Dropout and Adherence in Distance Versus In-person Therapy

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Abstract. Psychotherapy is traditionally performed in person. However, since the COVID-19 epidemic, distance therapy has become increasingly popular as a more practical option. This article aims to review and compare the characteristics and differences between distance and in-person psychotherapy in terms of dropout and adherence rates, through a literature review and cross-study comparisons. The main finding from this study is that a sense of responsibility, regular habits and therapeutic alliances all play essential roles in the continuous participation of clients in both modes. The difference lies in the fact that distance therapy is flexible and accessible, but it is more prone to early interruption or insufficient interaction. In-person therapy relies on fixed times and places, as well as non-verbal communication and immediate feedback to promote adherence. This paper aims to deepen the understanding of the psychotherapy process through a thorough analysis of dropout and adherence in the two counselling models. This study also provides therapists and institutions with insight regarding improvement strategies to reduce dropout and enhance the long-term engagement of clients.

Keywords: dropout, adherence, distance therapy, in-person therapy, counselling

1. Introduction

The demand for counselling and psychotherapy has been steadily increasing in recent years, particularly in colleges and community mental health centers [1]. Distance therapy had already been developed before the COVID-19 pandemic, but its popularity expanded rapidly afterward [2, 3]. Due to the widespread use of e-therapy and teletherapy, researchers have begun to compare the effectiveness of distance therapy and in-person therapy. The majority of studies focus on discussing the differences in outcomes between remote counselling and face-to-face counselling, and only a few studies examine dropout and adherence in different forms of therapy. These studies show different consequences in various situations.

Dropout has a direct impact on the effectiveness of the intervention. Generally, dropouts cause interruptions in treatment, and clients cannot fully benefit from the therapy [4, 5]. High dropout also wastes the limited health resources and lowers the cost-effectiveness [2].

Adherence is typically highly correlated with therapeutic alliance. Based on previous research, weaker alliances are associated with a higher risk of dropout, while stronger alliances are linked to better adherence among patients [6, 7]. Studying the differences in adherence between distance and

in-person therapy may help improve the design of treatment, especially for distance therapy, to increase accessibility and quantity.

Recent research focuses on symptom reduction and the therapeutic potential of two forms of therapy, and discusses how dropout or adherence occurs in a single therapy mode. However, few studies systematically compare dropout and adherence in both distance therapy and in-person therapy. Furthermore, the definitions of dropout and adherence are inconsistent, making it difficult to compare the results. Research on dropout types and reasons for different groups and disorders is insufficient.

Distance therapy has developed rapidly and been extensively studied due to the pandemic. However, it has led to a lack of research and empirical evidence in non-pandemic contexts. The mechanism of alliance in distance versus in-person dropout and adherence remains unclear. The measurement of adherence still relies on participation rates and requires further discussion.

The purpose of this paper is to re-summarize and clarify the concepts of dropout and adherence in distance therapy and in-person therapy. Meanwhile, analyze the factors influencing dropout and adherence in different counselling modes. Lastly, explore the similarities and differences between dropout and adherence in the two modes of therapy, and offer implications for practice and future research.

2. Literature review

2.1. Clarity definitions

Before discussing and comparing factors, it is essential to have a clear and consistent definition of the terms that will be addressed. The same concept may be operationalized into different indicators in different studies. For instance, dropout is defined as early termination in some cases, while others describe it as the rate of absence [2, 4, 8]. The research results will be difficult to compare and interpret if not unified. Therefore, this paper will adopt the APA Dictionary of Psychology as the basis of analysis [9].

This paper adopts a unified operationalization (Table 1). Dropout is defined as terminating before reaching the preset treatment goals or the planned number of treatments [9-12]. Adherence is defined as the combined fulfillment of attendance, task completion, and in-session interaction (Table 1, 'Operationalization adopted') [9]. To ensure compatibility with prior studies, alternative operationalizations such as attendance thresholds and self-reported early termination are retained and compared in the sensitivity analysis (Table 1, 'Alternative operationalization') [6, 7, 13, 14].

