It takes two to tango: a qualitative meta-synthesis on processes of psychotherapy dropout from the Single Case Archive

Liza Notaerts,[1] Melissa De Smet,[2] Martin Finn,[3] Kimberly Van Nieuwenhove,[1] Vicky Hennissen,[1] Reitske Meganck[1]

[1]Department of Psychoanalysis and Clinical Consulting, Faculty of Psychology and Educational Sciences, Ghent University, Belgium; [2]Department of Methodology, Tilburg School of Social and Behavioral Sciences, Tilburg University, Netherlands; [3]Department of Experimental Clinical and Health Psychology, Faculty of Psychology and Educational Sciences, Ghent University, Belgium

Correspondence: Liza Notaerts, Department of Psychoanalysis and Clinical Consulting, Faculty of Psychology and Educational Sciences, Ghent University, Henri Dunantlaan 2, 9000 Ghent, Belgium.
E-mail: Liza.Notaerts@UGent.be

Citation: Notaerts, L., De Smet, M., Finn, M., Van Nieuwenhove, K., Hennissen, V., & Meganck R., (2025). It takes two to tango: a qualitative meta-synthesis on processes of psychotherapy dropout from the Single Case Archive. *Research in Psychotherapy: Psychopathology, Process and Outcome, 28*(3), 876. doi: 10.4081/ripppo.2025.876

Contributions: LN, conception, coordination, data analysis, writing; MDS, reviewing, editing; MF, reviewing, editing; KN, data analysis; VH, data analysis; RM, conception, data analysis, reviewing, editing. All authors have read and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

Conflict of interest: the authors have no conflict of interest to disclose.

Ethics approval and consent to participate: not applicable.

Availability of data and materials: data supporting the findings of this study can be made available by the corresponding author upon request.

Further information: an earlier version of this study was presented by LN at the SPR Heidelberg 2021 and QRMH Malta 2021 conferences.

Received: 28 May 2025.
Accepted: 5 October 2025.

Research in Psychotherapy:
Psychopathology, Process and Outcome 2025; 28:876
doi:10.4081/ripppo.2025.876

ABSTRACT

Premature termination of psychotherapy is a challenging reality for both research and practice. This study aimed to contribute to a more comprehensive understanding of psychotherapy dropout by aggregating and synthesizing findings across dropout cases. A qualitative meta-synthesis was conducted on case studies from the Single Case Archive (SCA), a representative sample of published, peer-reviewed single-case psychotherapy studies. This meta-synthesis aggregated and synthesized the 11 case studies in the SCA published in English that described dropout substantively. The meta-synthesis identified 7 themes that influenced dropout: misattunement, inert therapeutic relationships, unmanaged therapist responses, unmanaged therapist interventions, rigid protocol adherence, readiness for change, and repeating interpersonal dynamics. These themes were arranged into the interrelated patient, therapist, and interactional clusters. The findings of the meta-synthesis were comprehensively represented by the metaphor of tango dancing, in which both partners co-create the dynamic that produces a (un)successful dance. One additional theme not fitting this structure includes instances in which dropout was a positive act on the part of the patient. The meta-synthesis revealed the complex and multifarious nature of psychotherapy dropout, a phenomenon that requires a sufficiently multifaceted conceptual framework for adequate comprehension. It was found that patients, therapists, and their dynamic interaction must be incorporated to account for the complex processes underlying psychotherapy dropout.

Key words: dropout, meta-synthesis, single-case.

Introduction

Psychotherapy dropout is a challenging reality in psychotherapy research and practice, consistently observed across different forms of psychotherapy (Massi *et al.*, 2003). Dropout rates vary between 20 and 60% (Baekeland & Lundwall, 1975; Garfield, 1986, 1994; Wierzbicki & Pekarik, 1993; Swift *et al.*, 2012), depending on the kind of study and how dropout is defined. Dropout has been associated with negative consequences for patients, therapists, and society (Barrett *et al.*, 2008; Le Pen *et al.*, 1994; Pekarik, 1985). However, conceptualizations of dropout lack consistency, indicating a need for a comprehensive definition of dropout (Barrett *et al.*, 2008; Swift & Greenberg, 2012). Understanding why people terminate therapy prematurely could aid in addressing dropout effectively.

Several dropout predictors have been examined, showing

mixed results. Among the identified predictors are patient characteristics (*e.g.*, age, gender, educational level, diagnosis), treatment characteristics (*e.g.*, theoretical orientation, setting), and therapist characteristics (*e.g.*, experience level, gender). A meta-analysis by Swift and Greenberg (2012) found that dropout was more likely to occur among clients with eating or personality disorders, younger clients, when therapy is given by a trainee, and in a university-based clinic. They found a relationship between the treatment format (individual *vs.* group) and client demographic variables (*e.g.*, gender, ethnicity, marital status), unlike previous meta-analyses. These results illustrate that quantitative research on dropout often leads to the discovery of static predictors (De Salve *et al.*, 2025; Notaerts *et al.*, 2021). These factors are useful in the prediction of psychotherapy dropout, but are often hard, if not impossible, for therapists to influence.

Swift and Greenberg (2015) described three reasons why patients drop out: dissatisfaction with the therapist or treatment, external reasons and environmental factors or obstacles, and experiencing insufficient improvement. However, the descriptions of the patients comprising these categories reveal that dropouts are not a homogeneous group. The inconsistent findings in the dropout literature also show that premature termination has a complex nature (*i.e.*, many different processes are at work), and therefore, an innovative approach that can shed light on this complexity is needed.

Swift *et al.* (2012) proposed a broader framework for understanding dropout from a cost-benefit perspective focused on reducing costs and increasing the benefits of therapy for patients. However, this framework covers only some of the factors identified in the literature. Several authors (*e.g.*, Barrett *et al.*, 2008; Khazaie *et al.*, 2016) have emphasized the need for qualitative methodologies in studying the predictors of and reasons for dropout, as they allow for examining idiosyncratic features of particular therapies and uncovering the complex motives and rationales for terminating therapy prematurely. Since nomothetic research producing information about static predictors has not led to reduced dropout rates, an approach focused on the changeable processes underlying dropout is required (American Psychological Association, 2006). As put by Barrett *et al.* (2008), "focusing on the reduction of attrition can enhance the effectiveness of existing treatments and may prove a more fruitful direction in improving therapy outcome than continuing the focus on randomized controlled trials (RCTs) of new treatments" (p. 261). Swift *et al.* (2018) also call for research that is readily applicable in practice. This way we contribute to understanding dropout and also bridge the science-practice gap (see De Salve *et al.*, 2024, for a recent example).

Though scarce, qualitative research on dropout, like quantitative research, has produced a varied literature (Bischoff *et al.*, 2020; Jung *et al.*, 2013; Khazaie *et al.*, 2016; Rhodes *et al.*, 1994; Roe *et al.*, 2006; Wilson & Sperlinger, 2004). This variety is in part due to the richness of qualitative research methodologies but also the differing definitions of dropout across studies (*e.g.*, early *vs.* advanced dropout or which criteria were used to decide on dropout) and the different perspectives that can be taken (*e.g.*, patient, therapist, or researcher) and the complexity of the phenomenon itself.

