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Ranking Determinants of Therapy Dropout Among Women

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A B S T R A C T

Objective: This study aimed to identify and rank the primary determinants contributing to therapy dropout among women through an integrated mixed-method approach, highlighting the personal, relational, and systemic factors influencing discontinuation of psychological treatment.

Methods and Materials: A sequential exploratory mixed-method design was employed. In the qualitative phase, an extensive literature review was conducted until theoretical saturation was achieved, and data were analyzed using NVivo 14 to extract thematic categories and conceptual patterns. Seven main themes were identified, encompassing individual, cultural, and institutional determinants. In the quantitative phase, a structured questionnaire based on qualitative results was administered to 260 Chinese women who had prematurely discontinued therapy. Participants rated the importance of each determinant on a five-point Likert scale. Data were analyzed using SPSS 26, employing descriptive statistics, Cronbach's alpha for reliability, and Kendall's coefficient of concordance to assess consensus in ranking.

Findings: Results revealed that therapeutic relationship issues ranked as the most influential determinant (Mean = 4.62), followed by financial and logistical barriers (Mean = 4.45) and personal and psychological factors (Mean = 4.31). Systemic and institutional barriers (Mean = 4.18) and life circumstances and external stressors (Mean = 3.97) were moderately ranked, while socio-cultural constraints (Mean = 3.85) and treatment process and structure (Mean = 3.66) were identified as less decisive factors. Kendall's W indicated a high level of agreement among participants, confirming the robustness of rankings.

Conclusion: Therapy dropout among women is shaped by intertwined relational, psychological, and structural determinants, with the therapeutic relationship emerging as the most critical factor. Enhancing empathy, cultural sensitivity, financial accessibility, and flexible service design is essential to reduce attrition and promote sustained engagement in therapy.

Keywords: *Therapy dropout; Women's mental health; Therapeutic relationship; Treatment adherence*

1. Introduction

Therapy dropout remains a significant obstacle to the effectiveness of mental health interventions, particularly among women who often face unique social, cultural, and psychological pressures that affect their engagement with therapy. Globally, research has shown that despite the expansion of evidence-based psychological treatments, premature termination rates continue to range from 30% to 60%, reducing the clinical impact of interventions and increasing the burden of untreated mental health issues (Ghafoori et al., 2022). Within the complex interplay of personal, relational, and systemic factors, gender-specific determinants have gained increasing attention, as women frequently navigate intersecting challenges such as caregiving roles, stigma, emotional expectations, and resource limitations (Shafierizi et al., 2024). Understanding these factors is essential to designing interventions that not only initiate but also sustain treatment adherence and engagement.

One of the leading explanations for therapy dropout lies in the mismatch between clients' expectations and the therapeutic process itself. For instance, research indicates that early attrition peaks often occur shortly after clients begin treatment, suggesting that initial sessions are a critical juncture where perceived relevance, therapeutic alliance, and motivational readiness interact (Krendl & Lorenzo-Luaces, 2022). Women, in particular, may struggle with emotional vulnerability and self-stigma when entering therapy, which can amplify anxiety about self-disclosure or reinforce avoidance of emotionally challenging material (Kazemi et al., 2024). Moreover, when therapy does not quickly alleviate distress or fails to validate lived experiences—especially those linked to gendered social roles—many women perceive treatment as ineffective or alienating, leading to discontinuation (Milanak et al., 2023).

Socioeconomic and cultural determinants also play a substantial role in therapy dropout among women. In many societies, mental health care is not equally accessible, and women often face financial dependency, lack of autonomy, or familial disapproval when seeking treatment (Lyles-Mckelvy et al., 2024). A consistent finding across global mental health research is that lower-income women are less likely to complete therapy due to both structural and psychosocial barriers, such as time constraints, childcare responsibilities, and transport difficulties (Dhaliwal et al., 2021). In low- and middle-income contexts, gendered expectations regarding resilience, emotional suppression, and duty to others can also reinforce dropout tendencies by framing self-care as selfish or non-essential (Lakin et al., 2020). These social narratives are particularly salient in collectivist cultures, where community reputation and relational harmony often outweigh individual well-being.

At the personal and psychological level, treatment adherence is often influenced by factors such as internalized stigma, perceived treatment efficacy, and readiness for change (Kazemi et al., 2024). Many women report feeling guilty for seeking professional help or perceive mental illness as a moral weakness rather than a health condition (Bakay et al., 2025). Cognitive factors, including low verbal mental capacity and limited understanding of therapeutic concepts, may further impede engagement, particularly when therapy demands sustained reflection and metacognitive awareness (Bakay et al., 2025). Moreover, clients who experience comorbid mental health conditions—such as anxiety, depression, or trauma—tend to have fluctuating motivation and emotional regulation difficulties, which can increase vulnerability to dropout (Changchien et al., 2024). The emotional toll of therapy, particularly in trauma-focused or exposure-based modalities, often evokes avoidance mechanisms that drive premature termination.

