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Exploration of the reasons for dropping out of psychotherapy: A qualitative study

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ABSTRACT

Elucidating the reasons for dropping out of psychotherapy can lead to the development of interventions aimed at reducing patient drop out. The present study aimed to explore patients' reasons for dropping out of psychotherapy in Kermanshah, Iran. The present qualitative study was performed using conventional content analysis. The current sample included 15 participants consisting of 7 patients who dropped out of psychotherapy and 8 psychotherapists who have previously experienced patient dropout. A semi-structured interview was used for data collection. All interviews were audio recorded and subsequently transcribed. Content analysis using constant comparisons was performed for transcribed interviews. Four main categories emerged as reasons for dropping out of psychotherapy: dissatisfaction with the quality of psychotherapy, financial problems in psychotherapy, unprepared socio-cultural context of psychotherapy, and psychotherapy as a non-user friendly treatment. Additionally, specific subcategories within each main category were documented. The results revealed distinct reasons for psychotherapy drop out in the current Iranian-based sample. These identified reasons should be considered and addressed at the onset of treatment as well as in the development of formal interventions aimed at reducing dropout. Further research investigating the antecedents leading to patient drop out is recommended.

1. Introduction

Patient initiated drop out or early termination of treatment is a commonly faced problem in psychotherapy that can significantly hinder treatment efficacy (Killaspy, Banerjee, King, & Lloyd, 1999; Killaspy, Banerjee, King, & Lloyd, 2000; Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010). In the process of dropping out of psychotherapy, the literature suggests that patients unilaterally decide to leave therapy against the recommendations of their treating therapist (Beardsley, Wish, Fitzelle, O'Grady, & Arria, 2003; Pulford, Adams, & Sheridan, 2008). Drop out has been associated with several negative outcomes: an attenuated effect of therapy, failure in achieving symptom remission, or an exacerbation of symptoms (McIvor, Ek, & Carson, 2004). In addition to concerns regarding patient welfare, drop out is associated with staff time consumption; therefore, limiting the access of resources for other potential patients (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; McIvor, Ek, & Carson, 2004; Mitchell & Selmes, 2007).

Taking into account these issues, drop out in psychotherapy has been a primary focus for investigation in several studies. These studies have documented the prevalence rates of and predictors for treatment drop out. Reported prevalence rates range from 25% to 50% with the highest frequency of client drop out occurring after the first session or at the 6–8 session mark (Barrett et al., 2008; Hamilton, Moore, Crane, & Payne, 2011). To determine possible predictors of psychotherapy drop out, studies have examined the differences among patients who terminated therapy early compared to those who completed their recommended course of treatment. These studies found that those who terminated early tended to be less satisfied with services (Pekarik, 1992), less likely to exhibit clinical improvements (Saatsi, Hardy, & Cahill, 2007), and more likely to display greater levels of impairment (Kazdin, 1996). Additional studies have shown that young age, lack of insurance, low income (Edlund et al., 2002), difficulty in access to service, and clinic setting (Barrett et al., 2008), and negative attitudes toward mental health (Hampton, Yeung, & Nguyen, 2007) are predictors for dropping out of psychotherapy.

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A large study using real-world administrative health care data examined the profession of provider, therapy modality, and DSM-IV diagnosis as predictors of early psychotherapy termination (Hamilton et al., 2011). Results showed that marital family therapists had the lowest client dropout rates compared to psychologists, social workers, and nurses. Additionally, clients who received a combination of psychotherapy and pharmacotherapy had lower rates of drop out when compared to those who received psychotherapy alone. The report also showed that clients suffering from substance use/abuse or schizophrenia are more likely to drop out prematurely from psychotherapy.

In Iran there is a paucity of literature regarding the critical dilemma of client drop out in psychotherapy. To the best of our knowledge, Iranian client drop out has only been studied as an afterthought within a large study investigating dropout rates in outpatient psychiatry. The study reported that approximately 20% of clients terminated after their initial session and lack of confidence in therapist ability and treatment efficacy, financial difficulties, and travel distance were documented as primary reasons for terminating (Khazaie, Rezaie, & de Jong, 2012).

