Indian Journal of Psychology and Education
January, 2023, Vol. 13 No.1, pp 48-53

Drop out in Psychotherapy: A Holistic View

Mehfooz Ahmad*

Abstract

Drop-out can be defined as when patients leave treatment sessions early in an unplanned manner before treatment has finished; patients stop attending without prior agreement. Drop out in therapy is caused by low socio-economic status, prior psychiatric treatment and personality variables, which include "social isolation, hostility, borderline diagnosis, lack of psychological mindedness, low tolerance for frustration, poor motivation, feeling uncomfortable with seeing a mental health professional and perception of the therapist as less competent and trustworthy". Those who reported higher levels of impulsivity, disorganized behaviors, and a diagnosis of conduct disorder were more likely to drop out of treatment. The phenomenon of drop out can be observed in cognitive behavior therapy, family therapy, dialectical behaviour therapy, cognitive therapy, group therapy etc. at least a closing session should be available for the client and the therapist to work through the treatment termination to process treatment progress, consolidate therapeutic gains, empower the client in his or her readiness to do without therapy, process emotions for the impending separation, and discuss how the client would proceed and continue the change process without having therapy in his or her life before closing the therapeutic relationship. The drop out can be minimized by understanding the goals and expectations and sending appointment letters to the patients whenever they missed a scheduled visit.

Key words: drop out, psychological disorders, psychotherapy

When the client discontinued the discontinue the psychotherapy intervention prematurely it has been termed as Therapy drop out. This discontinuation in therapy took place prior to recovery from the mental health issues that bring him or her to take treatment or before accomplishing the protocol of selective intervention (Garfield, 1994; Hatchett & Park, 2003; Swift, Callahan, & Levine, 2009; Swift & Greenberg, 2012). Similarly, Westbrook and Kirk (2005) defined drop-out as when patients stop coming for treatment sessions early in an unplanned manner before treatment has been completed. The patient leaves therapeutic intervention without prior agreement. The diversity of dropout should be taken into the consideration as the reason of drop out very fromclient to client, the timing of drop out may be different 'therefore' the impact of drop out may not be the same on client and the course of therapy(Acosta, 1980; Buddeberg, 1987; Fiester and Rudestam, 1975; Martin et al. 1988; Pekarik, 1983; Presley, 1987; Trepka, 1986).Poor need for psychiatric services can be observed among some cases of dropout, hence for people with psychiatric illnesses separation from mental health services can be a big problem that can lead to damaging consequences including violence against others, worsening of psychiatric symptoms, frequent hospitalizations, homelessnessand suicide (Dixon, Goldberg, Iannone, Lucksted, Brown, Kreyenbuhl et al.,2009; Fischer, McCarthy, Ignacio, Blow, Barry , Hudson et al., 2008).Further, ascompare to children who completed treatment, those who drop out were more likely to experience continuation of symptoms, fail to graduate from high school, remain unemployed, engage in delinquent activities and involved insubstancesabuse (de Haan, Boon, de Jong, Hoeve, &Vermeiren, 2013).

The reasons for premature termination of psychotherapy were explored in a qualitative study. The researcher interviewed 12 clients, four of which had stopped coming to the treatment before completing specified number of sessions.The outcome of the studyshoweda positive psychotherapy findings and healthy therapeutic alliance among dropouts. Such patients reported positive experiences with the termination. The arousal of certain feelings took place during this process which was discussed by the client with the therapists as the psychotherapy ended mainly for financial reasons or other logistic. In contrast, poor alliance and mixed results were reported by the premature terminators who negatively experienced the termination of therapy. It was observed that the termination of therapy was rarely planned in advance with therapists or discussed and as a result psychotherapy generally terminated abruptly (Knox, Noah, Adrians, Everson, Hess, Hill, etal., 2011). Koss (1980) conducted a study in a private setting and found thatas compare to clients seen in the public sector, the clients who belonged to well-educated, middle classand mild to moderate disturbed remained in treatment slightly longer period of time.A comprehensive review of various studies was done by Reis and Brown (2006) and found that psychological mindedness was significantly correlated with continuation in psychotherapy treatment. Moreover, important features linked with psychological mindedness, such as poor motivation, decreased frustration tolerance and impulsiveness revealed significantly strong relationship with dropout.