From a clinical perspective, the therapeutic relationship remains one of the most consistent predictors of continued participation or dropout. A strong alliance characterized by empathy, validation, and collaboration enhances engagement, whereas perceived judgment or misattunement can lead to early withdrawal (Thomas et al., 2025). This is especially relevant for women, who may value emotional safety and relational consistency in therapy. Evidence from trauma-informed care shows that when therapists fail to recognize power dynamics, gendered experiences, or sociocultural contexts, clients experience alienation and mistrust (Ghafoori et al., 2022). Conversely, when therapy creates a sense of agency and empowerment, it mitigates avoidance tendencies and reinforces adherence. Thus, the relational context of therapy cannot be separated from broader gendered power structures that shape women's experiences of care.

Systemic and institutional factors also significantly influence therapy adherence. Access to affordable, culturally competent care remains a persistent challenge across regions (Boakye et al., 2024). Health infrastructure disparities—such as shortages of female therapists, long waiting lists, and insufficient public funding—compound barriers for women who already face constraints in autonomy or mobility. In many mental health systems, particularly in low-resource

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settings, service design fails to account for the realities of women's lives, such as balancing therapy attendance with employment or family obligations. Research in community-based trauma clinics indicates that institutional inefficiencies and limited flexibility in scheduling are key contributors to attrition (Ghafoori et al., 2022). Moreover, policy-level gaps in mental health coverage and the absence of supportive frameworks for vulnerable groups exacerbate gender disparities in treatment continuation.

In the digital era, the rise of online and technology-assisted interventions has been proposed as a solution to accessibility challenges. However, studies show that virtual modalities also experience high dropout rates, particularly among women managing family or fertility-related stressors (Shafierizi et al., 2024). Despite the convenience of internet-based therapy, the lack of real-time interpersonal support and motivational reinforcement can hinder sustained engagement (Esfandiari et al., 2020). Moreover, technological literacy and privacy concerns may limit participation among older or socioeconomically disadvantaged women. These findings highlight the need for hybrid models that combine accessibility with relational depth—offering both flexibility and human connection to reduce dropout tendencies.

Health-related comorbidities and social determinants of health further complicate the issue. For women experiencing chronic conditions such as HIV/AIDS, the intersection of mental and physical health poses significant challenges to consistent therapy participation (Boakye et al., 2024). Studies from Sub-Saharan Africa and Asia reveal that depressive symptoms, stigma, and side effects of medications often diminish adherence to both mental health and medical treatments (Dhaliwal et al., 2021; Lyles-Mckelvy et al., 2024). The cumulative burden of physical illness and psychological distress can erode emotional resilience, leading to disengagement from care. Additionally, stressors related to socioeconomic status, discrimination, and gender inequities intensify dropout risks, emphasizing the need for integrative, cross-sectoral mental health policies.

In recent years, scholars have increasingly recognized the transdiagnostic nature of therapy dropout, emphasizing the overlap between mechanisms of attrition across various disorders. For example, avoidance, low motivation, and perceived inefficacy appear consistently in studies on depression, anxiety, substance use, and trauma (Milanak et al., 2023). These shared mechanisms suggest that dropout is not solely a function of diagnosis but a broader reflection of psychological readiness, treatment context, and relational quality. Moreover, clients who experience sleep disturbances, substance use, or chronic anxiety often report diminished cognitive resources and emotional regulation, further contributing to disengagement (Thomas et al., 2025). Addressing dropout, therefore, requires a systemic approach that integrates psychological, social, and environmental dimensions rather than focusing narrowly on symptom reduction.

Technological and multimodal interventions offer promising but complex solutions. For instance, smartphone-based chronic pain therapy and other telehealth innovations have improved accessibility but still face high rates of attrition due to insufficient human interaction and inconsistent follow-up (Morcillo-Muñoz et al., 2022). Similarly, app-based cognitive behavioral therapies have demonstrated efficacy in controlled environments but struggle to retain participants once implemented in real-world contexts (Esfandiari et al., 2020). These findings underscore the importance of designing interventions that maintain therapeutic presence and accountability even in digital formats. Integrating peer-support models and adaptive reminders could enhance adherence while preserving patient autonomy.

The intersection of cultural, social, and institutional determinants of therapy dropout also extends to gender-specific dynamics. In many cultural contexts, masculine norms and social expectations discourage emotional expression and help-seeking, whereas women may experience overburdening responsibilities that restrict time for self-care (Lakin et al., 2020). While male reluctance is often attributed to stigma, women's dropout tends to stem from overextension, relational strain, or feelings of inadequacy for prioritizing personal needs. Furthermore, differences in the way emotional labor and caregiving roles are distributed across societies directly influence how therapy is perceived and valued (Boakye et al., 2024). Understanding these contextual nuances is critical to building equitable, gender-sensitive mental health systems.

Recent work has also emphasized the role of verbal cognitive capacity and communication in sustaining therapy adherence. Individuals with stronger verbal reasoning and self-expression skills tend to engage more effectively in therapeutic dialogues, translating to better outcomes (Bakay et al., 2025). Conversely, those with limited verbal or cognitive flexibility may find it difficult to articulate emotions or grasp abstract therapeutic principles, leading to frustration and eventual dropout. This cognitive dimension

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aligns with findings from psychiatric populations showing that both verbal reserve and perceived side effects influence overall adherence (Bakay et al., 2025). Thus, cognitive readiness and communication style should be considered key components in assessing clients' risk for attrition.