Distance Therapy includes only synchronous modalities (video/phone) [9], while purely asynchronous formats are excluded; for comparability, the measurement indicators for in-person and teletherapy are aligned (Table 1, 'Measurement/Indicators') [4, 6, 14].

2.2. Dropout in distance therapy vs. in-person therapy

As mentioned in the previous part, dropout is one of the significant challenges in psychotherapy. Generally, the dropout rate in therapy is between 20% to 50% [12]. However, the definition of differences may significantly affect the results. Different operational definitions can cause dropout rates to fluctuate between 17.6% and 53.1% for the same participant group [8].

The differences between distance therapy and in-person therapy dropout have been repeatedly confirmed. Buyruk Genç et al. discussed the factors that may cause dropout from distance therapy, primarily technical issues, as well as concerns regarding the sincerity and privacy of the online

environment [15]. If clients have any concerns about these issues, dropout is more likely to occur compared to face-to-face counselling. One of the most significant factors is the presence of technical barriers. Hellstern & Robinson noted that unstable networks and unskilled technology were common causes of dropout in distance therapy during the COVID period [3].

Table 1. Operationalization of dropout and adherence constructs across therapy modalities

	Dropout	Adherence	Distance Therapy	In-person
Definition	A client or patient terminating treatment before the session is completed	"The ability of an individual to conform to a treatment regimen…as outlined by a healthcare provider"	All types of non-in-person psychotherapy are considered distance therapy (through internet, telephone, audio /video conference)	In-person therapy is defined as the form of psychotherapy in which the therapist and the client interact directly in the same physical space
Operation-alization adopted	Terminate before reaching the preset treatment goals or the planned number of treatments (early termination)	Comprehensive adherence standard: Attendance + Task completion + In-session interaction (compliance with any two or more items)	Only synchronous forms are included, such as video or phone psychotherapy	Traditional face-to-face counselling is conducted in institutions or clinics
Alternative Operation-alization	(1) When the number of absences/ unfinished courses reaches a certain threshold; (2) Reasons for early termination are based on self- /other descriptions (such as insufficient motivation, mismatch)	(1) Measured only by attendance rate; (2) Only measured by the completion rate of homework/tasks; (3) Multidimensional scoring scale	(1) Hybrid synchronous /asynchronous (message/email) mode; (2) Platform differences (Zoom/ phone, etc.)	Hybrid (In-person + Remote)
Measure-ment/ Indicators	Whether early termination occurred (Yes/No); Time of occurrence: N^{th} meeting; Attendance rate/number of absences	Attendance rate (%); Task/Homework completion rate (%); The frequency and duration of interaction during the meeting	Synchronous medium: Video/telephone; Platform stability/disconnection rate (if available)	Attendance, tasks, and duration are consistent with distance therapy
Notes / Boundaries (Inclusion/ Exclusion)	Uniformly use "whether to terminate in advance" as the standard; Other definitions are only for sensitivity control	Maintenance adherence during the follow-up period (≥3/6 months) was recorded separately	Exclude asynchronous intervention. Terms such as remote therapy or online counselling in this paper are also considered as distance therapy	The hybrid modality is excluded from the pure face-to-face analysis. Face-to-face counselling or traditional therapy are also considered as in-person therapy

Data from Dever at the University Counselling Center indicates that some students have reduced their participation due to difficulty adapting to remote platforms [2]. In low-income countries, the disruption of psychological services is more severe due to insufficient internet and hardware [7, 16]. Furthermore, Buyruk Genc et al. found through comparison that dropout from distance therapy occurred earlier, often in the first few meetings, which is referred to as "early separations" [15]. The low sense of social responsibility in online counselling may reduce clients' motivation to maintain the relationship. Thus, they are more likely to dropout at the beginning stage. Meanwhile, several studies have found that weak therapeutic alliances are highly correlated with dropout, and these

alliances are more fragile and difficult to maintain in remote situations [6, 7]. Especially before the relationship is stable, clients may give up more quickly.