Higher level of dropout was reported among individualswho lack social support (Self et al. 2005) as well as among individuals with poorsocioeconomic status(Armbruster& Fallon 1994).Further,

*Assistant Professor-II, Amity institute of Clinical Psychology, Amity University, HaryanaEmail- mehfooz.alig@gmail.com

Krupnick&Melnikoff (2012) revealed that the hindrances in taking care such as lack of childcare, transportation problems and conflicts of work schedule may make taking treatment overwhelming for low-income high-need families. Such families may face difficulties to bear up on the cost of continuing treatment because they primarily depend on public transportation. Moreover, keeping track of treatment sessions via appointment reminder or calendarmay be beyond their capacity. There are certain stressors and hindrances that may prevent families from attending and sticking to a treatment program such limited clinic hours cost, inconvenient clinic locations, transportationand difficulties obtaining childcare etc. In their study Jensen, Mortensen, and Lotz, 2014) reported that prior psychiatric treatment, certain personality factors and poor socio-economic status are the predictors of drop out in group therapy for the patients undergoing mental health issues. The important personality characteristics included hostility, social isolation, borderline diagnosis, low tolerance for frustration, lack of psychological mindedness, lack of motivation, getting discomfort in seeing a mental health professional and perception of the therapist as less competent and less trustworthy (p. 594). In addition to that Lerman (1978) has suggested that on the part of male professionals, evaluation efforts have been further motivated by an economic concern. It has been observed that an increasing number of feminist therapists recommend that only female therapists are chosen by the female patients.

Graham and Walton (2011) found higher rates of dropout in Bulimia Nervosa when compared to Binge Eating Disorder patients using CD-Rom CBT. In the initial phase of analytic therapy it has been noticed by Ogrodniczuk and Piper that patients with borderline personality disorder were more likely to terminate therapy at their own. Adolescent outpatients were the sample in several studies, the results revealed, those who reported to have diagnosis of conduct disorder disorganized behaviors and higher levels of impulsivitywere highly prone for drop out from the treatment (Baruch et al., 1998; Kazdin&Mazurick, 1994; Kazdin et al., 1993). The eating disorder cases appear to have high dropout rates which was ranging from 15% to 37% (Blouin et al., 1995), and for those who had a sense of external control and feel hopelessness (Steel et al., 2000). The dropout from inpatient treatment were studied by Gunderson et al. (1989) and found that such patients wererelated with lack of psychiatric treatment,occasional suicidal thoughts and less baseline psychopathology. In their study, Skodol, Buckley, and Charles, 1983) revealed that severe psychopathology at baseline in outpatients with Borderline Personality Disorder was associated with premature termination.When treatment was provided by master's-level therapists/ clinicians, Acceptance Commitment Therapy had higher dropout rates than comparison groups as was revealed in the study of Ong et al. (2018).It is considered that preferences of men for styles and types of therapy can differ significantly (Kealy et al., 2020; Zajac et al., 2020) and such type of attitude is associated with try before you by mentality

(O'Keeffe et al., 2019).

More frequent drop out of racial/ethnic minority (REM) clients has been observed in the study of Owen, Quirk, Hilsenroth&Rodolfa, (2012). As compare to racial/ethnic identification status of the client, cultural processes of the client related to race/ethnicity and the way in which they are attended to within the therapeutic processmay be more relevant. In one of the reviews of the drop out, across a number of psychiatric and medical and treatments Baekeland and Lundwall (1975) looked into the phenomenon of unplanned termination. Baekeland and Lundwallhighlighted that while doing psychotherapy in adults dropout rate has been seen between 31 percent to 79%percent. The authorrevealed that clients were highlyprone to drop out if they were at young age, female, poorly educated,lower socioeconomic status (SES) and belong to ethnic minority background.Moreover, they were of the view that if the therapist was less experienced, male andnot ready to adopt to different culture may more likely to llise patients in psychotherapy.Further, Owen et al. (2013) conducted a study and found that those who perceived high social stigma reported more session gains whereas the clients who perceived high self-stigma reported fewer session gains, which were moderated by the alliance. Before a decision to end therapy is made, the effects of stigma can be observed during the course of therapy. Kazdin&Mazurick, 1994; Pekarik& Stephenson, 1988; Wierzbicki& Pekarik,1993 came to the conclusion that most of the available researches does not differentiate between these two groups of age, which cannot clearly convey the specific influences that differently predict dropout within these two groups. Hence, it can lead to different outcomes.