Finally, addressing therapy dropout requires a holistic understanding that bridges individual, relational, and structural dimensions of care. The growing evidence base suggests that interventions must simultaneously enhance therapeutic alliance, address socioeconomic constraints, and reduce systemic barriers such as policy gaps and service fragmentation (Boakye et al., 2024; Dhaliwal et al., 2021; Ghafoori et al., 2022). Moreover, future therapeutic innovations should focus on integrating digital flexibility with interpersonal depth, ensuring that women receive both accessibility and empathy within the treatment process (Esfandiari et al., 2020; Morcillo-Muñoz et al., 2022). The confluence of these findings highlights that therapy dropout among women is not a matter of individual failure but a reflection of systemic insufficiencies and contextual pressures that undermine sustained engagement.

The aim of this study is to identify and rank the determinants of therapy dropout among women through a mixed-method approach combining qualitative synthesis and quantitative prioritization.

2. Methods and Materials

2.1. Study design and Participant

This study employed a sequential exploratory mixed-method design conducted in two distinct phases. The first phase consisted of a qualitative content analysis aimed at identifying the key determinants of therapy dropout among women. The qualitative stage relied exclusively on a comprehensive literature review as the data source, which continued until theoretical saturation was achieved.

The second phase involved a quantitative ranking analysis, designed to prioritize the determinants identified in the qualitative phase. The quantitative stage was conducted among 260 adult women from China who had previously participated in various forms of psychological therapy, including cognitive-behavioral, psychodynamic, and humanistic approaches. Participants were selected using a purposive sampling method to ensure adequate representation of diverse age groups, educational backgrounds, and therapy experiences. Inclusion criteria required that participants be female adults (aged 18–60), have experienced at least one episode of discontinuing therapy before the planned completion, and provide informed consent.

2.2. Measures

In the qualitative phase, data were collected through a systematic review of peer-reviewed journal articles, dissertations, and conference proceedings related to female therapy dropout. Searches were conducted across major academic databases, including PubMed, Scopus, and PsycINFO, using keywords such as "therapy dropout," "treatment attrition," "women clients," and "psychotherapy adherence." Articles published between 2000 and 2025 were included to ensure a comprehensive representation of the field. Extracted textual data describing determinants of dropout were imported into NVivo 14 software for coding and analysis. The process continued until no new categories emerged, confirming theoretical saturation.

In the quantitative phase, the list of determinants derived from the qualitative synthesis was converted into a structured questionnaire. Respondents rated each determinant's importance on a five-point Likert scale ranging from "very low" (1) to "very high" (5). Data were collected online via secure survey platforms to ensure participant accessibility and confidentiality.

2.3. Data Analysis

For the qualitative data, a thematic content analysis was conducted using NVivo 14 to code and categorize textual data into meaningful themes and subthemes. Repeated patterns and conceptual relationships among the determinants were identified through iterative coding, memoing, and comparison techniques. The emergent themes were organized into conceptual clusters representing personal, relational, and systemic determinants of therapy dropout among women.

In the quantitative phase, data analysis was performed using SPSS version 26. Descriptive statistics (mean, standard deviation, and frequency) were first computed to summarize the demographic data and overall ratings. Next, the identified determinants were ranked according to their mean scores to determine their relative significance. Reliability of the instrument was assessed using Cronbach's alpha coefficient, ensuring internal consistency. Additionally, inferential analyses such as Kendall's coefficient of concordance (W) were applied to measure the degree of agreement among participants regarding the ranking of determinants.

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3. Findings and Results

In the qualitative phase, a comprehensive review of the literature was undertaken to explore the multifaceted determinants of therapy dropout among women. Through systematic coding and conceptual clustering using NVivo 14, seven overarching themes emerged, reflecting the complex interplay between personal, relational, structural, and cultural factors influencing women's decisions to discontinue therapy. Each theme comprised multiple subthemes, which in turn contained several conceptual codes derived from repeated patterns and theoretical constructs within the reviewed studies. The analysis continued until theoretical saturation was achieved, ensuring that no new relevant categories emerged.

Table 1

Main Themes, Subcategories, and Concepts of Determinants of Therapy Dropout Among Women

