. Almost all clients were seen to adapt to some kind of defense mechanisms while they were interviewed. Despland et al. (2001) in their study highlighted the importance of client's defense mechanisms in the therapeutic setting and how it can influence processed like therapeutic alliance. Expectedly, few clients were seen to be under denial of many things. Denial of the importance of the therapeutic help or denial of the client's problem altogether. One highlighted response is of a mother who showed complete denial to all the information and suggestions revealed in the therapy by the therapist. She was noted to say "I don't think at that level. I didn't agree to what they told". On the other hand, denial of importance of therapy was also to be seen when a client completely disregarded the importance of the therapy at all in dealing with mental illnesses and went onto say "I am still not convinced about the therapy, one need to do it on his own". Apart from denial, the other defense mechanism identified from the responses was "rationalization". It was interesting to note how one of the client's mother on being asked what you think would have helped your child to improve on his illness replied "god and prayers made him better". This revealed how the mother totally rationalized the reason for the improvement in her son to overpowered spirituality and failed to accept the role played by the therapies in his improvement. Also when one of the clients was seen to get defensive about her conflicts with her mother and on being probed further for reasons why no one accompanied her for her therapies, she completely rationalized it by saying "I am an independent woman".

Withdrawal of clients from the therapy also was seen to be linked to their satisfaction with the therapy and its growth. It was a mixed response, where some of the clients were happy and satisfied with the help they were receiving but had to withdraw due to certain other factors. Whereas some of the clients were seen to be not so happy with the improvements with the therapy and thus considered dropping out after few sessions. Mother of a client was noted to say that "the therapy helped initially but later on there was a stagnant growth". Apart from satisfaction, motivation was another factor which came out interestingly in one of the client. A client with years of battling depression was seen to respond that "I have no motivation to seek therapy. Call it being lazy or anything". This client throughout the interview was seen to reflect demotivation in his responses and was seen to disregard seeking help from therapies altogether. Poor motivation has seen to affect many clients in failure to

continue and thus terminate the therapeutic treatment (Ogrodniczuk, Joyce, & Piper, 2005). Wierbicki and Pekarik (1993) in their study found that 50% of clients dropped out and due to lack of motivation to seek therapy.

Attitudes are one of the intrinsic factors which are key players in driving a person towards therapy or away from therapy. Attitudes that an individual hold can be conscious or even unconscious drivers. One of the attitudes which was mentioned before too was the attitude towards therapy. The client mentioned above who is completely demotivated towards seeking therapy and disregards its importance, purely believes in "Self-help". He was found to response on several occasions that how an individual is responsible for his/her own growth and improvement thus an individual should make his own efforts to come out of the illness rather than seeking therapies. He was noted to say "you can only do it, it's all your efforts". This also reflects the attitude of the client being naïve to the illness he is suffering from. The client is suffering from depression but still he reveals as episodes of depression being phases where he tries to isolate himself from the social world so that he doesn't harm them, but still doesn't believe therapy or medications can be of any importance to him. Infact, awareness of an individual's part is an important factor because if one is aware of the benefits and significance of therapeutic help he/she might make quicker choice of stepping towards it. The unawareness of importance of therapy can be simply due to the continued stigma attached with mental health interventions in our society. Denial of importance of therapy or believing that one can help his own self being at home reflects the attitude of society that how individuals till date have not been able to understand the role of a therapist and his importance. Stigma in the society continues to prevent people to take part in mental health care interventions (Patrick, 2004). As soon as the mother of the mentioned client saw few sensitive issues coming up with his child from past like aversion towards females or regression she quickly withdrew from the therapies scared of the unknowns to be revealed. Perception of mental health is likely to influence utilization of services available in the society (Kouyoumdjian, Zamboanga & Hanse, 2003).

Lastly, clients were seen to be still struggling with their illnesses and coping up after the incomplete intervention they had acquired. Few clients are seeking help elsewhere and trying out different methods of treatment whereas few are simply struggling by themselves in denial. For few, dropping out meant "we have got better" and this leave them struggling with their half improved health (Cahill et al., 2003).

These themes are not particular to one client but largely common to all showing a probable generalized mindset and attitudes of the clients towards therapies and common reasons why any client would drop out of the therapy prematurely. It was interesting to see how for them idea of professional help was a blurred concept and they optimistically believed that they are still continuing the therapy techniques which are needful. In support of this, Owens et al. (2002) highlight how clients perceptions is an important factor associated with dropouts.

Similarities were noted deeply amongst the clients. As mentioned before, common attitudes and beliefs or the act of simply hiding information was something most clients did. Defenses were also seen to be present in most of them. In support of the findings, a study by Baekeland and Lundwall (1975) showed how dropouts are likely to be more defensive and less wanting to disclose crucial information. Interestingly, there were few attitudes which were seen to be contradictory in clients. For instance, how few did believe in the therapies and were seen to be satisfied with the growth however few physical constraints forced them to withdraw whereas others was on the other side of spectrum, completely denying the need for therapies.