To give a sense of the heterogeneity of this literature, a brief summary of some of the findings in this literature is warranted. For example, Wilson and Sperlinger (2004) mention that premature termination often occurs when there is some kind of mismatch. This mismatch can happen on different fronts: between therapist and patient (Roos & Werbart, 2013), between patient and the kind of treatment (Elkin *et al.*, 1999), or depending on the patients' readiness to change (Brogan *et al.*, 1999). Another major factor identified in qualitative research is dissatisfaction with the quality of therapy (Khazaie *et al.*, 2016). Again, this dissatisfaction can be situated on different fronts, such as dissatisfaction with the therapist's skills (*e.g.*, therapist mistakes, therapist personal issues that intervene) or dissatisfaction with the therapeutic relationship (*e.g.*, early signs of negative transference and resistance or termination because of unresolved alliance ruptures). Distrust in the therapist is often the explanation given by patients for their dissatisfaction and the resulting dropout. However, the opposite is sometimes also true – certain patients are satisfied with the effects of therapy and therefore terminate their therapy (prematurely), often against the advice of the therapist (Bisschoff *et al.*, 2020; Jung *et al.*, 2013). In this case, patients might have experienced progress towards the accomplishment of goals. It often happens that there is a lack of agreement between patient and therapist about the tasks and goals of therapy or that the treatment goals are simply unclear. There are more reasons for dropout identified within the literature. Some patients feel a need for independence during their therapeutic trajectory, or they establish new meaningful relationships, which makes it no longer necessary for them to stay in therapy (Roe *et al.*, 2006); while other patients terminate early precisely because of a history of interpersonal problems making it difficult for them to stay engaged in therapy. Another finding is that some patients have a low readiness for change (Jung *et al.*, 2013), or they do not recognize their own participation in their problems, making engagement with therapy difficult. Another reason for dropout is that patients may shop around for a therapist or therapeutic approach that they can benefit from (Wilson & Sperlinger, 2004). A final major set of reasons for dropout were logistical/financial problems in therapy or circumstantial constraints (*e.g.*, scheduling issues; Bisschoff *et al.*, 2020; Khazaie *et al.*, 2016).

As mentioned above, some of the variety in reasons for dropout – both in qualitative and quantitative research – depend also on whose perspective is taken. Therapists tend to interpret the patient's premature ending in terms of defense mechanisms like avoidance (Kramer, 1986) or resistance (Lane, 1984), while patients attribute their (premature) ending, for example, to the fact they were dissatisfied or because they had improved (Todd *et al.*, 2003). Reasons for ending therapy are often closely related to treatment goals (Ferraro & Garella, 1997) and whether or not these goals have been achieved (Kogan, 1996).

Rather than the predominant idea of dropout as a sign of failure (*e.g.*, Frayn, 1992; Swift *et al.*, 2018), dropout has also been perceived as indicating a process of growth (*e.g.*, Roe *et al.*, 2006). Lopes *et al.* (2017) compared short- and long-term clinical outcomes of patients who dropped out and completed therapy. While dropouts improved less than completers, 17% of them still achieved a clinically significant improvement before they dropped out. These findings are in line with the phenomenon of the "good enough level effect" (Owen *et al.*, 2016), meaning that ending therapy prematurely should not always imply therapy failure. The idea that all patients, despite having dropped out prematurely, can obtain positive results and benefits from psychotherapy was also confirmed in the study of Jung *et al.* (2013). They highlighted that these benefits are unique to each patient.

To summarize, the qualitative literature on dropout lacks a singular theme and has yet to coalesce around a shared framework. Perhaps we could say, somewhat paradoxically, that the common theme is the lack of a common theme. The papers comprising the published literature have a variety of different ap-

proaches, and the resulting findings have little overlap. Each of them has validity, and the findings that they report have value. To note the variety in the literature and the lack of systematicity is not to criticize the quality and informational value of the literature itself. It is to say instead that a comprehensive conceptual framework that organizes and synthesizes the various findings is much needed.

Towards a better understanding of the dynamics of dropout

As mentioned, idiographic approaches allow in-depth investigation of therapeutic processes and take into account the complexity of the therapeutic situation. Case study research is particularly suited for such in-depth analysis. Within psychotherapy research, single case studies have always been conducted, and as such, it can be expected that dropout has occurred in some of the published cases. However, case study results are rarely considered together, which stymies the accumulation of knowledge across cases and reduces the impact they might have. Studying different cases on a certain topic to identify possible patterns that describe the dynamics across cases is the aim of meta-synthesis methods for case studies. However, meta-synthesis is not a common practice in psychotherapy research, partly because accessing case studies and easily identifying interesting case studies relevant to a certain research question has proven difficult. However, a recent technological development, the construction of the Single Case Archive (SCA), addresses these problems (Meganck *et al.*, 2022). The SCA is an online and freely accessible database that compiles a representative sample of published peer-reviewed psychotherapy single case studies. Case studies from 175 peer-reviewed journals, published between the years 1955 and 2019, from different theoretical orientations, discussing patients of different ages (from infant to elderly) and ethnicities and with a variety of presenting problems or diagnoses; with therapies from different theoretical orientations, settings, or duration of therapy; and with therapists from different age categories, ethnicities, training, and experience are aggregated in the online archive (Meganck *et al.*, 2022). Given the magnitude of the archive (*i.e.*, in terms of number of cases, journals, and theoretical perspectives it covers) and its systematicity in coding characteristics of both the patient and the therapist, amongst other information, the SCA offers the opportunity to study the phenomenon of psychotherapy dropout in-depth through a representative sample of case study material.

This study aimed to contribute to a more comprehensive understanding of patient dropout by conducting a meta-synthesis of published case studies in the SCA. Synthesizing knowledge from in-depth case studies on psychotherapy dropout can inform both research and practice on addressing and preventing premature termination. We take a qualitative approach to patient and therapist narratives on dropout to examine possible processes underlying premature termination of psychotherapy. The following research questions guide our research of published single case studies: Why do patients terminate therapy prematurely? And which processes are involved in therapy dropout?

Methods

Research design overview

This study uses the meta-synthesis method applied to case studies (Krivzov *et al.*, 2021). Meta-syntheses aim to build and develop theory and to reach higher levels of abstraction, with an emphasis on interpreting findings from a carefully selected collection of research studies in a chosen area of interest (Thorne *et al.*, 2004). Here, case studies were aggregated and findings synthesized to enhance understanding of psychotherapy dropout and to aid the construction of clinically relevant theories concerning this psychotherapy dropout. The meta-synthesis was performed as described by Iwakabe & Gazolla (2009), Timulak (2009), Paterson *et al.* (2001), Elliott & Timulak (2021), and Krivzov *et al.* (2021). We report our study in accordance with the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guidelines (Tong *et al.*, 2012).

The meta-synthesis began by selecting the topic, setting the scope of the study, and establishing the research team. The topic is psychotherapy dropout, and the scope of the study is the patient, therapist, and therapeutic relationship factors that influence dropout. Since a meta-synthesis combines theoretical, methodological, and clinical knowledge, the research team assembled included researchers with extensive interest and expertise in psychotherapy research, each with different theoretical, methodological, and clinical expertise. The research team consisted of the primary researcher (LN), a doctoral student and clinical psychologist; (KV) a post-doctoral researcher and experienced clinical psychologist and psychotherapist from a Freudian-Lacanian perspective; and (VH) a doctoral student and clinical psychologist with a background in philosophy. The whole process was supervised by the last author (RM), a professor in clinical psychology and qualitative methodology, and a senior psychotherapist from a Freudian-Lacanian perspective. All were part of the team leading the Ghent Psychotherapy Study (Meganck *et al.*, 2017), have several publications in psychotherapy journals, and have expertise in various qualitative research methodologies. Prior to the data selection and data analysis, the team members reflected upon their expectations, perspectives, and assumptions to ensure transparency and methodological integrity (Levitt, 2018). We engaged in several reflexive strategies, such as keeping a reflective diary and memo writing (LN), both before and during the research process, to reflect upon our own ideas during both the analysis and interpretation of the results.

Case selection

The second step of the meta-synthesis was the selection and appraisal of case studies on dropout. The data was retrieved from the SCA, which included more than 3,000 case studies at the time of retrieval. By making use of the SCA, which is a representative sample of published peer-reviewed psychotherapy single case studies, we can assume that we were able to select a set of cases that is representative of the case studies published on this topic in peer-reviewed journals within the English-speaking world (*i.e.*, the cases are representative of the SCA). We searched the SCA using a set of broad terms related to dropout with the intention of including as many cases of dropout as possible. We refrained from adhering to a particular definition of dropout during the search, as this may have resulted in excluding cases that would otherwise be included. Given the lack of consensus on the definition of dropout and the various ways the phenomenon is referred to in the literature, a broad set of terms related to dropout was deemed advantageously inclusive. In brief, by using a maximum variation sampling strategy (Suri, 2011), we selected cases that are in line with the current peer-reviewed literature on dropout. The number of articles returned by the following search terms used in the SCA were: “dropout” (16), “drop out” (4), “premature termination”

(15), "attrition" (3), "psychotherapy discontinuation" (0), "unilateral termination" (1), "premature discontinuation" (0), and "early dropout" (0).