Main Themes (Categories)	Subcategories	Concepts (Open Codes)
1. Personal and Psychological Factors	Emotional Avoidance	Fear of emotional exposure; Shame in discussing trauma; Avoidance of painful memories; Difficulty tolerating distress
	Low Motivation for Change	Lack of readiness for therapy; Passive attitude toward recovery; Ambivalence about improvement
	Self-Stigma and Guilt	Internalized stigma; Feeling undeserving of help; Self-blame for needing therapy
	Perceived Inefficacy of Therapy	Feeling therapy is not working; Loss of hope; Skepticism toward psychological treatment
2. Socio-Cultural Constraints	Gender Role Expectations	Pressure to prioritize family; Cultural ideal of emotional restraint; Perception that therapy is "selfish"
	Social Stigma	Fear of being labeled "unstable"; Gossip or social judgment; Confidentiality concerns
	Religious or Moral Beliefs	Belief in self-reliance through faith; Guilt about secular therapy; Reliance on prayer instead of therapy
3. Financial and Logistical Barriers	Therapy Costs	High session fees; Lack of insurance coverage; Hidden treatment costs
	Accessibility and Time Constraints	Long travel distances; Work–family conflict; Inconvenient appointment times
4. Therapeutic Relationship Issues	Therapist–Client Mismatch	Lack of empathy; Incompatibility of communication styles; Misalignment in goals
	Lack of Trust	Fear of judgment; Feeling misunderstood; Breach of confidentiality
	Power Imbalance	Therapist dominance; Lack of collaboration; Client feeling silenced
	Cultural Insensitivity	Ignoring gendered experiences; Cultural stereotypes in interpretation; Dismissal of women's narratives
5. Treatment Process and Structure	Inflexible Session Format	Rigid scheduling; Insufficient session time; Lack of individualized approach
	Unclear Therapeutic Goals	Confusion about treatment direction; Lack of measurable progress; Weak feedback mechanisms
	Therapy Duration Fatigue	Perceived excessive length; Declining engagement over time; Therapy burnout
6. Life Circumstances and External Stressors	Family Responsibilities	Childcare burden; Elderly care duties; Lack of spousal support
	Work and Academic Pressure	Overtime workload; Academic deadlines; Conflict between therapy and employment
	Unstable Living Conditions	Relocation; Financial instability; Domestic conflict or violence
	Health-Related Issues	Chronic illness; Medication side effects; Physical fatigue
7. Systemic and Institutional Barriers	Lack of Mental Health Awareness	Limited psychoeducation; Misconceptions about therapy; Poor dissemination of information
	Inadequate Service Infrastructure	Shortage of female therapists; Long waiting lists; Overcrowded public clinics
	Policy and Insurance Limitations	Lack of mental health coverage; Bureaucratic obstacles; Limited institutional support

The first theme, *personal and psychological factors*, encompassed the internal processes and emotional barriers that influence women's decisions to discontinue therapy. Many women experienced intense emotional avoidance, feeling overwhelmed by the prospect of revisiting traumatic memories or confronting distressing emotions during sessions. Shame, guilt, and self-stigma often compounded these feelings, leading them to perceive therapy as a sign of weakness or personal failure. Low motivation for change and ambivalence about the value of treatment were also recurrent patterns, particularly among those who felt uncertain about their capacity for recovery or doubted the

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efficacy of therapy. When perceived therapeutic benefits failed to meet expectations, feelings of hopelessness and futility often culminated in premature termination.

The second theme, *socio-cultural constraints*, reflected how cultural norms and social expectations shaped women's engagement with mental health services. Deeply rooted gender role expectations often pressured women to prioritize caregiving and family responsibilities over personal well-being. Within some cultural contexts, attending therapy was viewed as self-centered or incompatible with ideals of emotional restraint and endurance. Social stigma also played a powerful role, as fear of gossip or being labeled "unstable" discouraged open help-seeking. Furthermore, religious or moral beliefs sometimes served as both a coping mechanism and a deterrent, with some women viewing reliance on therapy as conflicting with faith-based ideals of self-reliance or divine healing.

The third theme, *financial and logistical barriers*, captured the practical challenges that limited sustained participation in therapy. High session fees, lack of insurance coverage, and the hidden costs of transportation or childcare created financial strain, particularly for women in lower-income households. Even when financial means were available, logistical barriers such as long travel distances, rigid scheduling, and competing work–family demands frequently interfered with regular attendance. These constraints often led women to deprioritize therapy in favor of immediate responsibilities, underscoring the need for more flexible and accessible treatment models.

The fourth theme, *therapeutic relationship issues*, emerged as one of the most influential determinants of therapy dropout. Many women reported disengagement when they perceived their therapist as lacking empathy, cultural understanding, or emotional attunement. A mismatch in communication styles or therapeutic goals often led to frustration and erosion of trust. Feelings of judgment, condescension, or emotional distance from therapists contributed to relational rupture. Additionally, perceived power imbalances—where therapists dominated the therapeutic process or invalidated clients' perspectives—exacerbated client resistance and dissatisfaction. Cultural insensitivity, particularly when therapists dismissed gender-specific experiences or relied on stereotypes, further alienated female clients from continuing therapy.

The fifth theme, *treatment process and structure*, related to the procedural and design aspects of therapy that affected women's continuity of participation. Inflexible session formats and rigid therapeutic protocols often failed to accommodate clients' dynamic needs or life circumstances. Unclear therapeutic goals and insufficient feedback left many women uncertain about their progress, weakening their sense of purpose in therapy. Furthermore, the duration of therapy sometimes contributed to dropout, as clients grew fatigued or discouraged when progress seemed slow or intangible. These findings highlight the importance of individualized pacing and collaborative goal-setting to maintain engagement.