FUTURE IMPLICATIONS

There were few suggestions given by one of the client where she talked about the ambience of the therapy room. She stated how she would prefer going to a therapist with better ambience like soft music and comfortable couches instead of a table chair set up.

Apart from these additions, the therapist can consider adopting some of the well-researched techniques of retaining clients in the therapy like role induction where client and the therapist sit down together to drawn out the rationale and goals of the therapeutic alliance and sessions mutually. Studies have shown that role induction has helped reduce stress in therapy sessions and improved the alliance and additionally decreased the dropout rates (Orlinsky, Grawe, & Parks, 1995). Other suggested technique is by Lambert et al. (2005) who gave the suggestion of therapist feedback. This requires a continuous feedback given to the therapist about the client's growth and functioning and this acts like a "warn-alarm" where in case of no or slow growth in client, the therapist would consider reviewing the therapy technique and incase of good improvement, he/she will make no alterations. Lastly, motivational interviewing can be an effective tool to manage premature dropouts from therapy. This technique works in stages right from the contemplation stage to next steps dependent on client's level of improvement and growth. This motivates the client to seek change and continue in the therapy (Humfress et al., 2002).

LIMITATIONS

The study could have revealed more in-depth insights with a larger sample size and variant client population. A fair distribution of gender in respondents would also have reduced gender bias, if any played a role in the response. Also, face to face interviews would have served a better rapport and comfort with the researcher which may have influenced clients to reveal more in depth information. One of the other limitations in the study can also be the fact that few interviews were done with the mothers of the clients rather than client's themselves which could have led to biased information in a certain way. Lastly, due to the short duration of the interview and brief opportunity of the rapport building the clients largely missed revealing complete information about their case which was later identified from their case reports.

CONCLUSION

The study revealed two broad themes of external and factors playing a role in client's decision-making power to continue being or withdraw from the therapy. The external factors

playing a role include familial support or support from other independent sources. Also, physical constraints such as time, distance and money can force a client to drop out of the therapy prematurely. Internal factors such as, satisfaction-motivation levels, attitudes of the clients, defenses employed by them or the stigma attached to mental health interventions can be significant key players in dropouts from therapy prematurely.

REFERENCES

Barrett, M.S., Chua, W.J., Christoph, P.C., Gibbons, M.B., Casiano, D., & Thompson, D. (2008). Early withdrawal from mental health treatment: implications for psychotherapy practice. *Psychotherapy (Chic)*, *45(*2), 247-267.

Beckham, E.E. (1992). Predicting patient dropout in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *29*(2), 177-182. Retrieved from doi:/10.1037/0033-3204.29.2.177

Bernard, H., & Drob, S. (1989). Premature termination: A Clinical Study. *Group, 13*(1), 11-22.

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin, 82,* 738–783.

Britt, T.W., Jennings, K.S., Cheung, J.H., Cynthia, L.S., & Zinzow H.M. (2015). The role of different stigma perceptions in treatment seeking and dropout among active duty military personnel. *Psychiatric Rehabilitation Journal, 38*(2), 142-149. Retrieved from doi: 10.1037/prj0000120

Campbell, L.F., Norcross, J.C., Vasquez, M.J., & Kaslow, N.J. (2013).Recognition of psychotherapy effectiveness: the APA resolution. *Psychotherapy (Chic)*, *50*(1), 98–101. Retrieved from doi:/10.1037/a0031817

Chamberlin, J. (2015). Are your clients leaving too soon? *Monitor on Psychology, 46, 4*. Retrieved from http://www.apa.org/monitor/2015/04/clients.aspx

Cuijpers, P., Donker, T., van Straten, A., Li, J. and Andersson, G. (2010) Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies, *Psychological Medicine*, *40*(12), 1943–1957. Retrieved from doi: 10.1017/S0033291710000772

Daly, J.E., & Susan, P. (2000). Predictors of Dropout among Men Who Batter: A Review of Studies with Implications for Research and Practice. *Violence and Victims*, *15*(2), 137-160.

Despland, J.N., Roten, Y., Despars, J., Stigler, M., & Perry, J.C. (2001). Contribution of patient defense mechanisms and therapist interventions to the development of early therapeutic alliance in a brief psychodynamic investigation. *The journal of psychotherapy practice and research, 10*(3), 155-164.

DeMaris, A. (1989). Attrition in batterers' counseling: the role of social and demographic factors. *Social Service Review, 63*(1), 142-154.

Humfress, H., Igel, V., Lamont, A., Tanner, M., Morgan, J., &Schmidt, U. (2002). The effect of a brief motivational intervention on community psychiatric patients' attitudes to their care, motivation to change, compliance and outcome: A case control study. *Journal of Mental Health, 11,*155–166.

