Predictors of dropping out were investigated for patients who participated in time-limited, interpretive individual psychotherapy in a randomized clinical trial. A sample of 22 dropouts was compared with a sample of 22 matched completers on both pretherapy and therapy process variables. None of the pretherapy predictors, which included demographic, diagnostic, and initial disturbance variables, significantly differentiated the two groups. In contrast, several of the therapy process variables, including the therapeutic alliance, work, patient exploration, and focus on transference, significantly differentiated dropouts from completers. For dropouts, there was a weaker alliance, less work, less exploration, and greater focus on transference. Examination of the last session of dropouts revealed a nonproductive pattern characterized by resistance and transference interpretation. Implications and limitations associated with the study are considered.

Although definitions vary, dropping out of psychotherapy generally refers to the situation in which a patient has made a unilateral decision to stop coming to therapy, which is contrary to initial expectations, a contract, or the recommendation of the therapist. While there are exceptions, this usually represents a negative state of affairs. The patient often experiences dissatisfaction with therapy or the therapist, which may include lack of improvement or worsening of problems. Addi-
tionally, both parties may experience a sense of failure, wasted effort, and demoralization. The therapist or clinic may lose income and, if therapy is part of a study, researchers may experience a compromised design. For all of these reasons, dropping out is an event to be avoided.

Reported dropout rates for psychotherapy are typically high, despite the fact that many current therapies are intended to be brief. In a recent meta-analytic review of 125 studies of different forms of psychotherapy, Wierzbicki and Pekarik (1993) reported an average dropout rate of 47%, which is consistent with rates reported in previous reviews (Baekeland & Lundwall, 1975; Garfield, 1986). Dropout rates for time-limited therapies may be lower, however. Sledge, Moras, Hartley, and Levine (1990) reported a rate of 32% for brief therapy that had a definite time limit compared to a rate of 67% for brief therapy that did not have a definite time limit. The rates may be even lower for manualized time-limited therapies that are provided in clinical research units that select patients carefully. Hunt and Andrews (1992) reported a rate of 17% for time-limited cognitive-behavior therapy that was provided in a clinical research unit, which stands in contrast to a reported rate of 50% for time-unlimited cognitive-behavior therapy that was provided in a private practice setting (Persons, Burns, & Perloff, 1988). Relatively low rates were also reported by Elkin et al. (1989) for the manualized forms of time-limited interpersonal psychotherapy (23%) and cognitive-behavior therapy (32%) that were provided in the National Institute of Mental Health (NIMH) collaborative treatment study of depression. Similarly, we experienced a dropout rate of only 17% for a manualized form of time-limited interpretive psychotherapy that was provided in a previous controlled-outcome study (Piper, Azim, McCallum, & Joyce, 1990). Even though the dropout rates for manualized time-limited therapies in clinical trials appear to be lower than therapies provided under other conditions, the rates remain higher than desirable and should not deter the search for contributing factors.

In general, the search for pretherapy predictors of dropping out has been disappointing. In their review, Wierzbicki and Pekarik (1993) reflect the conclusions of other reviewers who point out that there are many inconsistencies and replication failures and that statistically significant associations are often small in magnitude. An example is the frequently cited association between low social class and dropping out. They suggest that it may be time to abandon the search for simple demographic predictors in favor of more complex variables such as mutual expectations and interactions between patient and therapist. In addition to identifying strong associations, investigating such variables may provide understanding of the mechanisms that underlie dropping out of psychotherapy.

One variable that has been investigated in a number of dropout studies and that provides insight into the nature of the patient-therapist relationship is the therapeutic alliance, which reflects how well the two parties are working together. In regard to patient-rated alliance, three studies have reported an inverse relationship between early alliance and dropping out (Beckham, 1992; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1990), while two have not (Kokotovic & Tracey, 1990; Tryon & Kane, 1993). In regard to therapist-rated early alliance, two studies have reported an inverse relationship (Samstag et al., 1998; Tryon & Kane, 1993). Thus, the literature is suggestive of a relationship between a weak therapeutic alliance and dropping out. Although this relationship is important to document, it does not provide an understanding of the patient’s and therapist’s interactional contributions to the weak alliance and the dropout process.