The therapist should have sufficient skill to adjust with diversity of the clients during psychotherapy and hence can decrease the distress of the clients. This was possible only if factors related with therapy dropout are identified. (Kendall, Holmbeck, &Verduin, 2004; McMuran et al., 2010). Panepinto and Higgins (1969) in their study found that whenever patients missed a scheduled visit, the therapist sent appointment letters to the patients and by this strategy the therapist were able todecrease dropout rates in first month from 51 % to 28% at alcohol treatment center. Tryon and Kane (1993) mentioned some methods to prevent early dropout, such as understanding the goals and expectations of parents and children with regard to the treatment, as well as establishing a strong therapeutic alliance with them, since for child psychotherapy, the therapeutic alliance with the parents is more important than the

one established with the child. The process of early psychotherapy process between who completed and who dropped out of six adult clients with a dual diagnosis was investigated by Philips et al. (2018). In this psychotherapy, patients have undergone Metallization-Based Treatment (MBT). There was some deviation among therapist while applying the MBT approach and the patient subsequently dropped out. The therapist treats like in a teacher, gave more advice, interpret behavioral pattern of others, emotional conflicts of themselves and make unnecessary relationships. There was desire to be separated among patient and they appeared to be emotionally detached. Those metallization-based treatment therapists treated patients who completed the therapy and simultaneously observe the accuracy of treatment process, communicated clearly andgive input on the changes may affect the patients positively. In response to the treatment, the patients could talk with confidence about their interpersonal relationship, their issues and about themselves. In long-term group psychotherapy, the immediate situation--crisis and universal problem of every members are the premature drop out (Wheeler, 2014).Cuijpers, van Straten, & Warmerdam, 2008 conducted a comprehensive meta-analysis of the studies and suggested that group treatment was less effective than individual (mainly CBT) may also be associated with higher dropout rates in the treatment of depression. Compared to standard group therapy, DBT has half the number of dropouts and almost a 30% greater probability of completing the treatment. Dropout from DBT seems to be greater with patients who experience more trait anxiety and more experiential avoidance (Rüsch et al., 2008; Kröger et al., 2013). The therapeutic alliance, independent from symptom change, predicted dropout from CT combined with antidepressant medication (Cooper et al., 2016).

In the view of Barkham, Rees , Stiles, Hardy and Shapiro, 2002) some researches have revealed that is not essential that dropping out of psychotherapy related with treatment failure. For instance, it has been observed that in a randomized clinical trial of psychotherapy for mild depression 38 percent of patients have recovered from depressive symptoms inonly two sessions. Gorkin (1978) found that clients who either never came in for their first appointment at a psychoanalytic outpatient clinic or dropped out of therapy, 32% said they felt better after their minimal contact with the clinic. In three naturalistic studies, Berghofer, Schmidl, Rudas, Steiner, & Schmitz, 2002 revealed that the premature termination can be attributed to the therapist overestimation of symptom severity, time periodrequiredfor treatmentas well as underestimation of symptom relief. In comparison to the expectation of the therapist, when patients reportedspeedy improvement from the therapy, premature termination in suchcase is to be understood as complete psychotherapy treatment. Greenberg, 2002 viewed that with sufficient therapeutic progress, termination can be and should be approached and discussed – over multiple sessions if needed. At the end of the therapy, concluding session should be planned for the patient and the clinical psychologist to work upon the systematic termination of psychotherapeutic treatment to process treatment progress. The therapist should teach enough skills to the client in his or her readiness to cope without therapy and consolidate therapeutic gains. Moreover, the therapist should process emotions of patient for getting ready for separation and discuss in what way the client would move forward in life and maintain the change process without taking therapy in his or her life before ending the therapeutic sessions. In their study Harris, 1998; Howard, Krause, &Orlinsky, 1986 found that premature termination affects the findings of psychotherapy research studies. In the studies of treatment effectiveness dropouts are often not included in analyses. The inclusion of dropouts can influence internal validity by altering composition of control groups and external validity when early dropouts differ from completers on traits other than dropout status. It has been seen in some researches thatdropping out of psychotherapy may be related with the improvements in symptoms and self-esteem, Fluckiger, Meyer, Wampold, Gassmann, Messerli-Bu¨rgy and, Munsch, 2011); Kegel and Flu¨ckiger, 2015). which may indicate that some patients prematurely end the therapy because they feel better. In the field of psychotherapy, this pattern is often referred to as thegood enough leveleffect in psychotherapy (Owen, Adelson, Budge, Kopta and Reese, 2016).