The sixth theme, *life circumstances and external stressors*, emphasized the situational pressures that disrupt therapy continuity. Many women juggled multiple roles as caregivers, professionals, and students, which limited their emotional and temporal availability for consistent therapeutic work. Family responsibilities, workplace obligations, and financial instability often created conflicting priorities. For others, health problems or domestic instability—such as relocation, relationship conflict, or violence—made sustained therapy attendance nearly impossible. These external stressors, though often outside the therapist's control, profoundly shaped women's capacity to commit to the therapeutic process.

The final theme, *systemic and institutional barriers*, addressed the structural inequities embedded within mental health systems. Many participants highlighted the lack of accessible mental health education, which perpetuated misconceptions about therapy and delayed help-seeking. Institutional shortcomings—such as a shortage of female therapists, long waiting lists, and overcrowded clinics—undermined the quality and continuity of care. Policy-related limitations, including inadequate insurance coverage and bureaucratic inefficiencies, further restricted women's ability to sustain treatment. Collectively, these systemic deficiencies reinforced cycles of underutilization and dropout, suggesting that improving institutional infrastructure and public awareness is essential to promoting sustained engagement in therapy among women.

In the second phase, the determinants identified from the qualitative synthesis were transformed into measurable items for quantitative assessment. A total of 260 Chinese women who had discontinued therapy were surveyed to rate the importance of each main determinant on a five-point Likert scale. The collected data were analyzed using SPSS version 26, and the mean scores of each thematic category were calculated to determine their relative ranking. This phase provided a data-driven prioritization of the most influential factors contributing to therapy dropout among women.

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Table 2

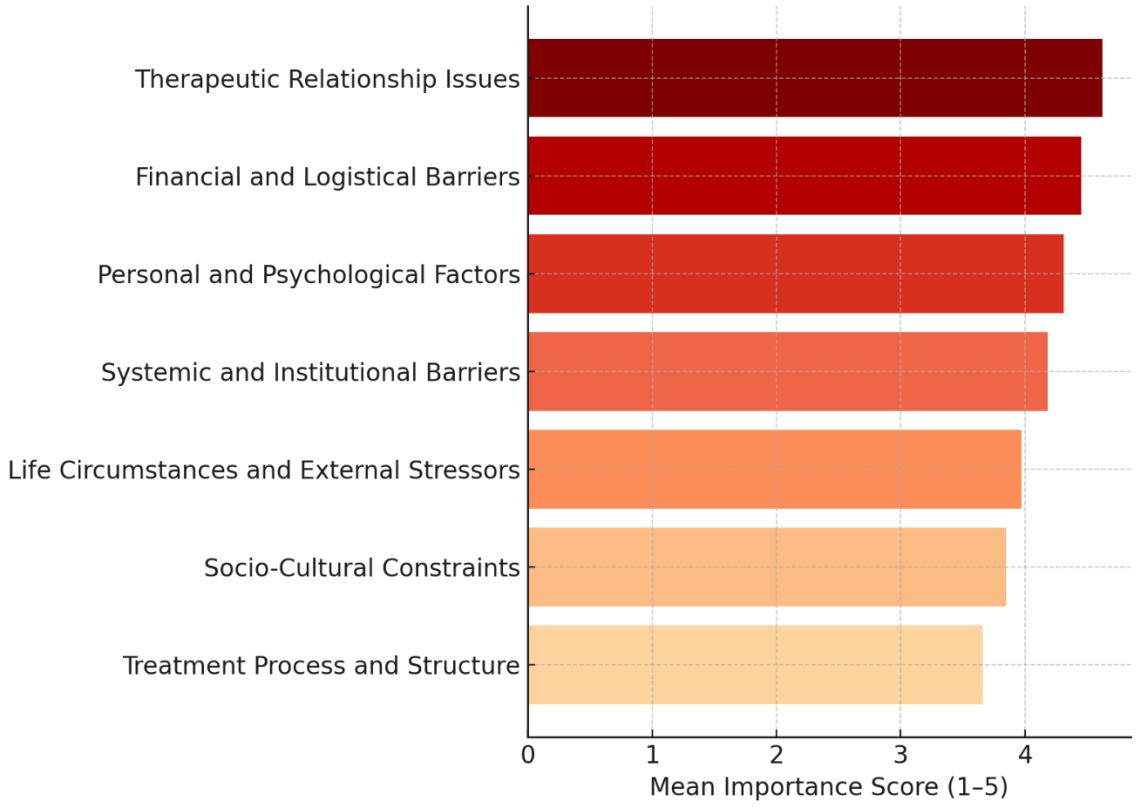
Ranking of Main Determinants of Therapy Dropout Among Women

Rank	Main Themes (Determinants)	Mean Score (1–5)
1	Therapeutic Relationship Issues	4.62
2	Financial and Logistical Barriers	4.45
3	Personal and Psychological Factors	4.31
4	Systemic and Institutional Barriers	4.18
5	Life Circumstances and External Stressors	3.97
6	Socio-Cultural Constraints	3.85
7	Treatment Process and Structure	3.66

The ranking results revealed that therapeutic relationship issues were perceived as the most influential determinant of therapy dropout among women, with the highest mean score of 4.62. This highlights the central role of therapist–client dynamics in sustaining engagement. Financial and logistical barriers ranked second, emphasizing the economic and temporal constraints faced by many women in accessing consistent care. Personal and psychological factors followed closely, reflecting the influence of internal motivation, self-stigma, and perceived treatment efficacy. Structural and institutional issues, including limited resources and inadequate policies, occupied the middle ranks, while life stressors and socio-cultural norms further contributed to discontinuation. Finally, treatment process and structure—though relevant—was perceived as the least decisive factor, suggesting that interpersonal and systemic elements weigh more heavily than procedural ones in dropout decisions.

