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## **Treatment Compliance in Group Therapy: Issues and Interventions**

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### **Abstract**

In this manuscript, research on treatment compliance and dropout in group therapy is reviewed. A number of variables found to be related to the compliance and dropout are identified including client characteristics, treatment characteristics, and therapist perceptions and behavior. Implications of these results for increasing treatment compliance are discussed.

### **Treatment Compliance in Group Therapy**

Treatment compliance has consistently been an issue in mental health treatment, and it can have very specific implications for group treatment. Premature loss of group members can result in lack of group cohesion, reduced client outcomes, disillusionment of the therapist, and other client dropouts (Rice, 1996; Joyce, Piper, Ogradniczuk, & Klein, 2007; Roth, 1990). This problem is extremely wide in scope, and therefore it is difficult to narrow down statistics on the frequency of its occurrence. Further, level of compliance varies based on the type of treatment offered and clients' specific characteristics. Though there are no general statistics regarding treatment non-compliance in mental health treatment as a whole, Wierzbicki and Pekarik (1993) conducted a meta-analysis of research studies throughout various types of treatment and found an overall dropout rate of 47%. Other studies support this dropout rate specifically in group treatment settings (Klein & Carroll, 1986). In a study of increasing compliance in group therapy, researchers found a 30% dropout rate even after extensive screening and preparing clients for treatment (Lothstein, 1978). Regardless, dropout is a significant problem that clinicians and researchers alike have been working to address for several decades.

The definitions of "treatment compliance" and "treatment dropout" in group treatment vary, as different programs and theoretical approaches may have a different conceptualization of what these terms mean (Joyce et al., 2007). *Treatment compliance* can include finishing a prescribed course of group treatment, completing homework assignments or objectives to meet treatment goals, or simply following through with treatment until both the client and therapist agree that the treatment goals have been fulfilled (Stone & Rutan, 1984). Conversely, Rice (1996) defines *treatment dropout* as "someone who

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chooses not to, or is unable to, make a commitment to the group and will most likely leave within 6 months of joining the group” (p. 10). However, these definitions can change with modalities as other researchers have specific time restrictions that define when a client has officially dropped out (McMurrin, Hubbard, & Overton, 2010). When clients drop out of therapy, they are less likely to experience improvement in mental health symptoms, and this can lead to further mental health problems down the road (Davis and Addis, 2002).

Some research suggests that non-compliance is related to the value our society places on mental health treatment. Clients seem to under value mental health treatment, and are less likely to be compliant and maintain mental health appointments in comparison with medical appointments (Carter, Turovsky, Sbrocco, Meadows, & Barlow, 1995). This creates a problem for mental health providers. How do we deliver quality care and treatment to clients when they refuse to comply with treatment, or terminate early? Evidence shows that there are characteristics of clients as well as characteristics of treatment that are correlated with group treatment non-compliance. Knowledge of these variables can help counselors and administrators prevent treatment drop-out and increase positive outcomes.

## Client Characteristics

### Demographics

The demographics found to be correlated with treatment compliance in group treatment include age, race, socioeconomic status, and education level. These findings have been consistent through several studies and literature reviews on the topic (Berrigan & Garfield, 1981; Baekland & Lundwall, 1975; Wierzbicki & Pekarik, 1993).

**Age.** Research suggests that the younger the client, the more likely he or she is to be non-compliant with group treatment. We may even be more specific in terms of age. In a study of alcohol-dependent patients, dropout rates were higher for patients who were 35 years old or younger, and a similar study found that clients aged 34 and younger were more likely to drop out (Hird, Williams, & Markham, 1997; Monras & Gaul, 2000).

**Education & Socioeconomic Status.** Level of education is a risk factor for treatment drop out. In one study comparing those who completed group therapy to those that did not, 68% of dropouts did not complete high school, as opposed to only 41% of completers (Fisher, Winne, & Ley, 1993). Often correlated with level of education, socioeconomic status is also a factor in treatment compliance, as research shows that lower levels of income are associated with higher levels of treatment dropout (Rabin, Kaslow, & Rehm, 1985). In fact, in a study of process groups for domestic violence offenders, the only predictor of drop out was low income (Chang & Saunders, 2002).