Conclusion: In nutshell, the dropout in psychotherapy can be understood as the discontinuation of treatment sessions by the patient in an unplanned manner. The patients stop attending the therapy sessions without prior agreement. If the therapist understood the reasons of therapy dropout, the therapist might be able to better plan therapeutic treatment as per the requirement of the patient with purpose to obtain continuation in a successful therapy process. The drop out can be minimized by understanding the expectations of the clients and setting achievable goals.Collaborative approach can facilitate the termination of therapy session in a systematic manner.

References:

Acosta, F. X. (1980) Self-described reasons for premature termination of psychotherapy by Mexican American, Black American, and Anglo-American patients. *Psychological Reports*, 47: 435–443.

Mehfooz Ahmad

Baekeland, F., &Lundwall, L. (1975). Dropping out of treatment: Acritical review.

Psychological Bulletin, 82, 738 –783. doi:10.1037/h0077132
Barkham M, Rees A, Stiles WB, Hardy GE, Shapiro DA. (2002). Dose-effectrelations for psychotherapy of mild depression: a quasi-experimentalcomparison of effects of 2, 8, and 16 sessions. *Psychother Res.*2002;12:463-74.
Baruch, G., Gerber, A., & Fearon, P. (1998). Adolescents who drop out of psychotherapy at a community- based psychotherapy centre: A preliminary investigation of the characteristics of early drop- outs, late drop- outs and those who continue treatment. *British journal of medical psychology, 71*(3), 233-245. doi: 10.1111/j.2044-8341.1998.tb00988.x
Ong, C. W., Lee, E. B., & Twohig, M. P. (2018). A meta-analysis of dropout rates in acceptance and commitment therapy. Behaviour Research and Therapy, 104, 14-33. https://doi.org/10.1016/j.brat.2018.02.004
Berghofer, G., Schmidl, F., Rudas, S., Steiner, E., & Schmitz, M. (2002). Predictors of Treatmentdiscontinuity in outpatient mental health care. Social Psychiatry and Psychiatric Epidemiology, 37, 276–282.
Blouin, J., Schnarre, K., Carter, J., Blouin, A., Tener, L., Zuro, C., et al. (1995). Factors affectingdropout ratefrom cognitive-behavioral group treatment for bulimia nervosa. *International Journal of Eating Disorders,*17, 323–329.
Buddeberg, C. (1987) Behundlungsabbruch – erfolglosekurztherapie? (Interruption of treatment– unsuccessful brief therapy?) *Praxis der Psychotherapie und Psychosomatik*, **32**: 221–228.
Cooper, A. A., Strunk, D. R., Ryan, E. T., DeRubeis, R. J., Hollon, S. D., & Gallop, R. (2016). The therapeutic alliance and therapist adherence as predictors of dropout from cognitive therapy for depression when combined with antidepressant medication. *Journal of Behavior Therapy and Experimental Psychiatry*, *50*, 113–119.
Cuijpers, P., van Straten, A., & Warmerdam, L. (2008). Are individual and group treatments equally effective in the treatment of depression in adults? A meta-analysis. *The European Journal of Psychiatry, 22,* 38– 51. doi:10.4321/S0213-61632008000100005
de Haan, A. M., Boon, A. E., de Jong, J. T. V. M., Hoeve, M., &Vermeiren, R. R. J. M. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical Psychology Review*, *33*(5), 698–711. http://doi.org/10.1016/j.cpr.2013.04.005
Dixon L, Goldberg R, Iannone V, Lucksted A, Brown C, Kreyenbuhl J, et al.(2009). Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. Psychiatr Serv. 2009;60:451–8. [PubMed]
Fiester, A. R. and Rudestam K. E. (1975) A multivariate analysis of the early dropout process. *Journal of Consulting and Clinical Psychology*, **43**: 528–535.
Fischer EP, McCarthy JF, Ignacio RV, Blow FC, Barry KL, Hudson TJ, et al.(2008). Longitudinal patterns of health system retention among veterans with schizophrenia or bipolar disorder. Community Ment Health J. 2008;44:321–30. [PubMed]
Fluckiger C, Meyer A, Wampold BE, Gassmann D, Messerli-Bu¨rgy N, MunschS.(2011). Predicting premature termination within a randomized controlled trial for binge-eating patients. BehavTher. 2011;42:716-25
Kegel AF, Flu¨ckigerC.(2015). Predicting psychotherapy dropouts: a multilevel approach. ClinPsycholPsychother. 2015;22:377-86.
Owen JJ, Adelson J, Budge S, Kopta SM, Reese RJ.(2016). Good-enough level and dose-effect models: variation among outcomes and therapists. Psychother Res. 2016;26:22-30.
Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 190–228). New York, NY: Wiley.
Gorkin, M. A. (1978). A comparison of remainers, dropouts, and rejectors at an outpatient mental health clinic. Dissertation Abstracts International, 38 (12-B), 6153.
Graham L, Walton M: (2011). Investigating the use of CD-Rom CBT for bulimia nervosa and binge eating disorder in an NHS adult outpatient eating disorders service. BehavCogn Psychother 2011, 39(4):443–456.
Greenberg, L. S. (2002). Termination of experiential therapy. *Journal of Psychotherapy Integration, 12*(3), 358-363.
Gunderson, J. G., Frank, A. F., Ronningstam, E. F., Wachter, S., Lynch, V. J., & Wolf, P. J. (1989). Early discontinuance of borderline patients from psychotherapy. Journal of Nervous & Mental Disease, 177, 38e42.
Harris, P. M. (1998). Attrition revisited. *American Journal of Evaluation, 19*(3), 293-305.
Hatchett, G. T., & Park, H. L. (2003). Comparison of four operational definitions of premature termination. *Psychotherapy: Theory, Research, Practice, Training, 40*, 226–231.