Figure 1

Ranking of Determinants of Therapy Dropout Among Women



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4. Discussion and Conclusion

The present study sought to identify and rank the key determinants contributing to therapy dropout among women using a mixed-method approach that combined qualitative content analysis and quantitative prioritization. The results revealed that the most influential determinant was therapeutic relationship issues, followed by financial and logistical barriers, personal and psychological factors, systemic and institutional barriers, life circumstances and external stressors, socio-cultural constraints, and treatment process and structure. These findings underscore the multifaceted nature of therapy dropout and highlight the importance of relational, structural, and individual dimensions in sustaining engagement among women. The results are consistent with the growing body of literature emphasizing the interplay between internal motivation, therapist–client dynamics, and contextual factors that influence treatment adherence (Ghafoori et al., 2022; Kazemi et al., 2024; Thomas et al., 2025).

The dominance of therapeutic relationship issues as the highest-ranked factor aligns with previous research that identifies the therapeutic alliance as one of the strongest predictors of treatment retention and positive outcomes. Women often value empathy, trust, and collaboration as key elements in feeling emotionally safe and understood during therapy (Thomas et al., 2025). When these relational qualities are absent—such as in cases of perceived therapist judgment, power imbalance, or emotional distance—clients may disengage prematurely. The results parallel findings from trauma-focused studies, where relational ruptures and perceived invalidation were among the leading causes of dropout (Ghafoori et al., 2022). Furthermore, women in this study emphasized the importance of cultural sensitivity and gender awareness, echoing evidence that therapy perceived as dismissive of women's lived experiences fosters emotional withdrawal and resistance (Lakin et al., 2020). Taken together, these findings suggest that the therapeutic relationship functions not only as a treatment component but also as a social and emotional context where gendered experiences of power and vulnerability are negotiated.

The second most significant determinant, financial and logistical barriers, highlights the structural inequities that continue to limit women's sustained engagement in therapy. High session fees, transportation challenges, and conflicting work–family responsibilities were identified as major obstacles to continuity. These findings resonate with evidence from multiethnic and global samples showing that socioeconomic stress, gendered caregiving roles, and lack of flexible scheduling contribute to mental health service attrition (Boakye et al., 2024; Dhaliwal et al., 2021). The results also reflect patterns observed in community and public health contexts where women—particularly those with dependents—are more likely to discontinue therapy due to competing life demands and insufficient institutional support (Lyles-Mckelvy et al., 2024). The emphasis on logistical accessibility further supports the need for hybrid service delivery models, including teletherapy options, which can mitigate geographic and temporal constraints (Esfandiari et al., 2020). However, as noted in digital treatment studies, online modalities also face high dropout rates if relational continuity and motivational reinforcement are lacking (Morcillo-Muñoz et al., 2022; Shafierizi et al., 2024).

Personal and psychological factors, ranked third, encapsulate the emotional, cognitive, and motivational barriers that influence therapy persistence. Many women in this study described feelings of shame, fear of vulnerability, and low readiness for change as central to their disengagement. These findings correspond with prior studies that link internalized stigma and emotional avoidance to early therapy termination (Kazemi et al., 2024). Women who perceive therapy as self-indulgent or morally questionable—especially in collectivist or religiously conservative cultures—may internalize guilt about focusing on personal distress (Lakin et al., 2020). Moreover, emotional regulation difficulties and cognitive exhaustion associated with anxiety and depression often hinder the sustained effort required for therapy participation (Milanak et al., 2023). As previous research indicates, ambivalence toward therapy outcomes and perceived inefficacy also reduce adherence, especially when clients experience minimal short-term relief (Krendl & Lorenzo-Luaces, 2022). These results reinforce the importance of assessing clients' motivational stages and emotional readiness before initiating therapy, as early alignment of expectations can significantly reduce attrition rates.

The study also identified systemic and institutional barriers as an influential determinant of therapy dropout. Limited access to affordable care, insufficient mental health literacy, and the scarcity of culturally competent female therapists were recurrent themes. Such institutional deficiencies mirror global mental health challenges described in recent literature, where service fragmentation and lack of public investment impede treatment continuity

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(Boakye et al., 2024; Ghafoori et al., 2022). In community-based trauma clinics, for instance, long waiting lists and administrative inefficiencies have been directly linked to dropout among female survivors of violence (Ghafoori et al., 2022). Furthermore, the absence of insurance coverage for mental health services remains a pervasive barrier across both high-income and low-income countries. The persistence of these institutional gaps underscores the need for policy-level interventions aimed at improving funding structures, expanding workforce capacity, and ensuring equitable service distribution.