Kazdin, A.E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65*(3), 453-463. Retrieved from doi: 10.1037/0022-006X.65.3.453

Lorber, J., & Satow, R. (1975). Dropout rates in mental health centers. *Social Work, 20(*4), 308-312.

MacNair, R.R., & Corazzini, J.G. (1994). Client factors influencing group therapy dropout. *Psychotherapy: Theory, Research, Practice, Training*, *31*(2), 352-362. Retrieved from doi:/10.1037/h0090226

Mohl, P.C., Martinez, D., Ticknor, C., Huang, M., & Cordell, L. (1991). Early dropouts from psychotherapy. *Journal of Nervous and Mental Disease*, *179*(8), 250-255

Patrick, C. (2004). How Stigma Interferes with Mental Health Care. *American Psychologist, 59*(7), 614-625. Retrieved from doi: 10.1037/0003-066X.59.7.614

Pekarik, G., & Stephenson, L.A. (2010). Adult and child client differences in therapy dropout research. *Journal of Clinical Child Psychology, 17*(4), 316-321. Retrieved from doi:10.1207/s15374424jccp1704_3

Ryan, R.M., Lynch, M.F., Vansteenkiste, M., & Deci, E.L. (2011). Motivation and autonomy in counselling, psychotherapy, and behavior change: a look at theory and practice. *The Counseling Psychologist*, *39*(2), 193-260. Retrieved from doi: 10.1177/0011000009359313

Shamir, D., Szor, H., Melamed, Y. (2010). Dropout, early termination and detachment from a public psychiatric clinic. *Psychiatria Danubina, 22*(1), 46-50.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*(2), 190-195. Retrieved from doi:10.1037/0735-7028.24.2.190

APPENDIX- A

Consent Form

Sahayam Intervention center invites you to participate in a study conducted by the organization in order to study the possible reasons behind the dropout of clients from therapy. Please read the following information carefully and decide whether you would like to participate in this study.

Purpose of the research is to study drop outs from therapy which will help us get an insight into the reasons for dropout. Hence, we will be able to change for the better and help our clients in an improved and efficient way. If you choose to participate, you would be required to be a part of an interview (approximate 20 minutes) which will try and gain understanding of your experience of the therapy and your feedback on the same. The interview questions will be basic, inquiring about your duration of the therapy, your relation with the therapist, your experience etc.

Your participation in this research is **voluntary**. If you don’t want to answer any question at any point of the interview, you can do that. You are also free to withdraw from the research at any stage by simply telling the interviewer.

Sahayam would like to ensure that any information you provide during the interview would be kept **confidential** and will be used in future only for the research purpose. Also, your **identity will NOT be revealed** to anyone at any time.

Interviews will be conducted as per your convenience, over Telephone/Skype call so as to further protect your identity. If you have any queries regarding this research, you may contact KashishBehl (mobile no.: 9873233752) or write to us at: kashish_behl@hotmail.com.
Thank you for your consideration.
If you agree to be a part of the following research, kindly sign below to mark your voluntary participation in this study.
I agree to be a part of this research

(Name and Signature)

____

APPENDIX- B

Interview Guide:
Q.1 Rapport questions
- Can you tell me a little bit about yourself?
- Your family, work/school, where you were brought up?
- What was your age when you came to Sahayam to seek therapy?
- What brought you to the centre to take therapy?
- For what did you want help with?

Q.2What do you think about your decision of taking therapeutic help?
- How did you reach this decision?
- Did anyone accompany you for your therapy? Who?

Q.3 Tell me about your experience at Sahayam?
- How was your relation with the therapist?
- Did you like your therapist?
- How did you feel about coming to the therapy sessions?
- How did you find your therapy sessions?
- How helpful were the therapy sessions?
- Can you describe the ways in which sessions were helpful?
- Can you describe the ways in which sessions were not helpful?

Q.4 Can you describe what all contributed to your decision of discontinuing the therapy sessions?
- Were there more factors you can think of which made you to discontinue?
- How were managing finances for your therapy?
- What about time?

- How far was sahayam from your home? Did this affect in any way?
- What motivated you to come for the therapies?
- How was familial support?
- How was your occupational/school/college support?

Q.5 How do you feel about your decision of discontinuing from the therapy?
- Can you describe your emotions after you discontinued therapy?
- If you were given a chance to change anything about your therapist, your therapy sessions, the circumstances, yourself or others at the time of therapy, what would it be?
- What is your general view on mental health and therapeutic help for them?

Acknowledgments
The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interests: The author declared no conflict of interests.

How to cite this article: Behl K & Rajagopal M (2018). Reasons for dropout of clients from therapy. *International Journal of Indian Psychology*, *6*(2), 135-150. DIP:18.01.014/20180602, DOI:10.25215/0602.014