At this point, we adopted a purposeful sampling strategy. As with all steps of the research process, triangulation among researchers was engaged in following the principles of consensual qualitative research (CQR; Hill *et al.*, 2005) to ensure the validity of the process. The total number of dropout cases found in the SCA was 39, of which 2 were duplicates and thus removed; 37 cases were retained. LN and KV then screened the 37 cases based on title, abstract, key words, and remarks. Notes were kept on reasons for inclusion or exclusion, and these were discussed for cases where different recommendations were made to achieve consensus. Fourteen cases were excluded for various reasons (*e.g.*, the abstract mentioned "[the risk of] dropout", but the case study talked about a successful treatment, or the cases focused on a different topic and were thus insufficiently rich for studying the processes of dropout). Only cases with individual adult patients were selected for further reading, since different mechanisms underlie child or couple therapy. Some cases provided no information regarding dropout in the title or abstract. These cases were included in the final stage of case selection to allow for reading the full text to determine the focus of the study. In the last phase of the case selection, the full text of the 23 cases was thoroughly read and reread and assessed by LN and KV. After discussion, consensus was reached on the removal of 12 more cases for reasons similar to those mentioned above (*e.g.*, not a dropout case, not rich enough for analysis, or because the case was written in German [the abstract was in English]). Eventually, 11 case studies were included in the meta-synthesis, which is considered sufficient for this type of research (Timulak, 2009). Case selection was conducted by LN and KV, who attended to all ambiguities that arose during the process to arrive at an informed consensus as suggested by the ENTREQ guidelines (Tong *et al.*, 2012). Details of the 11 cases and their characteristics are provided in *Supplementary Tables 1-3*.

Data analysis

Step three of the meta-synthesis was the qualitative comparison of the 11 case studies to identify key concepts and themes that go beyond the (dis)similarities of the individual case studies and towards a synthesis of constructs and dimensions. Data analysis began with the purposeful sampling of three rich cases (Benoot *et al.*, 2016). LN and KV read the full texts thoroughly and coded the cases as an example for analysis to facilitate agreement on how to code cases. The research team thus developed a coding system that offered a transparent and systematized analysis process. Data analysis was conducted by LN, KV and VH and supervised by RM. They worked individually and then together to reach consensus on codes, themes, and analytic categories. The principles of CQR (Hill *et al.*, 2005), in which triangulation and independent auditing are essential (Hill *et al.*, 1997), guided this process. Furthermore, the generic descriptive-interpretative approach outlined by Elliott and Timulak (2005, 2021) provided a conceptual framework for organizing and analyzing the data. This approach divides the analysis phase into four steps (Elliott & Timulak, 2005).

Collecting data into domains

Data analysis began by assigning the collected data into domains (*i.e.*, "*a conceptual framework that the researcher brings to or observes in the data*" [Elliott & Timulak, 2005, p. 595]). No specific conceptual framework was used to organize the data, and no *a priori* hypotheses were formulated. Epistemologically, our position can be situated between post-positivism (modified objectivist) and constructivism (subjectivist). We begin from the idea that the data describe a meaningful reality, yet also recognize that this is constructed and that the process of interpretation is hermeneutic and inevitably influenced by the researcher's pre-understandings of the phenomenon. These pre-understandings are personal, theoretical, and based on clinical experience. The reflexive process of discussing these possible pre-understandings and bracketing researchers' own ideas and backgrounds ensured a transparent data-analysis process that proceeds bottom-up. That is, although the researchers had a particular background (*i.e.*, psychoanalytic), this background was not specifically deployed in the analysis to inform the formation of codes, themes, subthemes, or overarching narratives. The themes, subthemes, and overarching categories were thus inductively derived. The research questions that guided our analysis were: Why do people terminate therapy prematurely? And which processes are involved in therapy dropout?

The analysis was a continuous dynamic process between the research team members.

Delineation of meaning units

Data analysis continued with the delineation of meaning units (*i.e.*, "descriptive codes" [Thomas & Harden, 2008]; "*the smallest units of the data that can stand on their own while conveying a clear meaning*" [Elliott & Timulak, 2005, p. 595]). We constructed (*i.e.*, inferred) meaning units through an iterative process. This process began with a line-by-line reading of the text. Nvivo was used to organize the data and to allow for an easy identification of the location of every meaning unit used later in the analysis. The process of constructing meaning units involved forming them based on a comprehensive consideration of the entire case description.

In the course of this process, all information we as a research team deemed significant in light of the dropout was taken into account. We then attempted to reach a consensus on the meaning units with the entire team. In some case studies the authors of those case studies offered interpretations regarding the therapeutic process. These interpretations did not inform the construction of meaning units (*i.e.*, we did not simply adopt the authors' interpretation). To avoid losing sight of the context of the findings, each case was considered the primary unit of analysis. We first identified meaningful units case-by-case and only later across cases.

Coding of descriptive themes

In a third step, we generated categories by comparing the meaning units and distilling the essence of similar units (*i.e.*, "*abstracted clusters of meaning units clustered on the basis of similarities between meaning units/according to similarities of their meanings*" [Elliott & Timulak, 2005, p. 595]). This is also often referred to as "*in-vivo* coding" due to the constant elaboration and adjustment of the categories as the comparison of meaning units proceeds. Thomas and Harden (2008) call these categories "descriptive themes". The purpose of this step is to produce categories that capture the essence of the data. The labels for the categories were chosen to be as self-explanatory as possible and could later be supplemented with a defining description. These categories

were developed by the primary researcher and further refined and elaborated in dialogue with the second and third authors. When agreement had been reached on the themes, all cases were reread based on these results to assess whether thematic saturation had been reached. Based on this rereading, it was concluded that thematic saturation had been achieved. The distribution of themes across cases is described in *Supplementary Table 4*.

Construction of a metaphor

Data analysis terminated with the abstraction of the main findings through a narrative. A meta-synthesis aims to go beyond the aggregation of individual findings and to contribute to theory development. At this point, the products of the final step of data analysis (*i.e.*, the narrative that was produced) fed into the final step of the meta-synthesis. Specifically, the final step is the integration of the results with current theoretical and clinical literature on dropout (Iwakabe & Gazolla, 2009). For this study, this integration is provided in the discussion section of this paper. To further ensure the adequacy of the interpretation of the data, quotations and excerpts from the primary studies were integrated into the results section. This way the reader can judge whether the data reflects the (sub)themes and categories that were constructed by the research team (Flowers *et al.*, 1997).

Results

The analysis of single-case data on psychotherapy dropout in adults resulted in three interrelated clusters of themes, each consisting of several subthemes, and one theme not fitting this structure. The three overarching clusters were: the interactional cluster, the therapist cluster, and the patient cluster. Note that not all (sub)themes were evident in every case study. Equally, some cases provided evidence of multiple (sub)themes. Of course, the extracted clusters and (sub)themes are not mutually exclusive and interact. Overall, (sub)themes and clusters reflect the underlying processes of dropout that were most apparent across the case studies that formed the dataset as a whole. In the following sections we present the clusters and themes before turning to a metaphor that captures the overall structure.

Interactional cluster

The interactional cluster covers problematic aspects of the therapeutic interaction involving both client and therapist that were not predominantly attributable to either party.