The fifth-ranked category, life circumstances and external stressors, reflects how situational factors—such as family obligations, employment strain, and health-related challenges—contribute to therapy discontinuation. The findings demonstrate that many women's therapeutic engagement is constrained not by unwillingness but by contextual pressures beyond their control. Similar conclusions were drawn in studies examining mental health adherence among women living with chronic illnesses such as HIV/AIDS, where daily survival demands often supersede the continuity of psychological care (Boakye et al., 2024; Dhaliwal et al., 2021). Moreover, research on social determinants of health shows that unstable housing, financial insecurity, and caregiving overload exacerbate psychological fatigue and time scarcity, thereby heightening dropout risk (Lyles-Mckelvy et al., 2024). These cumulative life stressors create a cycle of competing priorities, highlighting the necessity of integrated care systems that address both mental and social well-being.

Although socio-cultural constraints ranked sixth, their impact remains substantial, especially within cultural frameworks that discourage emotional expression or frame therapy as a deviation from traditional gender roles. The findings confirm that stigma surrounding mental illness and therapy continues to inhibit women's willingness to remain in treatment (Kazemi et al., 2024). In patriarchal or collectivist settings, the prioritization of family harmony over personal growth can lead women to internalize distress rather than seek sustained professional help (Lakin et al., 2020). Cross-cultural analyses also reveal that women who face social judgment for participating in therapy are more likely to discontinue once confidentiality fears or gossip emerge (Boakye et al., 2024). These results suggest that addressing therapy dropout requires not only clinical interventions but also public education campaigns to normalize psychological help-seeking among women.

Finally, treatment process and structure was ranked as the least influential determinant, though still relevant to therapy engagement. Participants reported dissatisfaction with rigid session formats, unclear treatment goals, and lack of perceived progress as reasons for disengagement. These procedural challenges resonate with findings from digital and face-to-face therapy studies showing that poorly defined objectives and insufficient feedback loops reduce clients' sense of purpose and control (Esfandiari et al., 2020; Morcillo-Muñoz et al., 2022). Research on internet-based CBT adherence among women facing fertility-related distress similarly demonstrated that unclear structure and limited personalization contributed to low engagement (Shafierizi et al., 2024). Moreover, therapeutic fatigue from prolonged or repetitive sessions often led to emotional burnout and loss of motivation (Milanak et al., 2023). These findings underscore the importance of adaptive therapy designs that allow flexibility, periodic reassessment, and collaborative goal-setting to enhance retention.

Overall, the results of this study support a multidimensional understanding of therapy dropout among women. The high prioritization of relational, structural, and psychological factors indicates that discontinuation is not a unidimensional phenomenon but rather an emergent outcome of interrelated experiences across personal and environmental domains. Aligning with previous findings, the data confirm that both micro-level (e.g., therapist empathy, emotional readiness) and macro-level (e.g., policy, access, stigma) variables interact dynamically to shape women's therapeutic engagement (Boakye et al., 2024; Ghafoori et al., 2022; Thomas et al., 2025). The integration of qualitative and quantitative methods in this study allowed for a nuanced understanding of these determinants, providing empirical evidence to inform both clinical and policy-level strategies.

5. Limitations and Suggestions

Despite its contributions, this study has several limitations. First, although the mixed-method design enhanced depth and generalizability, the reliance on self-report data in the quantitative phase may have introduced subjective bias. Participants' retrospective evaluations of therapy dropout could have been influenced by memory distortion or emotional reinterpretation of past experiences. Second, the sample was geographically limited to women in China, which may restrict cross-cultural applicability, particularly in contexts with differing health infrastructure

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and gender norms. Third, the qualitative phase relied on secondary data through literature review rather than direct interviews, potentially limiting the richness of firsthand emotional narratives. Finally, while the ranking analysis identified the relative importance of determinants, it did not examine causal relationships or potential interactions among variables, which future longitudinal or experimental studies could address.

Future research should explore therapy dropout through cross-cultural and longitudinal designs that capture temporal dynamics and contextual variability. Incorporating real-time monitoring of therapy engagement—such as digital tracking of session attendance or communication frequency—could yield more objective indicators of attrition patterns. Studies should also focus on intervention-based approaches, such as testing therapist training programs that enhance empathy, cultural competence, and gender sensitivity. Moreover, integrating structural equation modeling or path analysis could reveal mediating mechanisms between relational, personal, and institutional determinants. Finally, future work should investigate the moderating effects of digital literacy and socioeconomic status on therapy adherence, particularly as hybrid care models continue to expand globally.

Clinicians and policymakers should design gender-responsive therapeutic systems that address the relational and structural dimensions of dropout identified in this study. Therapists must prioritize building trust, validating lived experiences, and adopting culturally sensitive communication styles. Flexible scheduling, childcare support, and sliding-scale payment systems could reduce financial and logistical burdens that disproportionately affect women. Health institutions should invest in expanding the female mental health workforce, particularly in underserved regions, to enhance comfort and accessibility. At the systemic level, integrating public education campaigns to normalize therapy and reduce stigma could strengthen community support for mental health engagement. Ultimately, sustainable change will require a collaborative effort between clinical professionals, social services, and policymakers to create environments where women can pursue therapy without social, economic, or institutional barriers.

