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A Study of Patients who Lapsed from Group Psychotherapy

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This investigation is a direct sequel to the work on evaluation of group psychotherapy already published in this journal (Sethna and Harrington, 1971). The method, setting and aims of the main investigation were described in the original paper and will not be repeated here. The need for the present study became evident when it was found that of the 94 patients considered for the evaluation study as many as 37 (41 per cent) lapsed or discharged themselves without completing their treatment, and against medical advice.

Though interviewing patients who lapsed might seem the most obvious way of investigating reasons for lapsing, it was not always practicable, as many patients left without any warning; and even when they were contacted after they had left they invariably failed to turn up for the interview. It also became evident during the pilot study that when patients were interviewed after they had expressed their wish to leave prematurely they seldom revealed the real reasons for their leaving, and the explanations that they gave were no more than rationalizations for the underlying real reasons of which they themselves were quite often not aware. Because of these difficulties it was decided to obtain most of the data from the various staff conferences, including the initial diagnostic conference, the twice-weekly community meetings, the clinical records of the therapists, the nurses' notes and the ward reports.

The principal method followed for determining reasons for lapsing was to compare and contrast the patients who lapsed with those who did not. This was done by comparing the 53 patients who completed their treatment (who for convenience will be called the 'discharged' patients) with the 37 patients who lapsed during the same period after similar though shorter therapeutic experience.

Results

Though at times we have taken into consideration factors responsible for lapsing in a single or a very few cases, we have placed greater emphasis on the factors which were common to a reasonable number of patients. The object of doing this was to find out the more general and basic reasons for lapsing which were applicable to this category of patients as a whole. For convenience and simplicity the various factors responsible for lapsing are dealt with separately, but by doing so we do not wish to create the impression that they occur either singly or distinctly.

Threat of participation in group psychotherapy

The threat of active participation in group therapy was observed to be the commonest cause of lapsing. It was present in nearly all the patients who lapsed, and was even present among the 'discharged' patients but to a far less extent. On closer study it was found that threat of participation in group therapy was the most important factor in lapsing of 19 patients and a contributory factor in 5 more. This conclusion was supported by the fact that 11 of these patients had had in-patient psychiatric treatment in the past (7 of them at other psychiatric hospitals, and 4 at this Clinic at a time when intensive group psychotherapy was not practised) and none of them had lapsed on those occasions. From this it seems that conventional psychiatric treatment, in which patients receive support, encouragement, reassurance and anxiolytic drugs is less likely to cause lapsing; but analytic group psychotherapy in which patients are expected to reveal their inner thoughts, feelings and past experiences and allow psychotherapeutic exploration and interpretation of them is far more stressful, and therefore more likely to cause lapsing.

Diagnosis

Diagnoses of the patients were based on the phenomenology of their clinical state, as well as on the assessment of their psychodynamic defence mechanisms. It was customary at the Clinic to divide patients into two broad categories of 'hysterics' and 'obsessionals'. Such a practice proved very useful in showing considerable differences between the diagnoses of the discharged and the lapsed patients. Table I shows that out of 33 'obsessionals' 23 (69·7 per cent) completed their treatment and only 10 (30·3 per cent) lapsed, whereas out of 31 'hysterics' only 11 (35·5 per cent) completed their treatment and as many as 20 (64·5 per cent) lapsed. These differences were found to be significant ($p < \cdot 01$). One might expect this, since obsessionals, because of their personality traits, would find it easier than the hysterics to accept and conform to the routine of the Clinic and persevere with their treatment. But the main reason for the higher rate of lapsing among hysterics was found to be the attitude of the therapists, who tended to show greater dislike and intolerance of the hysterics because of their acting-out behaviour, manipulativeness, and seductiveness. Realization of this intolerance and hostility by the patients led to their leaving the Clinic prematurely. The nursing