**Minority Status.** Consistently, minority clients are less compliant with group treatment than their non-minority counterparts (Wierzbicki & Pekarik, 1993; Lothstein, 1978). Chang and Saunders (2002) found that clients enrolled in a domestic violence treatment program were more likely to drop out before treatment even began if they were a minority. Historically, research conducted

in the field of group counseling has been applied to Caucasians, which leaves much to be desired with regard to interventions specifically designed for racial and cultural minorities (Bemak & Chung, 2004). Clinicians may not be multiculturally competent which creates barriers for minority clients that other clients do not face, and puts them at higher risk for treatment dropout (Williams, 1994).

**Diagnosis.** There are a few diagnoses that continue to present themselves in the literature as predictors of dropout in group treatment: substance dependence, anti-social and borderline personality disorders.

**Drug and Alcohol Dependence.** AoD (Alcohol or Drug) dependence is one of the major predictors of dropout in group treatment. Addictions can be difficult to overcome, and relapse occurs frequently. Unfortunately, relapse is quite common with patients diagnosed with AoD dependence, and with relapse comes therapy drop-out (Daley & Zuckoff, 1999). Many studies on predictors of dropout in group therapy found that regardless of dependence, those who reported past or current AoD use were more likely to be non-compliant with treatment (Gilbert, Fine, & Haley, 1994). There is a significant amount of research available on reducing dropout in addictions treatment in comparison with other mental health diagnoses due to the high dropout rates (Carroll, 1997; Daley & Zuckoff, 1999).

**Antisocial Personality Disorder.** Of all the personality disorders, anti-social personality disorder has the highest rate of group treatment dropout (Chang & Saunders, 2002). Domestic violence and sex offender programs have high percentages of clients diagnosed with antisocial personality disorder, and also have a high dropout rate. In a study of sex offenders, clients with higher levels of personality disorder traits were less likely to complete the program, possibly due to the fact that they were less likely to report empathy for the victim (Chaffin, 1992). In a similar study of dropout in domestic offender treatment, 62% of the original sample dropped out of treatment prematurely, and anti-social personality disorder was a significant predictor of attrition (Chang & Saunders, 2002).

**Borderline Personality Disorder.** Clients diagnosed with borderline personality disorder (BPD) can be difficult to engage in treatment on a long term basis, and can be extremely non-compliant (Harper, 2004; McMurrin, Huband, & Overton, 2010). While percentages of dropout in this population vary by study, Stiwne (1994) found that as many as 60% of participants with BPD dropped out of a long term group treatment program by the end of 20 months. In a qualitative exploration of clients diagnosed with BPD, researchers found that non-compliant clients engaged in higher rates of impulsive, manipulative, and aggressive behaviors than other clients, and higher symptom severity is correlated with non-compliance in treatment for clients with BPD (Gunderson et al., 2006; Tanesi, Yazigi, DeMattos, & doNascimento, 2007).

**Treatment Attitude and Expectations.** Client attitude (how one feels about treatment) and treatment expectations (beliefs about the therapy experience) have a significant relationship with group treatment compliance. Research has found that even though these two aspects are different, treatment expectations mediate client attitudes toward treatment (Vogel & Wester, 2003). A positive attitude toward treatment not only increases treatment compliance,

but increases positive outcomes in therapy (Connelly, Piper, de Carufel, & Debbane, 1986; Wenzel, Jeglic, Levy-Mack, Beck, & Brown, 2008; Buchanan, 1996). Clients with expectations of treatment that are similar to that of the treatment rationale are more likely to comply with treatment (Davis & Addis, 2002). This can include satisfaction with treatment modality and rationale, and an expectation of positive outcomes (Carter et al., 1995; Favret, 1991; Kuusisto, Knuuttila, & Saarnio, 2011).

**Previous Treatment.** Individuals that have been in therapy before are more likely to comply with treatment. In a study of college students, MacNair (1993) found that students were more likely to continue in group therapy if they had engaged in individual counseling in the past, and another study found that dropouts were more likely to have no previous experience of therapy (Connelly et al., 1986).

**Interpersonal Relationships.** The quality of a client's relationships may indicate whether the client may be at risk for dropout. For example, in one study, predictors of drop out in group therapy in a university setting included roommate difficulties and interpersonal conflicts with others (MacNair, 1993).

**Impulsivity and Labile Emotions.** Impulsivity, or acting without forethought, is correlated with treatment dropout (Black et al., 2009). Binging and purging are impulsive behaviors used by clients with eating disorders to manage uncomfortable levels of emotions, and in one study of eating disorder treatment, non-compliance was correlated with frequency of binging and purging behaviors (Riebel, 1990). Another study found that women in group treatment for bulimia were likely to impulsively drop out if their immediate concerns were not addressed (McKisack & Waller, 1996). Emotional lability, or frequent and intense experience of emotions, often leads to impulsive decisions when clients are faced with the difficult emotions that present themselves in treatment. For example, in one study, those who were found to experience and express anger more frequently were more likely to drop out of treatment (Erwin, Heimberg, Schneier, & Liebowitz, 2003).