The factors of in-person therapy are various but common. The first is transportation distance. McGovern et al. found that the farther the clients are from the clinic, the higher the probability of dropout from the session [12]. Time conflict is also a frequent reason. The most common reasons for dropout among clients are that they struggle to balance their session and personal life, such as studying, working, or fulfilling family responsibilities [15]. For clients who are at a distance or have limited time, such factors may become the most significant cause of dropout. Khazaie et al. found that life events such as job changes, family responsibilities, and relocation were common causes of dropout [10]. Face-to-face counselling not only requires payment but also comes with transportation and time opportunity costs. Therefore, the pressure of life and the economy directly translates into the risk of dropout. In addition, counselling relationship mismatch and break can be predicted to lead to dropout [4]. The high level of interaction in a session makes relationship conflicts more directly affect the willingness to continue. Beckham also asserts that the client's initial impression of the therapist is crucial, as clients may be more likely to discontinue treatment more quickly [4].

However, it is hard to tell which form of psychotherapy has a high rate of dropout. Through comparison, there is a considerable divergence among academics on this matter. Some studies indicate that face-to-face counselling has a higher risk of termination. In contrast, other studies report results in the opposite direction [3, 15]. A few studies have even shown that there is no significant difference in dropout rates between distance therapy and in-person therapy [2]. This inconsistency is most likely due to differences in research design, sample characteristics and counselling methods. Researchers should pay closer attention to these factors in future studies and strive to draw relatively unified conclusions across different experiments and analyses.

The principal risks of dropout in distance therapy are technical issues, low engagement, early termination, and weakened therapeutic alliances. Most factors are indiscernible, and therapists are hard to track on time if clients dropout. The primary factors contributing to in-person therapy dropout are transportation and time costs, relationship breakdown, and life and economic pressures. The causes are easy to discover, therapists can immediately detect dropout. From the perspective of comparative studies, dropout is not only a technical or logistical issue, but also reflects the differentiated roles of relationship and responsibility in different modes of psychotherapy [14].

2.3. Adherence in distance therapy vs. in-person therapy

In psychotherapy, adherence usually refers to the extent to which the client continuously participates in the counselling as scheduled and completes the prescribed treatment tasks. Adherence is not only closely related to the therapeutic alliance and therapeutic effect, but also directly affects whether counselling can be completed [1]. Previous research has shown that distance and in-person psychological counselling share commonalities and differences in performance and mechanism, and have exhibited new changes during and after the COVID-19 pandemic [13, 16].

Firstly, on the one hand, the flexibility and accessibility of distance therapy are unparalleled in comparison to in-person therapy. Clients can participate in counselling at home or at the workplace, avoiding traffic pressure and reducing interruptions caused by time conflicts. A randomized controlled trial by Mohr et al. demonstrated that the dropout rate for telephone CBT was significantly lower than that for face-to-face CBT [13]. In addition, though the above parts mentioned that clients may dropout of distance therapy because of worry about privacy issues, there is no doubt that online counselling provides therapy anonymity, reduces the risk of social stigmatization, and makes some clients more willing to persist in completing the treatment course

[15]. Distance therapy also has substitutability during the pandemic. When there is a large-scale interruption in face-to-face counselling, various online channels have become the primary means of maintaining services, ensuring the continuity of treatment [16]. However, on the other hand, the factors that hinder adherence to distance therapy are also prominent. The most common one is the technical problem. An unstable network connection, poor audio and video quality, or insufficient equipment can all weaken the counselling experience, making it more difficult for clients to maintain regular attendance [3]. In contrast, Martins et al. do not believe this issue has a significant impact on adherence and the therapeutic alliance [7]. The therapists in their sample effectively addressed this issue and thought it would contribute to generating positive results. The limitations of the therapeutic alliance are also one of the essential reasons. Remote therapy lacks face-to-face nonverbal information, such as eye contact and body language, which may weaken the quality of alliances and reduce clients' motivation for long-term participation [6, 7].