TABLE I

Diagnosis: 'discharged' and 'lapsed' patients

		Patients discharged		Patients lapsed	
I	Anxiety state	3		—	
	Anxiety state in personality disorder	1		1	
II	Neurotic depression	2		2	
	Neurotic depression in personality disorder	1		—	
III	Obsessional neurosis	8		2	
	Obsessional personality	1		2	
	Phobic state in obsessional neurosis	4	*Obsessionals*	3	
	Anxiety state in obsessional personality	7		1	
	Neurotic depression in obsessional personality	3		2	
	Total	23 (69·7%)		10 (30·3%)	Total 33 patients
IV	Hysteria	2		—	
	Hysterical personality	1		7	
	Anxiety hysteria (phobic anxiety state)	4	*Hysterics*	6	
	Anxiety state in hysterical personality	3		2	
	Neurotic depression in hysterical personality	1		5	
	Total	11 (35·5%)		20 (64·5%)	Total 31 patients
V	Personality disorder	4		—	
	Sexual deviations	2		1	
	Adolescent emotional disorders	1		—	
VI	Endogenous depression	5		—	
	Schizophrenia	—		2	
	Total	53		36*	

Differences between obsessionals and hysterics among the discharged and lapsed patients ($\chi^2 = 7 \cdot 56$, $p < \cdot 01$).

* No diagnosis was arrived at in one more patient who lapsed.

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and other ancillary staff also appeared to resent the hysterics, and on occasions they went into collusion with the therapist to bring about lapsing of these patients.

The 11 obsessionals who lapsed differed considerably from the obsessionals who did not lapse. Nearly all those who lapsed showed either overt agressiveness or paranoid tendencies or both; these traits were conspicuously absent from the obsessionals who did not lapse. It seems that patients with these traits found it difficult to integrate in the psychotherapeutic group, and consequently unable to continue in it for very long. This view is supported by Graham (1959), who believes that patients with paranoid traits usually prove unsuitable material for group psychotherapy.

Sex and marital status

The main characteristics of the discharged and the lapsed patients are given in Table II. Between these two categories of patients there were 29 male patients and 61 female patients. Only 6 (20·7 per cent) of the male patients lapsed, whereas 31 (50·8 per cent) of the female patients lapsed. The high incidence of lapsing among female patients was considered to be mainly a reflection of the high rate of lapsing amongst patients diagnosed as hysterics, a diagnosis that was made exclusively amongst the female patients in this series.

It was thought that a large proportion of the female patients who lapsed would be married women who because of their domestic responsibilities, such as the care of young children, would find it difficult to attend the Clinic, and would therefore tend to lapse more often. But this was not found to be so, as the incidence of lapsing amongst married women was slightly lower (50 per cent) than amongst single women (53 per cent) as shown in Table II.

Only seven of the married women gave domestic responsibilities as a definite reason for dropping out, though many others gave the impression that it was one of the reasons why they wanted to leave. When these seven patients were offered help in coping with their domestic responsibilities either by their families or through the social services they rejected it for very trifling reasons; this confirmed our belief that domestic and other similar difficulties were only rationalizations for the deeper and more valid reasons. Though in many cases the deeper reasons were apparent, the patients remained unaware of them, and when their deeper reasons were interpreted to the patients, they strongly rejected them.

TABLE II

Characteristics of 'Discharged' and 'Lapsed' patients

	Discharged patients	Lapsed patients	Total no. of patients
Males	23 (79·3%)	6 (20·7%)	29
Females	30 (49·2%)	31 (50·8%)	61
Single	19 (63·4%)	11 (36·6%)	13
M. 11 (84·6%)		M. 2 (15·4%)	30
F. 8 (47%)		F. 9 (53%)	17
Married	34 (56·7%)	26 (43·3%)	16
M. 12 (75%)		M. 4 (25%)	60
F. 22 (50%)		F. 22 (50%)	44
In-patients	35 (71·4%)*	14 (28·6%)	49
Day-patients	18 (43·9%)	23 (56·1%)	41
Referred by general practitioners	41 (60·3%)	27 (39·7%)	68
Referred by psychiatrist	12 (54·7%)	10 (45·5%)	22
Average age	33·4 yrs	31·4 yrs.	

* Seven of these in-patients were later made day-patients but remained in the same group.
M. = Male F. = Female.

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Day-or in-patient status

Day-patients lapsed at a higher rate (56·1 per cent) than the in-patients (28·6 per cent) (Table II). This could be because of greater ease with which day-patients can lapse by merely failing to attend the Clinic, while in-patients would have to take more positive steps to discharge themselves by announcing their intentions and collecting their belongings. This explanation by itself seems inadequate when one considers that the in-patients were allowed to spend all but the first week-end at home and had plenty of other opportunities when they could have failed to return. The more likely explanation for the higher rate of lapsing among day-patients will be considered later when reasons for the variations in rates of lapsing between the different psychotherapeutic groups are dealt with.