Studies that have investigated the relationship between therapy session interactions of the patient and therapist and dropping out are quite rare. Najavits and Strupp (1994) used data from the Vanderbilt II study (Strupp, 1993) to focus on the therapist’s contribution to effective treatment, which was defined in terms of a composite of outcome variables and patient length of stay. They reported that effective therapists displayed more positive behaviors and fewer negative behaviors than ineffective therapists, and that most of the significant associations involved relationship-oriented behaviors. Strupp, Schacht, Henry, and Binder (1992) also published a case study of a patient who dropped out of treatment in the Vanderbilt II study. It detailed technical errors by the therapist that appeared to contribute to the premature termination. Other publications that have emanated from the Vanderbilt II study have also emphasized the therapist’s contribution to negative outcome (Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler,
Schacht, & Binder, 1993). Some of our previous work has also identified associations between therapist behaviors (e.g., high use of transference interpretations) and negative outcome for certain patients in time-limited individual psychotherapy (Piper, Azim, Joyce, & McCallum, 1991).

Recently we completed a comparative clinical trial that investigated the efficacy of interpretive and supportive forms of time-limited individual psychotherapy (Piper, Joyce, McCallum, & Azim, 1998). The dropout rate for interpretive therapy (23%) was significantly higher than the rate for supportive therapy (6%). As indicated by the reviews of the dropout literature, the rate for interpretive therapy in the clinical trial was not particularly high; the rate for supportive therapy was unusually low. Nevertheless, losing nearly one quarter of one's patients is undesirable, and this circumstance motivated our interest in identifying predictors of dropping out. As reported in the above publication, our initial effort to identify pretherapy patient characteristics was unsuccessful. A number of demographic, personality, and initial disturbance outcome variables, as well as interactions between certain personality variables and the form of therapy, failed to differentiate all dropouts from all completers or interpretive therapy dropouts from interpretive therapy completers.

In the current study, we continued the search for predictor variables, specifically the patient's and therapist's interactional contributions to the dropout process. Among a set of process variables, we investigated the therapeutic alliance, patient work, patient exploration, and focus on the transference (patient-therapist relationship). Ratings of the process variables were provided by multiple sources (patient, therapist, external observer) for multiple sessions. We focused on interpretive therapy, which produced most (82%) of the dropouts in the trial. Experienced therapists provided the therapy, which was found to adhere to the treatment manual. The trial provided the opportunity to compare the therapy process of 22 interpretive therapy dropouts with the therapy process of 22 interpretive completers. An additional strength of the study involved the variables that were controlled in making the comparison. The dropouts and completers were matched on personality, demographic, and use-of-medication variables. In addition, they were matched by therapist qualities, which controlled for such aspects as the therapist's personal characteristics (personality, psychological adjustment, demographic attributes) and professional characteristics (training, experience, theoretical orientation). We believed that control of these variables would enhance our chances to identify patient-therapist interactional differences between dropouts and completers.

Method

Setting and General Procedure

A detailed description of the design and methodology of the clinical trial is presented by Piper et al. (1998). Patients were referred for psychotherapy from a large psychiatric outpatient clinic of a university hospital. The sample consisted of a diagnostically mixed group of outpatients who presented with difficulties related to depression, anxiety, low self-esteem, and interpersonal conflict. After providing informed consent, patients participated in interview and questionnaire assessments of predictor, demographic, diagnostic, and outcome variables. Patients were matched in pairs on two personality variables (quality of object relations [Piper & Duncan, in press], psychological mindedness [McCallum & Piper, 1997]), two demographic variables (age, gender), and use of medication, and randomly assigned to interpretive or supportive therapy with one of eight therapists. Patients agreed to attend 20, once-weekly, 50-minute therapy sessions. Completers were defined as patients who attended 14 or more sessions ($M = 18.0$, $SD = 2.0$). Dropouts were defined as patients who attended 13 or fewer sessions ($M = 5.4$, $SD = 3.6$) and who terminated against the recommendation of their therapist. Seventy-four percent of the dropouts terminated during the first third of therapy, 41% during the first three sessions. There were 144 therapy completers and 27 dropouts (22 from interpretive therapy, 5 from supportive therapy). During the trial, each dropout was replaced with a matched patient who completed therapy. In the present study, the 22 interpretive therapy dropouts were compared with their 22 matched, interpretive therapy completers on a number of process variables such as patient work and focus on the transference, which were rated by external observers from audiotapes of the sessions. They were also compared on the therapeutic alliance, which was rated separately by the patient and therapist after each therapy session.