## Treatment Characteristics

**Group Cohesion.** Group cohesion is essential to the success of any group intervention (Yalom, 1985). Research has shown that clients who dropped out of group treatment reported experiencing less positive feelings during group than those that stayed (McCullum, Piper, Ogradniczuck, & Joyce, 2002). In addition, therapists' ratings of cohesion to the group are significantly lower for clients that terminate early (Ogradniczuk et al., 2006). In another study, difficulties trusting and relating to others increased the likelihood of group dropout (Blouin, Schnarre, Carter, Blouin, & Al, 1995).

Cohesion not only decreases dropout, but it increases treatment compliance. Research has shown clients who dropped out of therapy participated significantly less while in treatment than their compliant counterparts (Oei & Kazmierczak, 1997; Miller & Mason, 2001). Similarly, in a study of group treatment for domestic offenders, clients were less likely to continue abusive behaviors if they felt they had an alliance with the therapist and the group (Taft, Mur-

phy, King, Musser, & DeDeyn, 2003).

**Therapeutic Alliance.** The therapeutic alliance, or the working relationship between the client and therapist, is imperative in any therapeutic setting (Horvath & Luborsky, 1993). Despite the need of a pre-treatment orientation, simply having the client in individual therapy before group treatment (and during) can build the therapeutic alliance and is related to higher levels of attendance (Stone & Rutan, 1994). Studies have shown the therapeutic alliance is a significant predictor of compliance in all types of treatment, and pre-treatment can also facilitate the client's relationship with the therapist (McMurrin et al., 2010; Daley & Zuckoff, 1999). Murphy and Cannon (1986) also found that the establishment of a relationship between therapist and patient during orientation to group therapy was the highest predictor of compliance in group. Thus, encouragement, feedback, and support from the therapist are factors that predict treatment compliance (Blake, Owens, & Keane, 1990).

**Therapist Perceptions and Behavior.** While there have been studies of treatment compliance based on therapist demographics, (i.e. gender or race) these studies are inconclusive at best (Joyce et al., 2007). However, other therapist factors have a role in treatment compliance, including therapist attitude and perceptions. While this may seem obvious, often factors that can be attributed to the therapist are overlooked when examining client dropout. It may simply be easier to look at the client-related reasons for non-compliance as opposed to those associated with the clinical experience (Roth, 1990). For example, in one study, researchers found that therapists had a tendency to individualize and interact more with clients that were more engaged in session, leading to those clients staying in treatment, while the less engaged clients were more likely to dropout. Therapists also exhibited a tendency to rationalize group instability, citing client contributing factors as opposed to acknowledging their part in the disturbances of the group (Stwine, 1994).

There is evidence that how mental health workers and counselors perceive clients can be related to whether clients are compliant with treatment. In a study of mental health case workers' attitudes towards clients given a hypothetical situation, participants viewed clients more favorably, and were more likely to help them in the face of treatment noncompliance, (e.g. help with transportation or resources) if the client's noncompliance was infrequent and seemed related to factors out of his or her control, as opposed to clients who have frequent problems with noncompliance (Forsyth, 2007). This can have significant implications for treatment. If clinicians are less likely to help and work with clients that have a history of non-compliance or problems with treatment, they could be setting these clients up for failure.

## **Implications and Recommendations for Treatment**

Many themes have emerged from the research on group treatment non-compliance. These themes include client characteristics, treatment characteristics, and therapist perceptions and behavior. Though it is clear all of these variables are related to group therapy dropout, the extent to which they predict non-compliance, or how much they are related to each other is uncertain. For exam-

ple, if attitude toward treatment is directly affected by pre-treatment orientation, structure of treatment, and therapeutic alliance, but mediated by impulsive behaviors and diagnosis, it may be much more difficult to address these factors individually. Counselors must consider all of these factors when developing and maintaining a group therapy intervention in order to improve successful outcomes and to continue to serve clients in the most efficacious and beneficial means possible. Instead of looking solely at the client, it is necessary to look at treatment non-compliance as an interaction between client factors, therapist factors, and group factors (Roback & Smith, 1987). Unfortunately, other research findings suggest that many therapists remain unaware of the potential for clients to dropout, and this contributes to high rates of non-compliance (Stone, Blaze, & Bozzuto, 1980). The following sections discuss interventions to reduce group therapy dropout.