Source of referral

A view widely held by the staff of the Clinic that patients referred by psychiatrists from other hospitals lapsed more frequently than the patients referred directly by their general practitioners was supported by the figures in Table II; but these differences were far less than expected.

Referrals by other psychiatrists were often complicated by problems of 'counter-transference'. Many of these patients considered their referral to the Clinic as rejection by their previous therapist, and they were therefore unwilling to accept treatment under another therapist. Reasons for referral by other psychiatrists were found to be very varied, and this made it difficult to draw any definite conclusions. However, there was a tendency to refer cases of doubtful prognosis in whom all other therapies had failed, which was contrary to the generally accepted view, that for group psychotherapy to be effective the patients ought to be treated at a reasonably early stage of their illness.

Age

Another view held by the staff of the Clinic was that the older patients tended to lapse less readily than the younger patients. The average ages of the discharged patients (33·4 years) and of the lapsed patients (31·4 years) showed hardly any difference (Table II). However, there were differences when patients over the age of 40 years were compared with those under that age. Out of 25 patients over the age of 40 years only 7 (28 per cent) lapsed, whereas out of 65 patients under the age of 40 years 30 (46·1 per cent) patients lapsed. Thus, the tendency to lapse seems to get less after the age of 40 years.

Intergroup variations

Considerable variation in the rates of lapsing were found between the various psychotherapeutic groups (Table III). Groups A and B, composed of day-patients only, showed the highest rates of lapsing. This might, in part, be due to the comparative ease with which day-patients could lapse; but this, as already mentioned, did not provide a wholly adequate explanation.

TABLE III

Number of patients 'discharged' and 'lapsed' from each group

	Group							
	A	B	C	D	E	F	G	Total
No. of patients discharged ..	7	10	7	5	9	9	6	53
No. of patients lapsed	12	11	1	5	6	0	2	37

Another factor which contributed to the higher rate of lapsing in groups A and B was the tendency to admit less promising cases as day-patients rather than in-patients, which made admissions to these two groups selective. It was found on examining case summaries (which were made when patients were first seen as out-patients prior to admission) that in six of them statements were made which suggested that these patients might prove poor material for psychotherapy. Five of these six patients were offered day-patient care and were consequently allocated to groups A and B. It is quite likely that such doubts expressed in the case summaries by the consultant psychiatrists of the Clinic provided cues for the therapist and others in charge of the patients not to persevere with them and to encourage

them to leave prematurely. The therapists and the other members of the staff were able to accept lapsing of these patients without any sense of failure, as they were considered poor material for psychotherapy by their supervisors. It seems that lapsing was used in these cases (probably not deliberately) as a method of disposal under the guise of 'giving patients a chance'.

The foregoing reasons do not fully account for as many as 23 out of the 37 patients lapsing from groups A and B. Our observations led us to believe that the personalities, attitudes and techniques of the therapists of these two groups were the additional, and probably the more important reasons for the higher rate of lapsing.

In contrast to groups A and B no patients lapsed from group F. There appeared to be several reasons for this. In this group most of the patients were middle-aged (average age 47·1 years, compared to 28·5 years for groups A, B, C, D, and E), and, as has already been shown, tendency to lapse is less after the age of 40 years. When considering diagnosis of the lapsed patients it was shown that the tendency to lapse was much less among patients with obsessional personality traits, and in this group patients with obsessional personality predominated.

Another important reason for the absence of lapsing in this group was the method adopted by the therapist in running this group. He used a less probing and more supportive form of therapy to suit the type of patients in that group. This approach must have tended to produce less anxiety and distress among the patients in this group compared to the analytic groups in which the therapists were less supportive and more interpretive. Low incidence of lapsing in group G was also considered to be for similar reasons. It was run entirely on supportive lines, with reassurances and explanations which, compared to the other groups, was manifestly less stressful and anxiety provoking to the patients. As in group F, patients in this group were older (average age 41·5 years) compared to patients in the analytic groups, which also tended to reduce the likelihood of lapsing from this group.

Transference and countertransference

Though difficult to assess objectively, transference and countertransference problems were very important and common causes of lapsing. However, when it was decided to take into consideration only those cases of transference difficulties in which evidence for it was indisputable and relatively objective there were only five cases in which we could say with certainty that lapsing was caused by these difficulties. Transference difficulties were undoubtedly responsible for lapsing of many more patients, but the evidence in their cases was speculative.