Misattunement

The theme of misattunement was most prominent in the analysis. Misattunement is defined by the American Psychological Association as "a lack of rapport between infant and parent or caregiver such that the infant's efforts at communication and expression are not responded to in a way that allows the infant to feel understood" or "a lack of empathy by a therapist or analyst towards a patient" (VandenBos, 2015). The term misattunement is used in a broader way here. Specifically, we use this term to denote that the two parties involved in therapy are out of sync in one of many ways (see below). For example, misattumenent in timing between therapist interventions and how the interventions were received by the patient. Misattunement was found to result in the therapist feeling frustrated or incompetent, and the patient not feeling heard. In some cases, this in turn had serious consequences for therapy, such as deterioration of the therapeutic relationship and alliance rupture, where the therapeutic relationship reached a breaking point. The following quote illustrates what is meant by misattunement:

> He explained that he decided to focus on the client's thoughts as they related to her competency in this situation (*i.e.*, driving) because he perceived the accident to be an aspect of the client's concern as well as the most straightforward opportunity to demonstrate cognitive restructuring at that point in the treatment. The therapist also noted that he may have been overly focused on teaching techniques, possibly at the cost of missing the most relevant aspects of the situation for the client (*i.e.*, impact of husband's judgment). Although this may have stemmed from a desire to effectively impact change, it ultimately lost the thread of the client's actual anxiety experience. This incident underscores the importance, and the challenges therein, of ascertaining the most salient elements of topics brought in by our clients. (Boswell *et al.*, 2011, p. 232)

Another example is provided by Sarracino *et al.* (2013, pp. 79-80):

> Alliance ruptures came one after the other, from both patient and therapist, and were not repaired, as illustrated in the following exchange:
> P: So, you would like me to improve this relationship [with her foster father].
> T: At least you should try to change it.
> P: I don't think it's possible.
> T: So at the moment you think that going away is the best way [...].
> P: Yes, I do. [...] I would like to be more independent. I think our relationship would be better. I don't want to be constrained because...
> T: And what are you going to do about your mother?
> This passage is particularly relevant: We observe how the therapist's interventions become progressively less adequate and synchronized. Now, the patient and therapist move on two different levels of communication, with low chances of meeting one another.

The subthemes comprising the misattunement theme are described below in no particular order.

Bad timing. It consists of mistimed interventions during the analyzed cases, such as when the therapist asks a certain question or engages in a certain intervention at an inappropriate moment in treatment. An example is given by Dr. G in his treatment with Jack:

> Dr. G. asks, "How do you feel about being here today?" Jack is clearly unable to reflect on the patient-therapist relationship and may experience the therapist's repeated question as a confrontation, which he has said he dislikes. Dr. G.'s questions, in any case, seem somewhat abrupt and out of context from Jack's vantage point, although they do address an important issue (Strupp *et al.*, 1992, p. 194).

Another example is found in the case reported by Boswell *et al.* (2011, p. 232):

> The client would begin to offer specific details about a situation, to which the therapist would respond by requesting her to report a feeling. Occasionally, the client would be able to respond with an emotion, yet would continue to describe the interpersonal situation, to which the therapist would again respond by requesting her to report a feeling. When the client had difficulty with this, the therapist would reiterate the treatment rationale. In other instances, the reverse process would occur – the client would describe a feeling in response to her husband or son, and the therapist would switch the focus to interpersonal dynamics, often wondering about the client's potential impact on others.

Bad timing also captures instances in which the therapist pressured the patient to change when the patient was not yet ready or confronted the patient too early.

Empathic failure. In some cases, the patient and therapist were out of sync on an emotional level. Empathic failure resulted in patients not feeling heard, understood, or validated by their therapists and played a role in their decision to end therapy prematurely. In cases involving empathic failure, patients often perceive the therapist as harsh. An example of this dynamic can be found in the therapy described by Strupp *et al.* (1992, p. 204):

> There was a lack of basic kindness and caring. The therapist communicated little warmth, conveying instead a form of technical neutrality that was experienced by the patient as detached, aloof, and uninvolved. From the beginning, there should have been some acknowledgment from the therapist of how difficult it must have been for Jack to seek help from another person.

This is also found in the case by Sarracino *et al.* (2013, p. 80):

> Furthermore, we assumed that the patient-therapist collaboration levels and the rupture indices would show no improvement throughout the treatment, indicating precipitating ruptures mostly related to the therapist's failure to pay attention to tensions in the alliance or to the patient's subjective experience.

Mismatch between therapist and patient needs. Our analyses found instances of mismatch between the problems the therapists addressed and the needs the patients felt. This is illustrated by Sarracino *et al.* (2013, p. 81):

> This difficulty of communication between patient and therapist is illustrated by the fact that every time the patient introduced topics of intense emotional impact, the therapist failed to explore these feelings more deeply, shifting the focus from the emotional field to concrete matters.

This is also shown by Strupp (1990, p. 647):

> I don't need psychotherapy. Therapy, particularly with an older man, cannot help me. My problems are "reality" problems (taking care of children, coping with my job). What I need is a women's support group or a woman therapist.

Mismatch between therapy and patient expectations. In some cases, there was a mismatch between the therapy and the expectations of the patient, which contributed to premature termination. The following example illustrates this:

> Jack: "This one [*relationship*] right here? I don't think it's either… It's certainly not social... I mean, it has a purpose. I wouldn't call it a business relationship either. I didn't give it a lot of thought as to what kind of relationship. I've not had a lot to do with doctors during my life".
> Dr. G's question seems out of place, as the patient's response indicates. No one has explained to Jack thus far what psychotherapy is and that, in particular, it has to do with a "relationship". Jack may similarly feel that he is not getting any direction or "basics" from Dr. G.
> The therapist has made no effort to socialize the patient to psychotherapy (Strupp *et al.*, 1992, p. 194, italics added).

Power struggle. It refers to cases where the patient and therapist compete for control over the session or the narrative. The following example illustrates this subtheme:

> Jack had a pronounced tendency to control therapy sessions through his own analysis of himself and his repetitive discussions about his businesses. Regardless of what a therapist might do, the patient may experience him as unempathetic and incompetent. This invites a therapist to engage in countercontrol processes, particularly through subtle blaming (Strupp *et al.*, 1992, pp. 201-202).

Inert therapeutic relationships

Our analyses found that when the therapeutic relationship is not established or maintained (*e.g.*, due to alliance ruptures), therapy is moribund, and a failure is inevitable. This is therefore also a factor that is related to premature termination, as illustrated by the following excerpt from Sarracino *et al.* (2013, pp. 79-80):

> With regard to the collaboration levels, it proves more and more difficult for both therapist and patient to modulate and adapt their way of communicating. Collaborative exchanges decreased even further […], indicating the difficulty for the patient to benefit from the interaction. […] Alliance ruptures came one after the other, from both patient and therapist, and were not repaired. […] Now, the patient and therapist move on to two different levels of communication, with low chances of meeting one another.

In some cases, the therapeutic bond was never properly installed. Examples of the consequences of this are (unrepaired) alliance ruptures, a decrease in collaboration, or a loss of synchrony between patient and therapist. In sum, when the therapeutic relationship degenerates, negative outcomes follow. The opposite is also true. A higher quality of the therapeutic relationship or a better patient's perception of the therapeutic alliance is associated with lower therapy dropout and even better outcomes (Leahy, 2008; Sarracino *et al.*, 2013).

Cluster therapist factors

The second cluster is therapist factors and covers problematic aspects of the therapeutic interaction for which the therapist has (a certain) responsibility. This classification does not detract from

the fact that we see therapy as a complex and continuous interaction between patient, therapist, and contextual factors.

Unmanaged therapist responses

Our analyses found examples of unmanaged therapist responses. Although the therapist's own responses and reactions are necessarily involved in the therapeutic context, some patients, patient dynamics, or sessions affect the therapist on a personal level. Thus, the therapist may react emotionally to these events and depart from a neutral position. It is crucial that therapists reflect on their own practice, actions, and interventions, for example, through supervision or intervision. We found that without such reflection, therapy can easily go awry, and this can contribute to the premature termination of therapy. The following excerpt offers an illustration of this:

> Alan's fear of being emotionally open corresponded to the analyst's fear of what it would cost her emotionally to crack Alan's narcissistic defenses and involve herself in a regressive mode of relating. Alan recounted that he ended his analysis because he ran his head against a wall, and the analyst related that she could not proceed on the chosen road. Alan accused himself of not being able to be more open, and the analyst felt responsible for the experiment with the choice of what she regarded as a 2nd-rate technique, oriented toward strengthening Alan's narcissistic structure and compensating for his deficient self (Werbart & Levander, 2006, p. 116).