### **Pre-therapy orientation**

Pre-treatment orientation includes addressing client expectations, as well as engaging the client in treatment and building the therapeutic alliance. A study by Murphy and Cannon (1986) found that presenting the idea of group treatment so the client can take time to consider treatment increased the client's positive attitudes toward the group. Many other studies have found that implementing pre-treatment orientation increases the likelihood of compliance with group therapy and reduces dropout (France & Dugo, 1985; Garrison, 1987; Tolman & Bhosley, 1989). Clients are more likely to complete group therapy if they have realistic expectations about the length of treatment and effort needed (Kuusisto et al., 2011). Therapists should discuss client expectations before group treatment commences to be sure his or her expectations are in line with the treatment goals.

Research has also shown that pretreatment orientation can lead to higher group cohesiveness and more progress during group sessions, and it may be helpful to interview group members beforehand and consider the interaction between these individuals in order to increase cohesiveness in the group (France & Dugo, 1985). Finally, clients that receive pre-treatment orientation are also more likely to be viewed as engaged and compliant by the therapist (Garrison, 1978). Spending time engaging clients in pre-treatment orientation can often be overlooked and though the length of pre-treatment orientation needed may vary by modality, it is an aspect that is paramount in preventing dropout.

### **Risk Factors**

Several risk factors for dropout have been delineated in this manuscript. An initial assessment for these risk factors is crucial. For example, though further research is necessary to replicate these findings, clients under the age of 35 may be at higher risk for dropout. In addition, SES and education level could be contributing factors. It is important for clinicians to address the fact that minority clients may not perceive treatment in the same manner as non-minority clients, and thus therapists must engage in multiculturally competent counseling strategies. This includes the knowledge, skills, and beliefs related to working

with clients of different cultures (Arredondo et al., 1996). Diagnosis may also be a risk factor, including schizophrenia, substance dependence, or a personality disorder.

To begin, a clinician should assess whether the client has had previous treatment, his or her attitude toward treatment, and his or her propensity for impulsivity and labile emotions (this can be assessed through reported history and client diagnosis). The quality of a client's relationships may indicate whether the client is at risk for dropout, and this aspect should be explored with the client before commencement of group sessions. Similarly, other studies have shown that adequate social support may be an important protective factor to keep clients in group treatment (Ayuso-Mateos et al., 2007).

Once these factors have been identified, it may be helpful to have a discussion with the client regarding the possible barriers that will keep them from completing treatment. Discuss possible conflicts with culture, or with transportation. If a client has a low education level, consider the type of group and material to be covered to be sure it is appropriate for his or her comprehension. If a client has a history of impulsivity and/or labile emotions, problem solve ways to cope when emotions do arise, or when the client feels like ceasing therapy.

### **Therapeutic Interventions**

Assessing the structure and length of treatment can help increase treatment compliance. For example, behavioral interventions, such as positive and negative reinforcement, have been found to be helpful in increasing compliance with group treatment, especially in the area of substance dependence (Brooner et al., 2004). However, though these interventions increase compliance, they may not always increase patient satisfaction with treatment (Blake et al., 1990). Younger clients and clients diagnosed with schizophrenia may be more successful with shorter group sessions, and shorter overall treatment length.

Clients often give signs that they may terminate prematurely, such as decreasing engagement in group, or telling the therapist and/or group members that they are considering leaving group. Clients may also be more likely to drop out if they have a poor attendance record at the beginning and throughout treatment (Hunnicuttt Hollenbaugh, 2011). When a client does voice unhappiness with treatment, immediate response by the therapist is necessary, and confronting the situation directly with encouragement, support, and problem solving can be helpful in maintaining the client's compliance (Riebel, 1990; Valbak, 2003). In a study of AoD aftercare group treatment, participants who received feedback and prompts during group therapy were more likely to attend groups and less likely to relapse (Lash & Blosser, 1999).

### **Conclusions**

Though the available research does provide significant insight into the risk factors for dropout in group treatment, all clients should be assessed individually for their own personal risk of dropout. Further research on treatment compliance in group treatment is necessary, with specific regard to multicultural considerations in therapy dropout. Research may also identify specific modali-



ties that increase compliance with certain diagnoses and personality factors. Regardless of the effectiveness of our treatment interventions, if we are unable to keep clients in treatment, we are unable to effectively help them. Further research and applying interventions to protect against treatment dropout not only benefits the individual, but the local and national community.

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