The type of evidence used to support inclusion of the five cases of lapsing due to transference difficulties were: A letter written by a patient to her therapist after she ceased to attend the group in which she mentioned how strongly she felt attracted towards him and how she experienced extreme anxiety and embarrassment in the group when her feelings towards him were discussed. Another patient, when seen by the psychiatric social worker after she lapsed, expressed strong antipathy towards her therapist. She also expressed the fear she had of her feelings towards the therapist showing in the group and of his becoming aware of them. Similar evidence was present in the three remaining cases which left little doubt that their lapsing was also due mainly to transference difficulties.

Evidence of countertransference problems was found in six patients. While it was not uncommon for the group therapists to mention their difficulties and frustrations in dealing with some of their patients at the staff conferences, definite statements of hostility and dislike were made in connection with six patients and all of them later lapsed.

Sexual threat

As might be expected in mixed groups, patients at times developed relationships of varying intensity with other members of the opposite sex in their own group, or sometimes in the other groups. Such heterosexual attachments were not found to be an important cause of lapsing. However, when spouses of married patients became aware of such rela-

tionships, they often pressed for an early discharge of the patient. Homosexual threats appeared to be of greater importance in causing patients to lapse. In the case of three patients with homosexual tendencies, their respective therapists felt that one of the important reasons for their premature discharge was anxiety over homosexual involvement with members of their own or other groups.

Elimination by the group

It is generally recognized that the introduction of a new patient often arouses hostility in the existing members of the group, which in some instances is sufficient to cause lapsing of the new patient. This occurred in the case of three new patients, when the group as a whole, or some members of the group, made it impossible for the new members to continue in the group, and left them no option but to discharge themselves. Two other patients, who had been in the group for some time, also found it impossible to continue and were obliged to leave because of the increasingly hostile attitude of the other members in the group. In their cases it was felt that the group members were only reflecting the negative feelings of the therapist towards these patients.

Non-starters

Table IV gives details of the number of group therapy sessions that the patients attended before they lapsed. Thirteen patients (35·1 per cent) lapsed after attending less than five sessions and they were, therefore, classified as 'non-starters'. A generally held view at the Clinic was that the 'non-starters' differed from those who lapsed after a longer period of treatment, and that their lapsing was inevitable. When 'non-starters' were compared with those who lapsed later no important differences were found between them; all that we found was that anxiety associated with participation in group therapy was more marked among the non-starters; and that the transference difficulties did not play any part in their lapsing, as their stay in the group was far too short.

TABLE IV

Lapsed patients

Number of group therapy sessions attended before lapsing

Number of group therapy sessions	No. of patients	
Less than 5	13	(35·1%)
5 to 20	13	(35·1%)
20 to 40	6	(29·8%)
40 to 60	2	
60 to 80	1	
80 to 100	—	
100 to 120	1	
120 to 140	1	
	37	patients

The belief that lapsing of 'non-starters' was inevitable was not supported by the finding that six of the 13 'non-starters' had previously been in-patients either at this Clinic (before it became a unit for intensive psychotherapy) or at other psychiatric hospitals, and none of them had lapsed on those occasions.

Besides the causes of lapsing which have already been considered, additional causes, applicable to 'non-starters' only, were found. Failure of communication was evident in two of the 'non-starters'. These patients, who were referred from other hospitals, were inadequately informed about the Clinic or the form of treatment it offered. One of them thought he was referred for an out-patient consultation only, and not for admission as a day-patient as arranged by the referring doctor.

The nature of the reception given to the patient at the time of admission also seemed to matter. In the case of one of the 'non-starters' the therapist who was to take charge of the patient was unable to spend more than a few minutes with him on the day of admission, and this initial lack of attention was thought to be largely responsible for the patient lapsing on the following day. In some instances the patients already in the Clinic managed to make the newcomers anxious by making adverse comments about the Clinic and about the results of treatment by group therapy. Such attitude of the former patients could have contributed to the lapsing of the newcomers, but it was considered not to have played an important part, as the staff at the Clinic were aware of its happening and took adequate counter-measures.