Description of Dropout and Completer Sample

A series of statistical analyses (chi square, t test) revealed that the demographic characteristics
of the sample of 44 dropout and completer cases did not differ significantly from the characteristics of the entire set of patients who completed therapy in the trial. The average age of the patients was 33 years, and 59% were women. Thirty percent were married or living with a partner, 20% were separated or divorced, and 50% had never been married. Sixty-one percent were educated beyond high school, and 77% were employed. The racial composition was White (95%) and East Indian (5%). Many (73%) reported receiving previous psychiatric treatment, but few (9%) had a history of psychiatric hospitalization.

The diagnostic characteristics were also found to be similar. Axis I diagnoses were identified by the computer-administered Mini-Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders-3rd ed.-revised (DSM-III-R) (Mini-SCID; First, Gibbon, Williams, & Spitzer, 1990) and validated by an independent clinical diagnosis assigned jointly by the intake assessor and a psychiatrist, both of whom saw the patient on the day of intake. Axis II diagnoses were determined by the computer-administered Structured Clinical Interview for DSM-III-R Personality Questionnaire (SCID-II PQ) and Auto-Structured Clinical Interview for DSM-III-R (Auto-SCID II; First, Gibbon, Williams, & Spitzer, 1991). A total of 82% of the 44 cases received an Axis I diagnosis. The most frequent disorders were current major depression (45%) and dysthymia (10%), followed by alcohol abuse (9%), anxiety disorder (5%), and adjustment disorder (5%). A total of 45% of the 44 cases received an Axis II diagnosis. The most frequent Axis II disorders were avoidant (25%), borderline (25%), paranoid (23%), and obsessive-compulsive (18%). A total of 39% of the cases received both Axis I and Axis II diagnoses. Patients with primary problems related to psychosis, substance abuse, or sociopathic behavior had been excluded from the trial.

Therapists

In the trial, there were 8 therapists (3 psychologists, 2 social workers, 2 occupational therapists, and 1 psychiatrist). Seven were White and 1 was East Indian. Five were female. Their average age was 43.6 years ($SD = 6.1$, range = 37–52) and their average experience practicing individual psychotherapy was 11.8 years ($SD = 4.9$, range = 5–19). Each therapist treated 9 interpretive therapy completers and 9 supportive therapy completers. In regard to the interpretive therapy dropouts, 2 therapists had none and the other six had 7, 6, 4, 2, 2, and 1, respectively. A Fisher’s exact test indicated that differences among the 8 therapists in their numbers of completers and dropouts approached but did not reach statistical significance ($p = .07$).