Compared to distance therapy, the advantages of in-person therapy are more obvious. Much research has emphasized the importance of the depth of therapeutic alliance. Murphy et al. pointed out that in CBT for depression, the quality of therapeutic alliances is closely related to the patients' extent of persistence [6]. Strong alliances usually promote higher regular attendance and reduce the risk of decreasing participation. Franchini et al. also found that certain personality traits and the epistemic trust of the clients affected their persistence [1]. They indicated that the trust mechanism in face-to-face therapy is a crucial factor in maintaining long-term participation. Furthermore, Mohr et al. proposed that when comparing telephone CBT with face-to-face CBT, the presence of the therapist and non-verbal communication (such as expressions, tone of voice, and posture) might help maintain long-term efficacy [13]. These additional details enhance the sense of trust and responsibility, thereby increasing the likelihood of regular attendance. Mohr et al. pointed out that face-to-face counselling not only enhances trust and commitment through the non-verbal communication of therapists, but can also be regarded as a kind of "behavioural activation" in itself; the personal presence of therapists further promotes the continuous participation and compliance of clients [13]. However, there is almost no research that has studied the factors that may negatively affect adherence in in-person therapy. Therefore, this paper will not discuss this part.

Overall, the advantages of remote counselling lie in flexibility, anonymity and sustainability. However, the long-term efficacy is not well maintained and is limited by technological and therapeutic alliances. Besides, the advantages of face-to-face counselling lie in the depth of relationships, non-verbal communication and a sense of responsibility.

3. Mechanism models and practical implications

To better understand the differences between dropout and adherence in distance and in-person therapy, this section will integrate and discuss three perspectives: stage pathway, law-like differences, and intervention strategies. The integration can not only propose a phased explanatory framework but also offer specific inspirations for practical intervention.

3.1. Stage pathway

According to the previous review of the studies, dropout and adherence show a specific correlation. Dropout indicates that clients may experience early termination, absence, or stop therapy, whereas adherence rates show that attendants regularly complete homework and interact actively [4, 6, 8]. The relationship between dropout and adherence should not be considered as contrary. They are more like two stages in a counselling process. For example, lower client adherence will lead to

dropout. Several key mechanisms can help explain the situation. The first is motivation and expectation. When clients lack motivation or their changes do not align with their goals, adherence during counselling will decrease, increasing the risk of dropout [4, 12]. Therapeutic alliance is another significant factor. A strong alliance typically leads to high adherence; however, a weak relationship between therapists and clients can ultimately cause dropout [1, 6]. Generally, clients will not suddenly dropout with high adherence, but instead go through a process of gradual detachment. Low adherence performance, such as attending sessions late or being absent, should be noticed as a warning signal because it indicates a decline in clients' commitment to counselling and is highly likely to lead to dropout.

In both distance therapy and in-person therapy, the most crucial factor for improving adherence is therapeutic alliance. Whether online or face-to-face, a stronger alliance will significantly increase attendance and the completion rate of assignments [6]. Some research on a specific condition also showed that the type of counselling form does not affect adherence or outcomes [13]. Meanwhile, clients with a high sense of responsibility are more likely to comply consistently and are not significantly affected by modality differences [5, 10]. If clients have a strong sense of responsibility, even in an online environment lacking face-to-face constraints, they will still voluntarily adhere to appointments and complete homework. Similarly, in distance therapy, even if there are difficulties such as transportation or time, clients are more likely to make an effort. The last similarity is regular habits. In both therapy modes, regular participation will form a habit effect, further promoting long-term adherence [5, 13]. Clinicians generally believe that regular attendance arrangements are a necessary external support for enhancing adherence, as once a fixed schedule is formed, patients are more likely to maintain continuity. From the perspective of differences, the main distinctions between the two lie in flexibility and timeliness. The flexibility of distance therapy is more substantial. Distance therapy can eliminate distance and time barriers, enabling those who were previously unable to participate due to distance or schedule conflicts to continue attending [14]. Face-to-face therapy, in contrast, has the advantage of immediate interaction and feedback [13]. In-person communication enables therapists to capture non-verbal behaviour and immediately adjust treatment strategies promptly. This feedback loop can make clients feel cared for and supported, thereby enhancing their sense of engagement and commitment.