Unmanaged therapist interventions

In some cases, therapist errors or negative interventions took the form of failed interpretations, overestimating patients, not being attentive to signs of forthcoming dropout, aggressive questioning, or blaming the patient. Negative interventions of this sort can lead to premature termination of therapy. An example of blaming the patient is given by Strupp *et al.* (1992, p. 196):

> Dr. G.: "Is it something you choose not to do, or are you unable to do politics?"
> The question might be experienced as confrontational and blaming, with no context or exploration. Dr. G. continues to pursue a distinction between what the patient chooses and what he experiences by circumstance or inability. It is not clear why the therapist is pursuing this topic.

Rigid protocol adherence

Dogmatic persistence with particular therapeutic techniques as opposed to exploring patient difficulties adversely affects therapy in some cases, as illustrated by Boswell *et al.* (2011, p. 331):

> The client reported being in a car accident […]. She described handling the incident well and experiencing minimal anxiety […]. However, the client did report becoming significantly anxious when it occurred to her that she would have to explain this to her husband, and then described becoming incredibly anxious when he arrived on the scene. Rather than focusing on what may have been the more salient issue (*e.g.*, thoughts about interacting with her husband), the therapist chose to focus on the accident itself. […] He explained that he decided to focus on the client's thoughts as they related to her competency in this situation (*i.e.*, driving) because he perceived the accident to be an aspect of the client's concern as well as the most straightforward opportunity to demonstrate cognitive restructuring at that point in the treatment.

Cluster patient factors

The patient is the other actor in therapy to consider when analyzing factors contributing to premature treatment termination. Within this third cluster, the emergent themes were readiness for change and repeating interpersonal dynamics.

Readiness for change

We found that without commitment to therapy, a curative process will not take hold. This led the therapy in some cases to a standstill or to dropout. Some obstacles might be overcome during treatment (*e.g.*, skepticism about the usefulness of therapy), whereas others will lead to an early termination of therapy. An example of this is the case described by Boswell *et al.* (2011, p. 329):

> In addition, the client exhibited inconsistent readiness for change over the course of the 8 weeks. At times, she seemed ready to acknowledge the myriad problems in her life (*e.g.*, family, work, unsatisfying marriage); at others, she compared her life favorably to others and argued that she really didn't need treatment at this time.

Repeating interpersonal dynamics

A frequent pattern in the cases analyzed was the repetition of interpersonal behaviors from the patients' lives outside the therapy room. Such recurrence took many forms: distrust, hostility, separation (anxiety), defensiveness, a tendency to withdrawal, grandiosity, avoidance, and so on. These complex patterns require an attuned way of dealing with these problematic behaviors as they recur in therapy. Both patient and therapist must recognize that these patterns are a repetition rather than a feature of the therapy itself. Without recognition of this, the treatment might stall, and extant maladaptive patterns may manifest anew between patient and therapist. For example, when the patient deals with problems through hostility and distance, and the therapist fails to account for this, they may feel attacked and react in a way that repeats the patient's experience. This might lead to premature termination of therapy. Recognizing that behavior in therapy may be a repetition of a patient's dynamic, a different way of responding might lead to insight into this pattern and open the door to change. Sarracino *et al.* (2013, p. 80) give us an insight into these dynamics through the following quote:

> A detailed examination of the patient's functioning areas during the treatment period shows a pervasive presence […] of problematic areas concerning relationships, work, and, obviously, her body. Issues of separation, hostility, and withdrawal characterized the patient's functioning in her life and in her relationship with the therapist. The dysregulation of the corporeal area, as expected, was pervasive throughout the therapy. Anxiety and insecurity also emerged, principally in the latest sessions, when the patient decided to drop out of the treatment.

Dropout as a positive act in treatment

In the final theme, dropout is interpreted as a positive act. This is in contrast to the common portrayal of dropout as being negative or equivalent to a failed therapy. Therapeutic dropout does not always mean therapy failure. Moreover, it can be seen as progress for certain patients when they take an active role and make decisions for themselves for the first time. In such cases, stopping therapy "prematurely" can indicate improvement in patient functioning, rather than a failure. This is illustrated by Bishop and Lane (2002, p. 756):

> The patient's distrust finally took the form of increased devaluation of the therapist and defeat of the therapy. Although the patient left therapy prematurely, on the positive side, he had achieved his stated goal in treatment of improving his ability to verbally and directly express his feelings to another person.

As such, not all people dropping out are "dropouts".

Synthesis of the findings: it takes two to tango

A meta-synthesis aims to facilitate theory building by abstracting a figure or narrative from the findings. Here, the research team created a comprehensive narrative of the dynamic factors influencing dropout identified in our analysis, subsequent to data analysis (*i.e.*, the narrative was not present in the data itself). The three clusters (*i.e.*, interactional, therapist factors, and patient factors) can be integrated using the metaphor of dancing tango. The metaphor of tango contributes to understanding the phenomenon of dropout by articulating the interplay among the different therapeutic factors involved. This metaphor captures the overarching finding that a therapeutic process could be effective and a patient could remain in therapy only until a meaningful end had been reached when a mutually supportive pattern of interaction was developed between patient and therapist. This mutually supportive pattern of interaction in psychotherapy parallels a tango, which relies on mutual attention to the subtlety and specificity of this interactional process. Consequently, if this dance cannot occur, it is theorized that the therapy will be ended (prematurely). In what follows, we elaborate on this metaphor and its relation to each of the clusters.

The tango metaphor

Tango can be seen as a model relationship. It involves attuning to the partner and engaging in a continual equilibration of power and flexibility, control and trust, resistance and movement, leading and following. It is also about making contact, aligning, and improvising. Within the metaphor, the therapist is the leader, the patient is the follower, the embrace represents the interactional cluster, and the music's role maps onto each patient's subjectivity.

The comprehensive narrative we offer here is grounded in the specifics of tango, which involves four essential elements: the leader, the follower, partner connection, and the musicality of the dance. These elements abide by certain principles. In tango, the leader must choose the following steps while responding to the follower's current position and the musical setting. At its best, tango is an improvised dance guided by choreographic possibilities. All tango steps can be led and followed spontaneously. For this to work, the leader needs to be aware of the options. Upon the leader's initiation, all tango figures can be executed by virtue of good partner connection.

The therapist as leader

This aspect of tango mirrors the therapist's role, which is to enact a therapeutic framework in response to how patients present in therapy and their needs. A balance between the theoretical framework, therapeutic experience, therapy protocols, and the flexibility of adjusting this to the specific patient is necessary (*i.e.*, careful selection of steps). Improvisation in therapy means that while every therapist is guided by their therapeutic framework, every therapy process is a new encounter with a new patient. Adhering too rigidly to a therapeutic protocol disrupts connection with the patient, leading to possible ruptures in the therapeutic relationship and consequently dropout. If these or other difficulties (*e.g.*, personally confronting content) occur in therapy, it is important for the therapist to take responsibility, reflect on their actions, or seek supervision. Some negative feelings among therapists stem from patients placing them in a particular position, which may be a repetition of certain extra-therapeutic relationships. It is important for the therapist to identify these patterns as repetitions and interpret them in a constructive way (*i.e.*, manage their interventions in the context of the therapeutic relationship). Therapy opens the possibility of understanding and altering these patterns, and the therapy room can be a safe space where this can happen.

The patient as follower

In tango, the follower bears equal responsibility for a successful dance. The leader is only the leader because they initiate the movements. For the dance to work, the follower must respond to the guidance of the leader in that moment and not react with learned choreography, which would interfere with the leader's choices and disrupt the flow of the dance. The follower must actively trust the leader.