Therapy

For interpretive therapy, the primary objective is to enhance the patient’s insight about repetitive conflicts (intrapsychic and interpersonal) and trauma that serve to underlie and sustain the patient’s problems. The patient is expected to begin each session and assume responsibility for what follows. There is ongoing pressure for the patient to talk, and the therapist abstains from providing direct gratification or praise. The therapist encourages the patient to explore conflicts, which often involve uncomfortable emotions. Interpretations about sensitive topics, including transference, are often made. Overall, the therapist is active, interpretive, and transference focused. Relative to supportive therapy, the interpretive therapy situation is more demanding, depriving, and anxiety arousing. The therapists in the trial participated in a 6-month training seminar before taking cases in the project. This included treating pilot cases and attending a weekly training session in which technical principles were covered and cases were presented. The weekly seminar continued throughout the project. The therapists followed a technical manual that described, illustrated, and compared the technical emphases associated with interpretive and supportive therapy. Adherence to the technical manual was verified with a rating system used by a team of external observers (bachelor’s-level research assistants). The Adherence Scale consists of 14 items (7 interpretive and 7 supportive) rated on a 5-point Likert-type scale ranging from 0 (no emphasis) to 4 (major emphasis) after the rater listens to the entire session. The full-scale score, which is keyed in the interpretive direction, ranges from 0 to 56. In the trial, the mean full-scale score for the 72 interpretive therapy completers was 39.1 ($SD = 3.8$), which is clearly in the interpretive range of the scale. The reliability of the scale, which is reported by Ogrodniczuk and Piper (1999), is excellent.

Process Variables

Therapeutic alliance. Therapeutic alliance was defined as the nature of the working relationship
between the patient and the therapist. After each therapy session, it was rated by the patient and therapist by means of six, 7-point Likert-type items that ranged from “very little” to “very much.” The items focused on whether the patient had talked about private important material, felt understood by the therapist, understood and worked with what the therapist said, and felt that the session enhanced understanding, whether the therapist was helpful, and whether the therapist and patient worked well together. To determine psychometric properties, item ratings for each source (patient, therapist) were averaged across sessions and subjected to a principal components analysis. This was done for all 144 completers in the trial. One factor accounting for 87% of the variance emerged for the patient-rated items, and one factor accounting for 83% of the variance emerged for the therapist-rated items. Examination of the internal consistency of the items revealed high coefficient alphas (.97 for patient-rated items, .96 for therapist-rated items). Thus, the average of the six items was used as the alliance score for each source.

Vanderbilt Psychotherapy Process Scale variables. The Vanderbilt Psychotherapy Process Scale (VPPS) is a “general-purpose instrument designed to assess both positive and negative aspects of the patient’s and therapist’s behavior and attitudes that are expected to facilitate or impede progress in therapy” (Suh, Strupp, & O’Malley, 1986, p. 287). A subset of 44 of the 80 items of the VPPS was used. The items covered five of its subscale variables (patient participation, patient hostility, patient exploration, therapist exploration, negative therapist attitude) and three additional variables (patient focus on transference, therapist focus on transference, global impression of the session). To improve clarity and rater reliability, minor revisions of 20 of the 44 items were made. Each item was rated on a 5-point Likert-type scale ranging from “not at all” to “great deal.” A team of 7 raters was trained to listen to each therapy session and provide ratings. Rater reliability was determined for a sample of eight therapy sessions, which was independent of the sample used in the VPPS reliability determination. The reliability for dynamic work was moderate, ICC (2,2) = .51, while the reliability for supportive work was poor, ICC (2,2) = .06. Only the average of two raters’ scores for dynamic work was used in subsequent analyses. Each rater of the team rated different patients for the VPPS and work variables.

Results

Comparisons on Pretherapy Variables

Before comparing the dropouts and completers on the process variables, the two groups were compared on a number of demographic, diagnostic, and initial disturbance variables in addition to those on which they had been matched. These additional variables included marital status, educational status, employment status, previous psychiatric treatment, and previous psychiatric hospitalization, all of the Axis I and Axis II disorders indicated above, and 13 initial disturbance outcome variables used in the clinical trial. The outcome variables covered the areas of interpersonal distress and functioning, psychiatric symptomatology, self-esteem, life satisfaction, and use of defenses. There were no significant differences between the dropouts and completers. Thus, any differences found for the process variables could not be attributed to these variables.