3.2. Law-like differences

When comparing the factors contributing to dropout in distance therapy versus in-person therapy, many similarities are observed. Dropout is usually concentrated in the early stage of psychotherapy [11, 12, 15]. The research by Buyruk Genç et al. shows that over half of clients terminate early from the dropout group of the counselling process, with 71% of clients quitting therapy after the first session [15]. Regarding the differences, clients in distance therapy are more likely to experience sudden interruptions. They may stop replying to emails or messages. The weakening of anonymity and sense of responsibility makes this phenomenon more common [10]. In contrast, dropouts from in-person therapy clients are more inclined to gradual interruptions. It typically progresses from being late and absent to complete termination, with external factors playing a crucial role [5, 11]. In conclusion, the core mechanism of dropout is the same, but the performance process is opposite.

The signal of low adherence in distance therapy includes reduced responses and the frequency of interactions during sessions, as well as delayed or non-submission of assignments. Therapists often regard these signs as omens of dropout, but due to the lack of face-to-face scenarios, omens are easily overlooked or delayed in discovery. The common pathway of dropout typically begins with participation, followed by a gradual decrease in interaction, and ultimately, no response at all. This

process often spans an extremely short period of time, and therapists may also be affected by sudden termination. As mechanisms, anonymity and remoteness weaken the sense of responsibility among clients, and the lack of immediate feedback facilitates a quick transition from low adherence to dropout. The process of in-person therapy, from adherence to dropout, takes more time. The dropout path is generally characterized by intermittent absence or irregular attendance, ultimately leading to termination. This dropout is relatively slow to occur in distance therapy and may last for weeks or months. External obstacles, lack of motivation, or a weak therapeutic alliance slowly accumulate and exceed the tolerance range of the clients, eventually leading to dropout. Therefore, when comparing the differences between two modes, it is evident that the speed of termination varies. However, both demonstrate that dropout and adherence represent distinct stages of an ongoing therapy process.

3.3. Intervention strategies

According to research analysis, dropout rates in remote therapy often increase the risk of interruption due to technical issues, lack of interaction, and anonymity. In-person therapy is more affected by traffic, time scheduling conflicts and practical obstacles. Adherence in both modalities demonstrates the significance of a sense of responsibility and regular participation. Adherence with distance therapy relies more on the client's self-discipline and flexible arrangement, while face-to-face therapy benefits from a fixed structure, non-verbal communication and immediate feedback. These findings suggest that although the two modalities face distinct challenges, standard mechanisms can still be employed to promote long-term participation, providing a valuable reference for enhancing counselling sessions.

Since few previous papers have statistically analyzed the platforms used for distance therapy, it is challenging to provide specific recommendations for most platforms. Both therapists and clients should ensure that the platform is stable and easy to operate, and reduce technical barriers. The platform can offer automatic reminders and simplify the appointment booking process, thereby reducing instances of dropouts with no prior notice or response, helping to transform external reminders into self-disciplined habits [1]. Therapists should establish clear rules during the first session, including a no-show policy, privacy requirements, and guidelines for the physical environment.

In-person therapy also needs to optimize the appointment and reschedule process to reduce the accumulated pressure and obstacles for clients. The therapists need to inform the client in advance of the rules regarding attendance and provide flexibility in scheduling, making attendance itself a form of behavioural activation. This structural arrangement and immediate feedback align with the behavioural activation model and therapeutic alliance theory, which explain the advantages of face-to-face therapy in maintaining adherence [6, 13].