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Two of the 'non-starters' who were seeking termination of their pregnancies left as soon as they were refused termination. They made this decision in spite of offer of further help and treatment. Another, a Pakistani girl, stayed only a few hours, as she and her family, being strict Moslems, could not tolerate the free mixing of the sexes in the Clinic.

Threat of facing change

In some cases insight gained through therapy made the patients realize the need to face difficult changes in their lives, such as those in their marital or family situation or in their career. At such junctures in therapy, desire to leave was expressed by five patients. In three of them lapsing was prevented by early recognition of these difficulties by the therapist and by his effort in resolving them through the psychotherapeutic group. In the other two cases such intervention was either too late or the counter-measures inadequate to prevent the patients from leaving.

Flight into health

Three patients lapsed after announcing their unexpected and dramatic recovery at quite an early stage of their therapy. Though they claimed that they had recovered completely it was quite obvious to the therapist that this was far from being the case: their 'recovery' was considered temporary and due to fresh mobilization of their ego defence mechanisms. They invariably attributed their recovery not to the treatment they had received but to change in circumstances which they held responsible for their condition. The kind of changes that they mentioned were: finding suitable employment, chance of moving into more satisfactory living accommodation, or alteration in the attitude and behaviour of their spouses. These patients were also observed to use the defence mechanism of 'denial' quite frequently during their participation in group psychotherapy; and because of this it was difficult either to detect the real reason for lapsing or to take appropriate measures to prevent it.

Discussion

Reports on lapsing in group psychotherapy have been largely on out-patient groups; by contrast our study has been concerned with both in-patients or day-patients. The rates of lapsing in out-patient groups reported by other workers have been as follows: Yalom (1966) 36 per cent, Nash *et al.* (1957) over 50 per cent, Kotkov *et al.* (1952) over 50 per cent, Berne (1955) 29·5 per cent, Johnson (1963) 25 per cent (in-patients and out-patients), and Phillipson (1958) 46 per cent. From these figures it seems that the general attrition rate in group psychotherapy is from 30–50 per cent, with which 41 per cent in our series is comparable. Should this high rate of lapsing, therefore, be considered an inevitable feature of group psychotherapy? It would not be acceptable if lapsing was found to be detrimental either to the patients who dropped out or to those who continued, or to both. We believe that lapsing is in fact deleterious to both these categories of patients.

Yalom (1966) describes the various ways in which lapsing is deleterious. In his view, patients who terminate therapy after fewer than 10 to 12 sessions derive little or no benefit from it. Some of these patients, already demoralized because of their neurosis, are actually made worse by experiencing yet another failure. The patients who lapse could not be considered therapeutically recalcitrant either, as it is often found that they do well if treated in another group under a different therapist.

Yalom also believes that the members who remain in the group also suffer because of lapsing of other members. The group's work is slowed down, largely because of the repetition necessary for the benefit of the new arrivals who have replaced those who lapsed. Subgrouping also tends to occur between the original group members and the new arrivals, leading to dissipation of group cohesion. Group members may be greatly discouraged about the prospects of their getting better when they witness an acutely anxious patient leave the group without deriving any benefit or apparently worse. When a patient leaves because of group pressures, others often contemplate termination, in case they also are sub-

jected to similar pressures in the future. Lapsing also tends to demoralize the therapist, especially if he is in the early stage of his training, by arousing in him feelings of guilt, incompetence and failure.

As lapsing is clearly prejudicial to the patients who terminate therapy and to the group as a whole, it is important to find out reasons for lapsing and ways of preventing it. There are very few investigations with which we can compare ours, because of differences in approach, method of investigation, types of group therapy and the kind of patients treated. Despite some differences in approach between this inquiry and those of Yalom (1966) and Schorer (1965), there is considerable agreement in the findings, and the conclusions drawn from them.

Our study has suggested that anxiety associated with participation in group therapy is one of the commonest causes of lapsing, and largely responsible for 24 out of our 37 patients lapsing. Phillipson (1958) also believes that many patients who fail to complete their therapy do so because they 'are too acutely anxious to tolerate the group situation'. Yalom (1966) considers such anxieties under the headings of 'Problems of Intimacy' and 'Emotional Contagion' and believes that these anxieties were either the main or the secondary cause for lapsing in 23 out of his 35 drop-outs. Ten of these patients expressed a constant dread of having to reveal themselves in the group. At the other extreme, three of the patients suddenly revealed a great deal and were then too anxious to be able to continue in the group. Under 'Emotional Contagion' are described five patients who were frightened by seeing certain abnormal features of other patients in themselves, and became concerned in case they also got similarly affected if they continued to expose themselves to such patients. Exactly similar anxieties were found among our patients who left largely because of the various anxieties associated with participation in group psychotherapy.