strategy for psychotherapy research. *Journal of Consulting and Clinical*

Psychology.SpecialIssue: Psychotherapy research, 54(1), 106-110.
Jensen, H. H., Mortensen, E. L., &Lotz, M. (2014). Drop-out from a psychodynamic group psychotherapy outpatient unit. *Nordic Journal Of Psychiatry*, *68*(8), 594- 604.
Kazdin, A. E., Mazurick, J. L., & Bass, D. (1993). Risk for attrition in treatment of antisocial children and families. *Journal of Clinical Child Psychology, 22*(1), 2-16. doi: 10.1207/s15374424jccp2201_1
Kazdin, A.E., &Mazurick, J.L. (1994). Dropping out of child psychotherapy: Distinguishing early and late dropouts over the course of treatment. *Journal of Consulting and Clinical Psychology*, *62*, 1069-1074.
Kealy, D., Seidler, Z. E., Rice, S. M., Oliffe, J. L., Ogrodniczuk, J. S., & Kim, D. (2020). Challenging assumptions about what men want: Examining preferences for psychotherapy among men attending outpatient mental health clinics. *Professional Psychology: Research and Practice,* 52(1), 28–33.
Kendall, P.C., Holmbeck, G., &Verduin, T. (2004). Methodology, design, and evaluation in psychotherapy research. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 16–43). New York: John Wiley.
Kröger, C., Harbeck, S., Armbrust, M., &Kliem, S. (2013). Effectiveness, response, and dropoutof dialectical behavior therapy for borderline personality disorder in an inpatient setting. *Behaviour research and therapy*, 51(8), 411-416.
Knox S, Noah A, Adrians N, Everson E, Hess S, Hill C, etal.(2011). Clients' perspectives on therapy termination. Psychother Res. 2011;21:154-67.
Koss, M. P. (1980), Descriptive characteristics and length ofpsychotherapy of child and adult clients seen in private psychological practice. *Psychotherapy,* 17:268-271.
Krupnick, J. L., &Melnikoff, S. E. (2012). Psychotherapy with low-income patients: Lessons learned from treatment studies. *Journal of Contemporary Psychotherapy, 42*, 7-15. doi: 10.1007/s10879-011-9182-4
Lerman, H. Some thoughts on cross-gender psychotherapy. Psychotherapy: Theory, Research and Practice, 1978, 15, 248-251.
Martin, G. A., McNair, D. and Hight, W. (1988) Contributing factors to early premature termination at a college counseling center. *Journal of Counseling and Development*, **66**: 233–236.
McMuran, M., Huband, N., & Overton, E. (2010). Non-completion of personality disordertreatments: A systematic review of correlates, consequences, and interventions. *Clinical Psychology Review, 30,* 277–287.
Panepinto, W., & Higgins, M. (1%9). Keeping alcoholics in treatment: Effective follow through procedures. *Quarterly Joumai of Studies* Oil*Alco/wl, 30,* 414-4]9.
Pekarik, G. (1983) Follow-up adjustment of outpatient dropouts. *American Journal of Orthopsychiatry*, **53**: 501–511.
Pekarik, G. & Stephenson, L.A. (1988). Adult and child differences in therapy dropout research.*Journal of Clinical Psychology, 17*, 316-321.
O'Keeffe, S., Martin, P., Target, M., & Midgley, N. (2019). 'I Just Stopped Going': A mixed methods investigation into types of therapy dropout in adolescents with depression. Frontiers in Psychology, 10, 75.
Ogrodniczuk JS, Piper WE. (1999). Use of transference interpretations in dynamically oriented individual psychotherapy for patients with personality disorders. J Personal Disord. 1999;13:297–311.