In therapy, the patient and the therapist share responsibility for making therapy succeed, mirroring the responsibility of the follower in tango. The patient must commit to the process and trust the therapist. The patient is the expert of their story and the problems they bring into the therapy room. They also bear a responsibility towards therapy, however, and must commit to change and question themselves for treatment to work.

The therapeutic relationship as connection between dancers

The relationship between the dancers is essential to tango. The better the relation, the better the dance. Constant attunement between both partners is needed to make it work. Due to its delicate nature, it can easily go awry. Leader and follower co-create the embrace, a close space where subtle movements of the other are attended to and reacted to for the benefit of the dance as a whole. The relation involves a balance between closeness of connection and maintenance of individual freedom of movement. Good partner connection is both centered (symmetrical where possible) and synchronized, meaning the rhythms and weight transfers of both partners are attuned to each other. Also, each partner is responsible for their own weight and should match the tension and pressure of the other partner.

The interactional cluster is analogous to the attunement between both partners and the music. The therapeutic relationship is essential to successful therapy. This relationship offers a safe

space where patients' patterns can be repeated and altered. The therapeutic relationship is a vulnerable bond to be handled with care. The therapist can make interpretations at the wrong moment, fail to respond empathically when needed, or fail to address significant problems for the patient. It is also possible that there exists a discrepancy between the patient's needs and the therapist's approach or their therapeutic framework. All these factors can lead to a premature ending of the therapy. Attunement can refer to many factors in treatment that should be attuned, as illustrated above.

Patient subjectivity as musical accompaniment

Finally, the musical accompaniment to tango makes every dance unique. Tango has a unique freedom of musical interpretation. Even the basic steps can be performed to different rhythms. Thus, a dancer's relationship with the music is central, though challenging. To make space for musical freedom, a good partner connection is necessary. The leader needs to adjust to the follower. The leader not only needs to listen to the music but also to how the follower interprets it and responds to the leader. The patient's subjectivity is the musical accompaniment to therapy, making every encounter unique. The therapist must attune to the specific patient in front of them; their story and their subjectivity are key.

Discussion

This qualitative meta-synthesis on psychotherapy dropout integrated and compared findings from 11 published single case studies from the SCA. The consensual qualitative analysis of processes and reasons for dropout, as reported in the cases, produced the central narrative: *it takes two to tango*. The tango metaphor offers a comprehensive understanding of premature treatment termination as a phenomenon involving the patient, the therapist, and their mutual interaction. Both parties are equally important and responsible. There is also the aligned process both parties are involved in, which cannot be connected to the individual parts.

Interactional breakdowns

A central finding of our study is the notion of misattunement in psychotherapy dropout. The interaction and attunement between the two agents were often considered the primary reason for dropout, rather than the sole responsibility of either party. This finding echoes previous observations in the literature. Wilson and Sperlinger (2004), among others (*e.g.*, Brogan *et al.*, 1999; Elkin *et al.*, 1999), highlighted that dropout often occurs when there is "a mismatch of one kind or another" (p. 221). Wilson and Sperlinger (2004) found a mismatch between the patient and the therapist, the patient and the therapeutic approach, and the patients' readiness for change and the opportunity to change. McKenna and Todd (1997) describe five functions of treatment episodes differentiated according to what the patient sought at particular stages in life: exposure, discrimination, formation, consolidation, and holding episodes. The conceptualization of McKenna and Todd is preliminary but can offer a beginning framework from which to look at premature termination of psychotherapy. They also hypothesize that the premature termination phenomenon is most clearly embodied in the exposure (*i.e.*, introduction to therapy) and discrimination functions (*i.e.*, shopping around for therapy/therapists that fit best). The misattunement identified in our study manifested at several levels, for example, in being temporally or emotionally out of sync.

Another example was the mismatch between the therapist's actions and the patient's needs or between the kind of therapy and the patient's expectations. Being out of sync often led to deterioration of the therapeutic relationship, alliance ruptures, and even to failure of the therapy itself. This idea of "mismatch" and the idea that some of the dropouts "just had enough therapy for now", mentioned by McKenna and Todd, is also supported by Hill *et al.* (1996, p. 214): "Clients may not be 'finished' with their work or 'cured' but may not be willing to do any more work at the time or may feel that they cannot do any more work with a particular therapist". It appears that synchrony within therapy is desirable and beneficial and that both parties co-create and bear responsibility for managing it. Retaining synchrony is likely impossible, but an attempt to do so appears important. This echoes the concept of responsiveness within psychotherapy.

Our theme of inert therapeutic relationships reflects previous qualitative research. For example, Hill *et al.* (1996) conducted interviews with eight therapists who encountered therapeutic impasses and found that the therapeutic relationships within these interventions were characterized by deficiencies or deterioration. In some cases, the therapeutic relationship was never established, and in others, it deteriorated after alliance ruptures. Our meta-synthesis has other similarities with the study by Hill *et al.* (1996). Our subtheme, "*power struggle*", and the subthemes under "*mismatch between patient, therapist, and therapy*" are consistent with the theme of "*lack of agreement*" in Hill *et al.* They reported that patients' history of interpersonal problems, a lack of agreement between therapist and patient about the tasks and goals of therapy, therapist mistakes, and therapists' personal issues were variables linked to the occurrence of impasses. Patients' history of interpersonal problems ties in with our theme of "*patients repeating interpersonal patterns*". Patients may project negative expectations from prior experiences onto therapists, who may, in turn, not react appropriately. Transference issues can develop when therapists perceive their patients' reactions as hostile and they feel personally attacked, which may lead to countertransferential reactions. Sometimes therapists' personal issues are implicated in impasses, as in our theme, "*unmanaged therapist responses*". Finally, Hill *et al.* noted therapist mistakes, which correspond to our theme of "*unmanaged therapist interventions*".

We found that dropout is multifactorial, as did Jung *et al.* (2013). However, they focused on patient factors, such as low readiness to change and limited recognition of the patient's participation in their own problems. They highlighted the lack of understanding of therapist factors and the connections between patient and therapist variables, and proposed an interesting hypothesis about technical flexibility (*i.e.*, adjusting to the patient in front of you rather than rigidly adhering to your theoretical model; Castonguay *et al.*, 1996). The researchers conjectured an association between rigid adherence to a psychotherapy model and premature termination. We found in our study that rigid protocol adherence is indeed a significant factor involved in early dropout. This idea of rigid protocol adherence is both connected to and somewhat contradictory of the concept of responsiveness in psychotherapy (Stiles *et al.*, 1998).

Dropout as a positive act

One final observation is that not all people who drop out are considered dropouts. Likewise, not all premature terminations should be seen as failed therapy, but can also mean a process of

growth. Leaving therapy early can sometimes indicate that the patient has made progress and is able to take an active role, leading to a breakthrough in therapy. This finding is in line with the research from Roe *et al.* (2006), Lopes *et al.* (2017), and Jung *et al.* (2013). Interpreting dropout as a failure rather than a process of growth depends on how change is conceptualized. This varies depending on the therapy's theoretical orientation and the therapist. Some theoretical perspectives view termination as a moment of choice rather than an ending (Roe *et al*., 2006). Roe and colleagues also stress the different perspectives on termination between research and practice. Research often links termination to the achievement of treatment goals, whereas in practice, it can occur for a broader range of reasons. Given that much of the literature views dropout as inherently problematic, an interesting finding from our study is that this was not always the case. Similarly, Roe *et al.* (2006) found instances of termination due to a need for independence or because patients had engaged in the formation of meaningful new relationships. These findings also reflect the process of positive growth rather than failure to meet treatment goals, but further research is needed to shed more light on this interpretation.

Methodological reflections

Our findings are less consistent with previous quantitative research. This demonstrates that a methodologically pluralistic approach (McLeod, 2000) to studying dropout, specifically, and to psychotherapy research in general is recommended. What is consistent with findings from both quantitative and qualitative research is that dropouts cannot be considered a homogeneous group due to the complexity involved. As such, an overarching framework for understanding dropout that accounts for patient, therapist, and interactional factors is needed.