Therapists should actively identify warning signs of low engagement (such as lateness, absences, and incomplete assignments) and set short-term, achievable goals for clients to enable a sense of achievement and accountability. Therapists should also clarify expectations and responsibilities between both parties to reduce the risk of dropout due to unrealistic expectations. Institutions and mental health clinics should establish a unified electronic attendance and reminder system to facilitate therapists in monitoring the risk of dropout, thereby determining whether adjustments to the counselling sessions are necessary. In addition, institutions can promote the hybrid model and psychoeducation or group support when necessary to collaborate with psychological counselling for treatment. These strategies aim to help institutions and policies reduce dropout and enhance adherence through service design and resource allocation.

3.4. Limitations and future directions

The paper has some limitations that need to be considered. The first and most important factor is the definition of dropout. Due to inconsistencies in the operation of the therapists or previous research, this has affected the comparisons in this study. Meanwhile, a considerable portion of the research information is derived from the reports and records of therapists or clients, which are relatively subjective and may therefore contain biases. The therapeutic approaches are also one of the limitations. Currently, the research background of the literature is primarily in the English language environment or influenced by the approaches of psychological counselling in North America. Therefore, the therapeutic approach is primarily CBT, lacking comparisons across approaches. Another limitation, also stemming from the research background, is the cultural context. Furthermore, few studies have discussed the relationship between adherence and counselling alone; therefore, this paper utilizes dropout and therapeutic alliance to assist in the analysis of adherence. For this reason, therapeutic alliances may be overemphasized, while economic, social, and cultural factors are overlooked. Different types of distance therapy, such as videoconferencing, teletherapy, and online therapy, may also impact the analysis of dropout and adherence. This paper aims to unify these models into a unified distance therapy approach. Lastly, several research studies on distance therapy discuss the relevance of COVID-19, noting that the relevant factors may have particularities.

Future studies should strive to solve these limitations. First, the field of psychological counselling should unify the concepts of dropout and distance therapy or clearly distinguish the types, and increase independent research related to adherence. Second, longitudinal studies should be conducted to track the long-term dynamics of dropout and adherence. Third, research participants should be expanded; the sample should encompass regions beyond Europe and North America, particularly those where the primary language is not English or where the culture differs significantly from that of Europe and North America. The sample should also include clients with different expectations and a wide age range. Fourth, additional therapeutic approaches should be explored beyond CBT and compared to determine whether different approaches have distinct influencing factors on dropout and adherence in both distance and in-person therapy. Finally, in-depth research should be conducted on distance therapy in non-pandemic situations, and whether hybrid therapy can reduce dropout and improve adherence should be explored.

4. Conclusion

The research objective of this paper is to compare dropout and adherence in distance and in-person psychotherapy, and to identify the similarities and differences between them. Through analysis, it was found that both modalities carry specific risks. Distance therapy is prone to dropout due to technological limitations and low interaction, while in-person therapy often increases the possibility of dropout due to external factors. However, both also have the same factors that promote adherence. Research claims that dropout and adherence are influenced not only by the counselling model itself, but also by the interaction of individual differences, the external environment, and the therapeutic alliance. Low adherence does not directly lead to dropout, but rather is a gradual process that can be observed over multiple counselling sessions. Understanding the relationship between different counselling models helps expand the existing statements of loss clients, emphasizing a multidimensional perspective rather than single causal explanations. The clinical significance of this paper lies in improving accessibility, reducing dropout rates, and enabling more clients to complete their treatment. Distance therapy requires an increase in interaction frequency, improvement in

technical support, and monitoring of low compliance signals. In-person therapy requires a flexible response to time conflicts and also enhances responsibility and therapeutic alliances. Most current studies focus on specific groups or those with special conditions, lacking integration of particular definitions and cross-cultural comparisons. Future research should build on independent studies of adherence and continue to explore the feasibility of the hybrid model. Conducting longitudinal tracking and long-term investigation also helps to monitor the dynamic processes of adherence and dropout. Additionally, researchers should focus on specific individual difference factors related to dropout and adherence, such as the level of responsibility and therapeutic motivation, and explore the roles of these factors in both models.

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