Sessions Selected and Method of Comparison

For the current study, primary focus was on the last session attended by each dropout and the
Prediction of Dropping Out

TABLE 1. Reliable Variables and Items for the Vanderbilt Psychotherapy Process Scale (Modified)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Hostility</td>
<td>1. Negative reaction to the therapist's comments</td>
</tr>
<tr>
<td></td>
<td>2. Hostile</td>
</tr>
<tr>
<td></td>
<td>3. Frustrated</td>
</tr>
<tr>
<td></td>
<td>4. Impatient</td>
</tr>
<tr>
<td></td>
<td>5. Intellectualizing</td>
</tr>
<tr>
<td></td>
<td>6. Defensive</td>
</tr>
<tr>
<td>Patient Exploration</td>
<td>1. How productive was this hour?</td>
</tr>
<tr>
<td></td>
<td>2. Seemed to be motivated for therapy</td>
</tr>
<tr>
<td></td>
<td>3. Concerned with how to deal more effectively with self or others</td>
</tr>
<tr>
<td></td>
<td>4. Focused on a particular problem</td>
</tr>
<tr>
<td></td>
<td>5. Tried to understand the reasons behind the problematic feelings or behavior</td>
</tr>
<tr>
<td></td>
<td>6. Struggled to achieve better control over feelings or impulses</td>
</tr>
<tr>
<td></td>
<td>7. Talked about his or her feelings</td>
</tr>
<tr>
<td>Patient Focus on Transference</td>
<td>1. Discussed his or her feelings and perceptions about the therapist</td>
</tr>
<tr>
<td></td>
<td>2. Discussed his or her feelings as a patient and his or her progress in therapy</td>
</tr>
<tr>
<td>Therapist Exploration</td>
<td>1. Tried to help the patient evaluate his or her reactions and feelings</td>
</tr>
<tr>
<td></td>
<td>2. Placed the patient's report in a new perspective or reorganized the patient's experience</td>
</tr>
<tr>
<td></td>
<td>3. Tried to get a better understanding of the patient, of what was going on</td>
</tr>
<tr>
<td></td>
<td>4. Tried to help the patient recognize his or her feelings</td>
</tr>
<tr>
<td></td>
<td>5. Tried to help the patient understand the reasons behind his or her reactions</td>
</tr>
<tr>
<td></td>
<td>6. Encouraged depth rather than shallowness</td>
</tr>
<tr>
<td></td>
<td>7. Identified themes in the patient's behavior and experiences</td>
</tr>
<tr>
<td></td>
<td>8. Encouraged the patient to accept responsibility for his or her problems</td>
</tr>
<tr>
<td></td>
<td>9. Maintained focus on therapy-related topics</td>
</tr>
<tr>
<td></td>
<td>10. Modeled behavior or set an example for the patient</td>
</tr>
<tr>
<td></td>
<td>11. Tried to help the patient to achieve better control over his or her feelings and impulses</td>
</tr>
<tr>
<td></td>
<td>12. Conveyed expertise</td>
</tr>
<tr>
<td></td>
<td>13. Disclosed his or her own feelings, attitudes, values, or experiences</td>
</tr>
<tr>
<td>Therapist Focus on Transference</td>
<td>1. Dealt with interpersonal dynamics between himself or herself and the patient</td>
</tr>
</tbody>
</table>

comparable numerical session of the matched completer, for example, session 6 for each. We believed that the last session might be particularly charged and important to examine, given that the dropout never returned. VPPS and work variable ratings were obtained from the audiotape of the last session. While therapist-rated therapeutic alliance ratings were also obtained, too few dropouts provided patient alliance ratings after their last session to allow a meaningful comparison with completers. We also focused on an early session in therapy, usually session 3 or 4. VPPS and work ratings were obtained from the audiotape of the early session. Again, while therapist-rated therapeutic alliance ratings were also obtained, there were many missing alliance ratings for the patients. Therefore, we instead used the average of the available patient ratings for sessions 1–3. Comparisons were made between dropouts and completers using independent t tests.