In light of the growing body of literature addressing patient drop out, two important issues should be considered. First, numerous studies have utilized quantitative methods to document predictors of patient drop out; thus, potentially missing the unique and often complex reasons as to why patients may choose to discontinue therapy. Therefore, as recommended by Barrett et al. (2008) qualitative studies investigating the predictors of drop out should incorporate the use of semi-structured interviews with clients who have dropped out and therapists who have experienced early client drop out. These studies can offer insight on the nonevident reasons for engagement and disengagement in psychotherapy. Therefore, having a greater potential for deeper exploration of this phenomenon (Strauss & Corbin, 1990), qualitative methods may be better suited to capture the predictors for dropping out of psychotherapy. Secondly, there is a significant lack of documented evidence about drop out in psychotherapy in Iran, and the few studies focusing on this topic (e.g., Khazaie, Rezaie, & de Jong, 2012) call for further research to be completed. Therefore, as the first study in Iran focusing solely on this topic, the present study employs qualitative methods using content analysis to explore the reasons as to why clients drop out of psychotherapy living in Iran from client and psychotherapist report.

1.1. Psychotherapy in Iran

Psychotherapy practices in Iran are commensurate with that of other countries, since mental health training in Iran has been heavily influenced by western societies. It is important to note that, to our knowledge, a historical movement of psychotherapy in Iran has not emerged (Mehryar, Muharreri, Nouri, & Khajavi, 1986). The dominant psychotherapy theories and techniques exercised in Iran (e.g., behavior therapy, cognitive behavior therapy, and psychoanalytical therapy) are the theories and techniques employed in western countries, especially the United States (Mehryar et al., 1986). To the best of our knowledge, there is no Iranian culture based psychotherapy method in Iran. Despite the ease and availability of different classes of psychotropic medications, psychotherapy is still considered an effective treatment for a variety of disorders. Psychotherapy has been integrated into the training of psychiatrists (Tavakoli, 2014), and is currently performed by psychiatrists and psychologists alike. Additionally, psychotherapy that is usually performed in outpatient clinics is now being conducted at inpatient facilities (e.g., psychiatric hospitals). Routinely, clients who are referred to a psychiatrist may either undergo psychotherapy by said psychiatrist or be referred out to a psychologist. Therefore, both psychiatrists and psychologists are commonly known as psychotherapists. Furthermore, there are several clinics in which a psychiatrist may work alongside one or more psychologists, while other clinics may be solely directed by psychologists. Unfortunately, mental health benefits provided by insurance companies are inconsistent in Iran (e.g., some private insurances may cover psychotherapy sessions, while others are not responsible for coverage). Nevertheless, psychotherapy can be provided for the majority of clients; especially for presenting issues such as marital problems, depression, and anxiety disorders (Mehryar et al., 1986).

2. Methods

2.1. Study design

The current study employed a qualitative approach using conventional content analysis. Information was gathered directly from participants without a priori hypotheses. Therefore, produced knowledge is based on the participants' responses. Codes and categories were derived through an inductive process and continuously modified based on the content of the semi-structured interviews (Strauss & Corbin, 1990, 1997).

2.2. Participants and setting

Based on the study protocol, having experience in and information about psychotherapy drop out was our primary inclusion criterion. Therefore, both the patients who dropped out of psychotherapy and the psychotherapists who have experienced patient drop out were enrolled in the study Purposeful sampling with maximum diversity, a popular method used in qualitative research designs, was used to select the study's participants. Additional inclusion criteria were (1) willingness to participate in the study protocol, and (2) to be fluent in Farsi. Specific to patients, drop out had to have occurred within 1–3 therapy sessions. This criterion was used because research has shown that 50% of terminations occur by the third session and 35% occur following the first session (Barrett et al., 2008). To avoid recall bias, drop out occurred approximately one month prior to the client's interview. Psychotherapists were required to have at least five years of clinical experience in conducting psychotherapy. It should be noted that some of the study participants interviewed were the psychotherapists of the clients who discontinued therapy.

Based on these criteria, the final sample consisted of 15 participants that included seven patients (2 males and 5 females with mean age of 31.1 ± 9.31) who discontinued psychotherapy services and eight psychotherapists (6 males and 2 females, 4 psychologists and 4 psychiatrists) who have provided psychotherapy services in Kermanshah, Iran. See Tables 1 and 2 key demographic characteristics of study participants. Kermanshah, located in western Iran, is the capital city of the Kermanshah province with a population of 851,405 based on 2012 census data. In Kermanshah, psychotherapy is provided by licensed psychiatrists or therapists who have earned either a master's degree or a PhD in psychology. After obtaining institutional approval for the study, local psychiatrists and therapists were contacted for participant recruitment. Between April and December 2014, interviews with patients who had terminated therapy were conducted at the psychiatry department of Kermanshah University of Medical Sciences (KUMS), while providers were interviewed in their private offices.

2.3. Ethical consideration

The current study was approved by the ethical committee of Kermanshah University of Medical Sciences (KUMS) in Iran. Prior