Apparent dramatic recovery with a flight into health is another way of patients terminating treatment. Three of our patients fell into this category. Yalom (1966) also describes a patient who terminated therapy because of very early recovery. This patient, as ours, tended to utilize denial as the chief defence mechanism. Train (1963), in his paper 'Flight into Health', has made a similar observation that 'patients often avoid coming to grips with painful irrational conflicts and suddenly assume apparent health'.

Elimination of patients by group pressures occurred in five of our cases. Similar occurrences in four cases were listed under 'Complication of Sub-grouping' by Yalom. These patients felt that they were attacked, excluded and finally driven out of the group by a tightly knit clique of original members.

Yalom also mentions under 'Complication of Sub-grouping' heterosexual involvement between group members leading to six of them leaving prematurely. Though such involvement was not infrequent in our study, the patients did not lapse because of it. But we did find that three of our patients with homosexual tendencies dropped out because of their anxieties over homosexual involvement with other patients in their group. Two of Yalom's patients with homosexual tendencies also left prematurely, but because of their fear of having to reveal their homosexual tendencies. We found transference difficulties as the cause of lapsing in five of our patients. Similar difficulties have been described by Yalom under 'Inability to Share the Doctor' in the lapsing of seven of his patients.

In our investigation 23 out of the 37 patients who lapsed came from two of the seven groups. Similarly in Yalom's work 19 out of the 36 patients who lapsed came from two of his nine psychotherapeutic groups. Yalom largely attributes this to the shortcomings of the therapists of these two groups. We also felt that the personalities, attitudes and techniques of our two therapists were responsible for the high rate of lapsing in their groups; but we found an additional reason also, which was the allocation of 5 out of the 6 patients who were considered poor material for group psychotherapy to these two groups.

In contrast to our study and that of many others, Schorer (1965) considers the therapist to be wholly responsible for patients discharging themselves A.M.A. (against medical

advice). He compared a group of doctors with a very high rate of discharge A.M.A. with a group with a very low rate, and found considerable difference between these two groups of doctors on the Edward Personal Preference Schedule. Doctors with high A.M.A. discharge rate scored high for abasement, achievement and aggression; the doctors with a low A.M.A. discharge rate had high scores for deference, introspection and nurturance. Schorer considers aggression to be the key component in the doctor with high A.M.A. discharge rates. He believes that the doctor's aggression is directed towards achieving outstanding success, but in case of failure it is directed against the doctor himself. To put it another way, the doctor is determined to force his patient to get better, but if he fails in the attempt he wishes to openly record his failure by having the patient discharge himself A.M.A. rather than cover the matter over by allowing an uneventful discharge.

Our findings suggest that blame for lapsing cannot be laid exclusively on the therapist or the patients. The interaction between the therapist and his patients and the resultant relationships are the essence of group psychotherapy, and it is in these complex therapeutic relationships that the causes of lapsing should be sought.

Several reasons for lapsing emerged by comparing discharged with lapsed patients; for instance, the marked variation in their diagnoses. Schorer (1965) and many others failed to find these differences because they matched these two categories of patients for age, sex, diagnosis etc., the very variables in which we found the differences. We found these differences because our samples consisted of unmatched patients who lapsed or were discharged over a certain period during which they had the same therapeutic experience.

On considering the different causes of lapsing, the conclusion we can draw is that in any given case there is rarely a single cause for lapsing. Several causes varying in degree and combination produce in each case a unique situation or a gestalt of causes which is responsible for the patient terminating therapy prematurely.

As lapsing is deleterious both to the patients who drop out and to those who continue, the ways in which premature discharges can be avoided need to be considered. We do not consider it fair to work out ways of predicting patients who are likely to lapse so that they could be excluded. This would be a way of avoiding rather than solving the problem. Making the therapeutic process acceptable and tolerable to the patient is a very vital part of the therapy, and in this sense rejection of treatment could be seen as failure of treatment.