**Last Session Quantitative Findings**

For therapist-rated therapeutic alliance, dropouts were lower than completers, \( t(42) = 3.18, p = .003 \). For VPPS variables, dropouts were lower on patient exploration, \( t(41) = 2.33, p = .025 \), and higher on patient focus on transference, \( t(41) = 2.23, p = .031 \). They were also higher on therapist focus on transference, \( t(41) = 1.99, p = .054 \). There were no significant differences for patient hostility and therapist exploration. Similarly, there was no significant difference for dynamic work.

**Last Session Qualitative Findings**

In order to achieve a better clinical understanding of the patient-therapist interactions during the last session, two of the authors (WEP, JSO) listened to the audiotapes of each of the last sessions of the dropouts. We were particularly interested in the sessions of those patients who had the high-
est ratings for patient and therapist focus on transference. In the present study, these process variables significantly differentiated dropouts from completers; and in our previous study of interpretive therapy, a high focus on transference was associated with difficulties in the patient-therapist relationship (Piper et al., 1991). For the dropouts in the current study who had the highest focus on transference, the pattern that we observed over the course of the last session was consistent and striking. The pattern is represented by a sequence of nine features. For the seven dropouts with the highest transference focus (top third), the features were nearly unanimously present. For the middle third, the features were present for many of the patients, and for the bottom third, only some of the features were present for a few of the patients. The nine features are:

1. The patient made his or her thoughts about dropping out clear, usually early in the session.
2. The patient expressed frustration about the therapy sessions. This often involved expectations that were not met and the therapist's repeated focus on painful feelings.
3. The therapist quickly addressed the difficulty by focusing on the patient-therapist relationship and the transference. Links were made to other relationships.
4. The patient resisted the focus on transference and engaged in little dynamic exploration (work). Resistance was often active, for example, verbal disagreement, and sometimes passive, for example, silence.
5. The therapist persisted with transference interpretations.
6. The patient and therapist argued with each other. They seemed to be engaged in a power struggle. At times the therapist was drawn into being sharp, blunt, sarcastic, insistent, impatient, or condescending.
7. Although most of the interpretations were plausible, the patient responded to the persistence of the therapist with continued resistance.
8. The session ended with encouragement by the therapist to continue with therapy and a seemingly forced agreement by the patient to do so.
9. The patient never returned.

Early Session(s) Quantitative Findings

For patient-rated therapeutic alliance, dropouts were lower than completers, $r(26) = 2.25$, $p = .003$. Similarly, for dynamic work, dropouts had lower scores than completers, $r(41) = 2.05$, $p = .047$. There were no significant differences for therapist-rated therapeutic alliance and the VPPS variables.

Discussion

The present study has provided additional information about predictors of dropping out in time-limited, interpretive individual therapy. Following our initial report of a significantly higher dropout rate for interpretive therapy patients relative to supportive therapy patients in our recently completed comparative clinical trial (Piper et al., 1998), we compared the interpretive dropouts with a matched group of interpretive therapy completers on additional pretherapy variables and on process variables. We found no significant differences on pretherapy predictors, which is similar to the findings of many previous investigators. When we turned to process variables that reflected patient-therapist interactions, however, a number of significant differences emerged.

A weaker therapeutic alliance was reported by patients early in therapy and by therapists at the last session of therapy for the dropouts. These findings are consistent with most previous studies that have examined the therapeutic alliance of dropouts and completers. We also found evidence indicating that dropouts engaged in less dynamic work early in therapy. Taken together, these findings suggest that it may be possible to identify potential dropouts early in therapy. This might allow the therapist time to address and remedy the problems before they result in dropping out. Suggested interventions such as clarifying the patient's and the therapist's roles in interpretive therapy, facilitating positive transference, and providing support early in therapy have been made in the literature. Unfortunately, the early difficulties may also indicate that the patient lacks the capacity to engage in interpretive therapy, which, despite the therapist's efforts, may persist and eventually lead to dropping out.