Our meta-synthesis extends previous research on dropout, which has typically focused on either patient or therapist perspectives, by integrating both viewpoints and examining their interaction within therapy processes through case studies. In response to the diverse conceptualizations and fragmented literature on dropout, we provide a comprehensive understanding. A concept that resonates with our findings is responsiveness, which "implies a dynamic relationship between variables, involving bidirectional causation and feedback loops" (Stiles *et al.*, 1998, p. 439). This concept supports our view that we need to move from a static and linear understanding of dropout to a more dynamic way of understanding dropout.

In this meta-synthesis, we conducted a secondary analysis of published case studies, aggregating accounts and interpretations of primary studies. This could raise questions about the validity, generalizability, and representativeness of our analysis. As mentioned above, the SCA systematically collects published case studies from peer-reviewed journals, thereby safeguarding the quality of the primary studies and the representativeness of our sample. It would have added value to our study to have access to the primary data sources (*i.e.*, the actual therapy sessions) for the cases described. This would allow us to base interpretations on the primary data itself. Jung *et al.* (2013) also highlighted the importance of analyzing therapy sessions to clarify the associations between patient and therapist variables in dropout research. From a balanced standpoint, the examination of pre-existing case studies may be interpreted as offering both methodological advantages and potential limitations. The limitation is that the analysis is restricted to the material provided in the published case. The full details of the therapeutic process are not available for analysis. For example, we know that extra-therapeutic factors influence therapy (Lambert & Barley, 2001), but our analyses did not reflect this, as such factors were not described in the cases analyzed. Reanalyzing existing material is also beneficial since it is somewhat assured of quality because it has already undergone peer review. In addition, the reuse of published material contributes to sustainable research practices. As mentioned above, dropout rates vary substantially across studies, depending on how dropout is conceptualized and the methodology used. The dropout group is not only heterogeneous, but the concept also encompasses as many different definitions as synonyms. In our study, we did not examine how dropout was conceptualized in each case or whether it might have influenced our results. On the other hand, the idiosyncratic approach taken suggests that we understood dropout within the unique context of each case. In future research, it is advisable to consider the appropriateness of different conceptualizations, based on the context of the study and the research questions.

Conclusions

Our study addressed the complex issue of dropout and attempted to contribute to a better understanding of its underlying processes by conducting a meta-synthesis of published case studies. Our results show that the patient, therapist, and their interaction must be considered to understand the phenomenon of dropout. Like it takes two to tango, both perspectives should be regarded to expose the dynamic processes involved. In addition to the added value of qualitative research, our study also showed that case studies are a rich data source for aggregating knowledge on this topic. It is also a way to stay close to clinical practice. Dropout cases are often regarded as failed therapies. However, we added the important caveat that not everyone who leaves therapy should necessarily be considered a dropout. Moreover, it is essential to recognize that dropout research essentially concerns the termination of therapy, and the entire process – whether a treatment ends too early or at the right time – is inherently subjective (Roe, 2007). Dropping out is only one possible form of therapy termination. In research, particularly in RCTs, dropout cases are often treated as noise or excluded from analyses. However, our study suggests that these cases, perhaps even more than successful completions, can provide valuable insights into the processes that unfold within therapy.

References

American Psychological Association. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271-285. doi: 10.1037/0003-066X.61.4.271

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: a critical review. *Psychological bulletin*, *82*(5), 738. doi: 10.1037/h0077132

Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., Casiano, D., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. Psychotherapy: Theory, Research, Practice, Training, *45*(2), 247-267. doi: 10. 1037/0033-3204.45.2.247

Benoot, C., Hannes, K., & Bilsen, J. (2016). The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. *BMC Medical Research Methodology*, *16*(1), 1-12. doi: 10.1186/s12874-016-0114-6

Bischoff, T., Krenicki, L., & Tambling, R. (2020). Therapist reported reasons for client termination: A content analysis of termination reports. *The American Journal of Family Therapy*, *48*(1), 36-52. doi: 10.1080/01926187.2019.1684216

Bishop, J., & Lane, R. C. (2002). The dynamics and dangers of entitlement. *Psychoanalytic Psychology*, *19*(4), 739-758. doi: 10.1037/0736-9735.19.4.739

Boswell, J. F., Llera, S. J., Newman, M. G., & Castonguay, L. G. (2011). A case of premature termination in a treatment for generalized anxiety disorder. *Cognitive and Behavioral Practice*, *18*(3), 326-337. doi: 10.1016/j.cbpra.2010.09.001

Brogan, M., Prochaska, J., & Prochaska, J. (1999). Predicting termination status in psychotherapy using the Transtheoretical Model. *Psychotherapy*, *36*(2), 105-113. doi: 10.1037/h0087773

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: a study of unique and common factors. *Journal of Consulting and Clinical Psychology*, *64*(3), 497. doi: 10.1037/0022-006X.64.3.497

De Salve, F., Rossi, C., Gioacchini, E., Messina, I., & Oasi, O. (2025). Dropout in Psychotherapy for Personality Disorders: A Systematic Review of Predictors. *Clinical Psychology & Psychotherapy*, *32*(3), e70080. doi: 10.1002/cpp.70080

De Salve, F., Rossi, C., Messina, I., Grecucci, A., Falgares, G., Infurna, M. R., & Oasi, O. (2024). Predicting dropout and non-response to psychotherapy for personality disorders: A study protocol focusing on therapist, patient, and the therapeutic relationship. *BMC Psychology*, *12*(1), 625. doi: 10.1186/s40359-024-02086-w

Elkin, I., Yamaguchi, J. L., Arnkoff, D. B., Glass, C. R., Sotsky, S. M., & Krupnick, J. L. (1999). "Client–treatment fit" and early engagement in therapy. *Psychotherapy Research*, *9*, 437-451. doi: 10.1093/ptr/9.4.437

Elliott, R., & Timulak, L. (2005). Descriptive and interpretive approaches to qualitative research. In J. Miles & P. Gilbert (Eds.), *A handbook of research methods for clinical and health psychology* (pp. 147-159). Oxford University Press.

Elliott, R., & Timulak, L. (2021). *Essentials of descriptive-interpretive qualitative research: A generic approach*. American Psychological Association.

Ferraro, F., & Garella, N. (1997). Termination as a psychoanalytic event. *International Journal of Psycho-Analysis*, *78*, 27-41.

Flowers, P., Smith, J., Sheeran, P., & Beail, N. (1997). Health and romance: Understanding unprotected sex in relationships between gay men. *British Journal of Health Psychology*, *2*, 73-86. doi: 10.1111/j.2044-8287.1997.tb00524.x

Frayn, D. H. (1992). Assessment factors associated with premature psychotherapy termination. *American Journal of Psychotherapy*, *46*(2), 250-261. doi: 10.1176/appi.psychotherapy.1992.46.2.250

Garfield, S. L. (1986). Research on client variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 213-256). New York: Wiley.

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.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, *25*(4), 517-572. doi: 10.1177/0011000097254001

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, *52*(2), 196. doi: 10.1037/0022-0167.52.2.196

Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology*, *43*(2), 207. doi: 10.1037/0022-0167.43.2.207

Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research*, *19*(4-5), 601-611. doi: 10.1080/10503300802688494

Jung, S. I., Serralta, F. B., Nunes, M. L. T., & Eizirik, C. L. (2013). Beginning and end of treatment of patients who dropped out of psychoanalytic psychotherapy. *Trends in Psychiatry and Psychotherapy*, *35*, 181-190. doi: 10.1590/S2237-60892013000300005

Khazaie, H., Rezaie, L., Shahdipour, N., & Weaver, P. (2016). Exploration of the reasons for dropping out of psychotherapy: A qualitative study. *Evaluation and Program Planning*, *56*, 23-30. doi: 10.1016/j.evalprogplan.2016.03.002

Kogan, I. (1996). Termination and the problem of analytic goals. Patient and analyst, different perspectives. *International Journal of Psycho-Analysis*, *77*, 1013-1029.