Authors' Contributions

Authors contributed equally to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

References

Bakay, H., Karaağaç, M., Yaman, N. O., & Gıca, Ş. (2025). Verbal Mental Capacity and Medication Adherence in Psychiatric Outpatients: The Impact of Verbal Cognitive Reserve and Side Effects. *Neuropsychiatric Investigation*, *63*(1), 1-7. https://doi.org/10.5152/neuropsychiatricinvest.2025.25045

Boakye, D. S., Setordzi, M., Dzansi, G., & Adjorlolo, S. (2024). Mental Health Burden Among Females Living With HIV and AIDS in Sub-Saharan Africa: A Systematic Review. *Plos Global Public Health*, *4*(2), e0002767. https://doi.org/10.1371/journal.pgph.0002767

Changchien, T.-C., Hsieh, T.-J., & Yen, Y. C. (2024). Erectile Dysfunction Among Male Patients Receiving Methadone Maintenance Treatment: Focusing on Anxiety-Related Symptoms. *Sexual Medicine*, *12*(4). https://doi.org/10.1093/sexmed/qfae052

Dhaliwal, J. S., Chan, L. G., Goh, J., Koh, K. H. E., & Wong, C. S. (2021). Mental Health and Implications for Antiretroviral Adherence in a Multiethnic Asian Cohort. *Sexually Transmitted Infections*, *98*(7), 497-502. https://doi.org/10.1136/sextrans-2021-055153

Esfandiari, N., Mazaheri, M. A., Sadeghi-Firoozabadi, V., & Cheraghi, M. (2020). Internet-Delivered vs Face-to-Face Cognitive Behavior Therapy for Anxiety Disorders: Systematic Review and Meta-Analysis (Preprint). https://doi.org/10.2196/preprints.18275

Ghafoori, B., Matos, M., & Gonçalves, M. (2022). Dropout From Evidence-based Trauma Treatment in a Community Mental Health Clinic Serving Victims of Interpersonal Violence.

PWJ Psychology of Woman Journal
E-ISSN: 3041-8615

Journal of Traumatic Stress, *35*(3), 1025-1041. https://doi.org/10.1002/jts.22811

Kazemi, F., Omidi, F., Shahmoradi, Z., Ranjbaran, F., & Tajerian, A. (2024). Internalized Stigma and Adherence to Treatment Among Outpatients With Mental Illness. *Iranian journal of psychiatry and behavioral sciences*, *18*(1). https://doi.org/10.5812/ijpbs-139384

Krendl, A. C., & Lorenzo-Luaces, L. (2022). Identifying Peaks in Attrition After Clients Initiate Mental Health Treatment in a University Training Clinic. *Psychological Services*, *19*(3), 519-526. https://doi.org/10.1037/ser0000469

Lakin, D. P., Win, K. S., Aung, H., Soe, K. N. C., Kyi, B., Marcell, A. V., Tol, W. A., & Bass, J. (2020). Masculinity and Mental Health Treatment Initiation for Former Political Prisoners in Yangon, Myanmar – A Qualitative Investigation. https://doi.org/10.21203/rs.3.rs-18159/v3

Lyles-Mckelvy, S., Wiafe, A., Zhang, X., Gupta, M. D., Hanna, M., Lee, H., Mejia, R., & Morton, K. R. (2024). Examining Social Determinates of Health in Adult Sickle Cell Disease Patients. *Blood*, *144*(Supplement 1), 7678-7678. https://doi.org/10.1182/blood-2024-211727

Milanak, M. E., Witcraft, S. M., Park, J. Y., Hassell, K., McMahon, T., & Wilkerson, A. K. (2023). A Transdiagnostic Group Therapy for Sleep and Anxiety Among Adults With Substance Use Disorders: Protocol and Pilot Investigation. *Frontiers in Psychiatry*, *14*. https://doi.org/10.3389/fpsyt.2023.1160001

Morcillo-Muñoz, Y., Sánchez-Guarnido, A. J., Calzón-Fernández, S., & Baena-Parejo, I. (2022). Multimodal Chronic Pain Therapy for Adults via Smartphone: Randomized Controlled Clinical Trial (Preprint). https://doi.org/10.2196/preprints.36114

Shafierizi, S., Basirat, Z., Nasiri-Amiri, F., Kheirkhah, F., Geraili, Z., Pasha, H., & Faramarzi, M. (2024). Predictors of Nonresponse to Treatment and Low Adherence to Internet-Based Cognitive Behavioral Therapy in Depressed/Anxious Women Facing the Couple's Fertility Problems: A Secondary Analysis of a Randomized Control Trial. *BMC psychiatry*, *24*(1). https://doi.org/10.1186/s12888-023-05484-3

Thomas, M., Bramoweth, A. D., Seo, Y. J., Buysse, D. J., & Soreca, I. (2025). Evaluating Participation in Cognitive-Behavioral Therapy for Insomnia in Veterans Using Electronic Health Records. *Sleep*, *48*(Supplement_1), A256-A256. https://doi.org/10.1093/sleep/zsaf090.0587