At the last session, we found that dropouts engaged less in exploration of their problems. They also focused more on transference, as did their therapists. Clinical observations of the last session revealed a consistent pattern for many of the dropouts, in particular those with the greatest focus on transference. The patient and therapist appeared to be caught up in an unproductive power struggle that increased the frustration of
both. Persistent use of transference interpretations on the therapist's part was not successful in resolving the impasse. Despite considerable clinical experience and success in treating many other patients in interpretive therapy, the therapist was often unable to avoid countertransference concerns. After the difficult session, the patient never returned.

The patient-therapist pattern that was observed in the current study is consistent with findings from a previous study of interpretive therapy that we conducted where high use of transference interpretations were found to be associated with a weaker alliance and less favorable outcome (Piper et al., 1991). Examination of the therapy process in that study also revealed that experienced therapists at times got caught up in a negative cycle involving patient resistance and transference interpretation. This tendency may be heightened in a situation where the therapist is faced with the threat of premature termination. Once reasonable efforts have been made to address evident problems through the use of transference interpretation or other types of noninterpretive interventions and those efforts have not been successful, the therapist may be best advised to refrain from making additional transference interpretations. It may be preferable to allow the patient to save face and end therapy under more amicable conditions. The pattern observed in the current study also resembles findings from the Vanderbilt II study (Henry, Schacht et al., 1993; Henry, Strupp et al., 1993), which provided evidence that manualized training of experienced clinicians can result in sessions characterized by both technical adherence and undesirable therapist interventions and characteristics. Although the dropout rates for time-limited therapies carried out in research trials appear to be lower than those in strictly clinical settings, there may be a danger that therapists in research studies feel compelled to adhere to features of designated therapies when they should be flexible, for example, persisting with transference interpretations in interpretive therapy. Researchers and therapists need to be aware of this possibility and be prepared to make adjustments that are appropriate to the clinical situation.

Limitations in our knowledge in the current study should prevent us from unequivocally attributing primary responsibility for the dropout phenomenon to the therapists. We do not know whether a different technical or stylistic approach could have prevented the dropping out or whether, given the particular patients, dropping out was inevitable. We also do not know whether there were sessions in which the completers also threatened to drop out, but were dealt with differently and successfully. What we do know is that the approach taken by the therapists in the case of the dropouts was not successful in resolving the problem despite the fact that it met criteria for technical adherence regarding transference interpretation, which is a hallmark of dynamic therapy.

Given that the dropout rate for supportive therapy (6%) was significantly lower than the dropout rate for interpretive therapy (23%) in the comparative trial, while the outcomes were similar, it can be argued that supportive therapy is more broadly applicable and, is therefore, preferable to interpretive therapy. This may be true for many patients. Some patients and therapists prefer an interpretive approach, however, and some patients appear to benefit more from interpretive therapy. For example, recent examination of follow-up findings from the comparative trial revealed that after 1 year, patients with a history of mature interpersonal relationships benefited more in interpretive than supportive therapy in the area of social-sexual adjustment (Piper, McCallum, Joyce, Azim, & Ogrodniczuk, 1999). This raises the important issues of considering patient characteristics when recommending interpretive or supportive therapy, and being attentive to potential problems early in therapy when providing the former.

Although the current study possesses certain strengths, there are also limitations. Despite the fact that the clinical trial included a large number of patients, the number of interpretive therapy dropouts (22) was a relatively small number. In addition, not all of the interpretive dropouts fit the observed clinical pattern. Patients drop out for many reasons. The current study has highlighted only one pattern. In addition, only 6 of the 15 process variables that were included in the comparisons between interpretive therapy dropouts and completers were statistically significant. Although the number of significant variables is greater than would be expected by chance, some may represent error. This possibility is lessened somewhat by the consistency of the current findings with those of previous studies, however.

In addition to suggesting potential technical pitfalls in the provision of interpretive therapy, the
current study also endorses the investigation of process variables that focus on patient-therapist interactions. Of the many pretherapy variables examined, none significantly differentiated dropouts from completers. In contrast, a small but conceptually meaningful number of interactional, therapy process variables differentiated the two groups. While it will continue to be important to discover significant pretherapy predictors of dropping out, the current study indicates that researchers should not limit themselves to studying such variables.

References