Owen, J., Quirk, K., Hilsenroth, M. J., &Rodolfa, E. R. (2012). Working through: Insession processes that promote between session thoughts and activities. *Journal of Counseling Psychology*, *59*, 161–167.
Owen, J., Thomas, L., Rodolfa, E. (2013). Stigma for seeking therapy: Self-stigma, social stigma, and the therapeutic process. *The Counseling Psychologist, 41*, 857-880
Presley, J. H. (1987) The clinical dropout: a view from the client's perspective. *Social Casework*, **23**: 603–608.
Philips, B., Karlsson, R., Nygren, R., Rother-Schirren, A., and Werbart, A. (2018). Early therapeutic process related to dropout in mentalization-based treatment with dual diagnosis patients. Psychoanal. Psychol. 35, 205–216.
Reis BF, Brown LG. Preventing therapy dropout in the real world: The clinical utility of videotape preparation and client estimate of treatment duration. Professional Psychology: Research and Practice 2006;37:311–316.
Rüsch, N., Schiel, S., Corrigan, P. W., Leihener, F., Jacob, G. A., Olschewski, M., ... &Bohus, M. (2008). Predictors of dropout from inpatient dialectical behavior therapy among women with borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 39(4), 497-503.
Self R, Oates P, Pinnock-Hamilton T & Leach C: The relationship between social deprivation and unilateral termination (attrition) from
Mehfooz Ahmad
there a characteristic pattern to the treatmenthistory of clinic outpatients with borderline personality? *Journal of Nervous & MentalDisease,* 171, 405e410.

Steel, Z., Jones, J., Adcock, S., Clancy, R., Bridgford-West, L., & Austin, J. (2000). Why the high rate of dropout from individual cognitive-behavior therapy for bulimia nervosa. *International Journal of Eating Disorders,* 28, 209–214.

Swift, J. K., Callahan, J. L., & Levine, J. C. (2009). Using clinically significant change to identify premature termination. *Psychotherapy: Theory, Research,Practice, Training, 46,* 328 –335. doi:10.1037/ a0017003

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A metaanalysis. *Journal of Consulting and Clinical Psychology,80,* 547–559. oi:10.1037/a0028226

Trepka, C. (1986) Attrition from an out-patient psychology clinic. *British Journal of Medical Psychology*, **59**: 181–186.

Tryon G, Kane AS.(1993). The helping alliance and premature termination. *Counsel Psychol Quart.*1993;3:233-8.

Westbrook, D. and Kirk, J. (2005). The clinical effectiveness of cognitive behaviour therapy: Outcome for a large sample of adults treated in routine clinical practice. *Behaviour Research and Therapy*, 43: 1243-1261.

Wheeler, K. (2014) Psychotherapy for the advanced practice psychiatric nurse: how to guide forevidence based practice. USA: Spinger. pp. 649-710.

Wierzbicki, M., &Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, *24*, 190-195.

Zajac, I. T., Rice, S., Proeve, M., Kealy, D., Oliffe, J. L., &Ogrodniczuk, J. S. (2020). Suicide risk, psychological distress and treatment preferences in men presenting with prototypical, externalising and mixed depressive symptomology. *Journal of Mental Health,* 1–8

Received on 27-10-2022
Revised on 02-12-2022
Accepted on 05-12-2022