Kramer, S. A. (1986). The termination process in open-ended psychotherapy: Guidelines for clinical practice. *Psychotherapy*, *23*(4), 526-531. doi: 10.1037/h0085652

Krivzov, J., Hannon, D., & Meganck, R. (2021). Approaching psychotherapy case studies in a metasynthesis: deficit vs. conflict in treatment of medically unexplained symptoms. In Borsca, M., & Willig, C. (Eds.). *Qualitative Research Methods in Mental Health: innovative and collaborative approaches* (pp. 37-64). Switzerland: Springer.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 357-361. doi: 10.1037/0033-3204.38.4.357

Lane, R. C. (1984). The difficult patient, resistance, and the negative therapeutic reaction: A review of the literature. *Current issues in psychoanalytic practice*, *1*(4), 83–106. doi: 10.1300/J256v01n04_07

Le Pen, C., Lévy, E., Ravily, V., Beuzen, J. N., & Meurgey, F. (1994). The cost of treatment dropout in depression A cost-benefit analysis of fluoxetine vs. tricyclics. *Journal of Affective Disorders*, *31*(1), 1-18. doi: 10.1016/0165-0327(94)90122-8

Leahy, R. L. (2008). The therapeutic relationship in cognitive-behavioral therapy. *Behavioural and Cognitive Psychotherapy*, *36*(6), 769-777. doi: 10.1017/S1352465808004852

Levitt, H. M. (2018). How to conduct a qualitative meta-analysis: Tailoring methods to enhance methodological integrity. *Psychotherapy Research*, *28*(3), 367-378. doi: 10.1080/10503307.2018.1447708

Lopes, R. T., Gonçalves, M. M., Sinai, D., & Machado, P. P. (2017). Clinical outcomes of psychotherapy dropouts: does dropping out of psychotherapy necessarily mean failure? *Brazilian Journal of Psychiatry*, *40*, 123-127. doi: 10.1590/1516-4446-2017-2267

Massi, M. V., Miller, R. B., & Olson, M. M. (2003). Differences in dropout rates among individual, couple, and family therapy clients. *Contemporary Family Therapy: An International Journal*, *25*(1), 63-75. doi: 10.1023/a:1022558021512

McKenna, P., & Todd, D. (1997). Longitudinal utilization of mental health services: A timeline method, nine retrospective accounts, and a preliminary conceptualization. *Psychotherapy Research*, *7*(4), 383-395. doi: 10.1080/10503309712331332093

Mcleod, J. (2000). The contribution of qualitative research to evidence-based counselling and psychotherapy. In N. Rowland & S. Goss (Eds.). *Evidence-Based Counselling and Psychological Therapies* (pp. 111-126). London and Philadelphia: Routledge.

Meganck, R., Krivzov, J., Notaerts, L., Willemsen, J., Kaluzeviciute, G., Dewaele, A., & Desmet, M. (2022). The single case archive: Review of a multitheoretical online database of published peer-reviewed single-case studies. *Psychotherapy*, *59*(4), 641-646. doi: 10.1037/pst0000431

Notaerts, L., Desmet, M., & Meganck, R. (2021, June 23-26). *Meta-synthesis of Published Single Case Studies on Premature Termination of Psychotherapy.* [Paper presentation]. The 52nd International Meeting of the Society for Psychotherapy Research, Heidelberg, Germany.

Owen, J. J., Adelson, J., Budge, S., Kopta, S. M., & Reese, R. J. (2016). Good-enough level and dose-effect models: Variation among outcomes and therapists. *Psychotherapy Research*, *26*(1), 22-30. doi: 10.1080/10503307.2014.966346

Paterson, B. L., Thorne, S. E., Canam, C., & Jillings, C. (2001). Meta-study of qualitative health research: A practical guide to meta-analysis and meta-synthesis. Thousand Oaks, CA: Sage.

Rhodes, R. H., Hill, C. E., Thompson, B. J., & Elliott, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counseling psychology*, *41*(4), 473. doi: 10.1037/0022-0167.41.4.473

Roe, D. (2007). The timing of psychodynamically oriented psychotherapy termination and its relation to reasons for termination, feelings about termination, and satisfaction with therapy. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *35*(3), 443-453. doi: 10.1521/jaap.2007.35.3.443

Roe, D., Dekel, R., Harel, G., & Fennig, S. (2006). Clients' reasons for terminating psychotherapy: A quantitative and qualitative inquiry. *Psychology and Psychotherapy: Theory, Research and Practice*, *79*(4), 529-538. doi: 10.1348/147608305X90412

Roos, J., & Werbart, A. (2013). Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review. *Psychotherapy Research*, *23*(4), 394-418. doi: 10.1080/10503307.2013.775528

Sarracino, D., Garavaglia, A., Gritti, E. S., Parolin, L., & Innamorati, M. (2013). Dropout from cognitive behavioural treatment in a case of bulimia nervosa: The role of the therapeutic alliance. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *16*(2), 71-84. doi: 10.4081/ripppo.2013.138

Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice, 5*(4), 439–458. doi: 10.1111/j.1468-2850.1998.tb00166.x

Strupp, H. H. (1990). The case of Helen R: A therapeutic failure? *Psychotherapy: Theory, Research, Practice, Training*, *27*(4), 644. doi: 10.1037/0033-3204.27.4.644

Strupp, H. H., Schacht, T. E., Henry, W. P., & Binder, J. L. (1992). Jack M.: A case of premature termination. *Psychotherapy: Theory, Research, Practice, Training*, *29*(2), 191. doi: 10.1037/0033-3204.29.2.191

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63-75. doi: 10.3316/QRJ1102063

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: a meta-analysis. *Journal of Consulting and Clinical Psychology*, *80*(4), 547. doi: 10.1037/a0028226

Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. *Professional Psychology: Research and Practice*, *43*(4), 379. doi: 10.1037/a0028291

Swift, J. K., & Greenberg, R. P. (2015). *Premature termination in psychotherapy: Strategies for engaging clients and improving outcomes*. American Psychological Association. doi: 10.1037/14469-000

Swift, J. K., Spencer, J., & Goode, J. (2018). Improving psychotherapy effectiveness by addressing the problem of premature termination: Introduction to a special section. *Psychotherapy Research*, *28*(5), 669-671. doi: 10.1080/10503307.2018.1439192

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(1), 1-10. doi: 10.1037/rmh0000283

Thorne, S., Jensen, L., Kearney, M. H., Noblit, G., & Sandelowski, M. (2004). Qualitative meta-synthesis: Reflection on methodological orientation and ideological agenda. *Qualitative Health Research*, *14*, 1342-1365. doi: 10.1177/1049732304269888

Timulak, L. (2009). Meta-analysis of qualitative studies: A tool for reviewing qualitative research findings in psychotherapy. *Psychotherapy Research*, *19*(4-5), 591-600. doi: 10.1080/10503300802477989

Todd, D. M., Deane, F. P., & Bragdon, R. A. (2003). Client and therapist reasons for termination: A conceptualization and preliminary validation. *Journal of Clinical Psychology*, *59*, 133-147. doi: 10.1002/jclp.10123

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology*, *12*(1), 1-8. doi: 10.1186/1471-2288-12-181

VandenBos, G. R. (2015). *APA dictionary of psychology* (2nd ed.). American Psychological Association. doi: 10.1037/14646-000

Werbart, A., & Levander, S. (2006). Two sets of private theories in analysands and their analysts: Utopian versus attainable cures. *Psychoanalytic Psychology*, *23*(1), 108. doi: 10.1037/0736-9735.23.1.108

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

Wilson, M., & Sperlinger, D. (2004). Dropping out or dropping in? A re-examination of the concept of dropouts using qualitative methodology. *Psychoanalytic Psychotherapy*, *18*(2), 220-237. doi: 10.1080/14749730410001700705