Adequate preparation and briefing of patients for group therapy is essential in preventing patients from lapsing. Many patients have erroneous ideas and misconceptions about group therapy. Pre-group interviews with the patients can serve a useful purpose. It gives the therapist a chance to acquaint the patient with how the group functions and to what purpose, and also gives him an opportunity to establish rapport and determine the patient's ability to accept interpretations, particularly transference interpretations. Parloff (1961) in his paper 'Therapist—Patient Relationship and Outcome of Psychotherapy' has shown not only that the satisfactory outcome of therapy depends upon the therapist-patient relationship, but that definite association exists between the quality of relationship and the incidence of drop-outs. There is no doubt that a sound relationship between the patient and the therapist could counteract most of the factors which are responsible for patients leaving prematurely.

As regards anxiety associated with participation in group therapy, it is essential that such anxieties are not missed, and if detected not ignored. These anxieties should be freely discussed in the group at the earliest opportunity and appropriately interpreted.

It is essential for the therapist and other members of the staff to realize that covert antipathy or frank dislike of patients can often lead to their leaving prematurely. The therapist needs to be constantly on the look out for such countertransference difficulties and to deal with them when they arise. This is not easy for a therapist when he functions in isolation, but when opportunity to take part in clinical conference exists it should not be difficult.

When hostility of a group towards one or more of its members is likely to cause lapsing, it should not be difficult to prevent it through the normal group processes, provided the therapist has not failed to detect such hostility in time. The therapist also needs to bear in mind that quite often group members are only reflecting his own negative feelings, which they have detected from the cues he may have inadvertently given.

At times patients are accepted for intensive group therapy when in fact they are poor material for such treatment. Quite often it seems that lapsing was expected and was used (probably not deliberately) as a method of disposal under the guise of 'giving the patient a chance'. A more realistic approach would be to treat such patients in less intensive psychotherapeutic groups more suited to their ability and needs.

Gaining insight can at times be traumatic to patients; especially when they come to realize the need to face difficult changes in their lives such as those in their marital or other relationships or in their careers. This could be prevented by effective therapy which should not only promote gaining of insight but also help in facing change.

Strong positive or negative feelings towards the therapist or other members of the group frequently lead to premature termination of therapy. This should not occur if transference feelings are properly handled and not allowed to develop indiscriminately so that they become intolerable to the patient.

Environmental or reality reasons for lapsing are relatively uncommon and are often no more than rationalizations for the more subtle and deeper reasons. In such cases interpretation of the real motives for the patient's wish to leave is the only likely way of changing his decision. There are times when the patient's departure is desirable to the therapist, and in such cases there is a tendency to accept reality reasons too readily.

Prevention of lapsing cannot be seen in isolation, and at this Clinic other aspects of the general unco-operativeness of the patient have been investigated (Burgess and Harrington 1964; Harrington, 1963). These studies show that the problem of lapsing should be seen in the context of the whole therapeutic set up, and of all aspects of patient's behaviour.

More work needs to be done to further understanding of the reasons for lapsing and methods of preventing it. In no other field would an attrition rate of 30 per cent to 50 per cent be acceptable. Before group therapy can be established as an effective method of treating neurotic and personality disorders ways of reducing the high attrition rate need to be found.

Summary

This investigation is a direct sequel to the work on evaluation of group psychotherapy already published in this journal (Sethna and Harrington, 1971). It is a study of 37 patients who while undergoing group psychotherapy lapsed or discharged themselves against medical advice.

The causes of lapsing were ascertained by comparing the 37 patients who lapsed with the 53 patients who were discharged on completion of their treatment. The commonest cause of lapsing was found to be the threat associated with active participation in group psychotherapy. Another important factor was the diagnosis; patients with hysterical features lapsed far more frequently than those with obsessional ones. The other factors which influenced lapsing were the group to which the patient belonged, transference problems of the group, personality of the therapists, sexual involvement between the group members, in-patient or day-patient status, the source of patient's referral, and the patient's age, sex and marital status. The remaining less frequent causes of lapsing were listed as 'threat of facing change', 'elimination by the group' and 'flight into health'.

Despite differences in approach, considerable agreement was found between our findings and those of other published studies. Because of the present high rate (30 per cent to 50 per cent) of lapsing in group therapy, and because lapsing is considered prejudicial to those who lapse as well as to those who continue in the group, ways and methods of reducing lapsing have been suggested.

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