Why Do Patients Discontinue Psychoanalytic Psychotherapy from a Low-Fee Clinic

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Abstract

Patient discontinuation is explored using a mixed method study design in a sample of 188 patients from a low-fee clinic in Melbourne, Australia, offering 24 months of twice-weekly psychoanalytic psychotherapy. Patients were separated into three groups: those who discontinued during assessment (session 1-4) (Group 1), those who discontinued during therapy proper (Group 2), and therapy completers (Group 3). In Phase 1, patients' baseline scores on the NEO-FFI, BSI, and CORE-OM were analysed using one-way analysis of variance. Higher levels of paranoid ideation, global distress and poorer life and social functioning were found in Group 1 compared to Group 2. There were no other differences between groups on these measures. In Phase 2 of the study, thematic analysis was used to analyse interview notes from 20 patients who discontinued. The results suggest that perception of the clinic setting, individual characteristics of the therapist, therapist style or technique, the therapeutic alliance and dissatisfaction with therapy process and outcomes, have more of an influence on discontinuation than patient factors.

Declaration

I, Jessica Cooke, declare that the Doctor of Psychology (Clinical) thesis entitled **Why do Patients Discontinue Psychoanalytic Psychotherapy from a Low-Fee Clinic** is no more than 60,000 words in length, exclusive of tables, figures, appendices, and references. This thesis contains no material that has been submitted previously, in whole or part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature: 

Date: 24/5/2016

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Chapter 1: Introduction

Premature Termination

Not all psychotherapy endings are planned or successfully negotiated (Ogrodniczuk, Joyce, & Piper, 2005). Unexpected endings are generally referred to as 'premature terminations' in the psychological literature. Patient-initiated premature termination, also known as unilateral termination, is when a patient makes the decision to end psychotherapy against the therapist's current recommendations and the original agreement between patient and therapist (Kazdin, 1996; Ogrodniczuk et al., 2005). Usually the termination process is negotiated between patient and therapist, but Ogrodniczuk and colleagues (2005) propose that if one party disagrees about the date that therapy should end, this can be classed as unilateral premature termination. It is necessary to clarify that premature termination, which occurs in the midst of therapy in an unplanned fashion, is distinct from termination that occurs during the initial assessment phase, which is more appropriately described as disengagement, or during the later 'termination phase' of therapy (Van Denburg & Van Denburg, 1992). In psychodynamic therapy the termination phase is the final stage of the therapy process that typically lasts a number of months, and allows the patient to process the impending separation and ending of the therapeutic relationship, and is characterised by its own distinct set of issues.

Premature termination has been recorded and discussed in the psychological literature since the beginning of psychoanalysis. For example, Freud described his disappointment when Dora, suddenly and without warning, decided to terminate analysis (Freud, 1905e). The unexpected nature of her departure left him to grapple with this experience for some

time afterwards. Dora's case had a considerable flow on effect because it contributed to Freud's understanding of the transference, its potential to disturb treatment, and the importance of negotiating endings (Firestein, 1982). However, as Freud experienced with Dora, one of the realities of psychological treatment is that many patients leave prior to the intended or agreed upon time.

The definition of premature termination changes depending on the therapy type because each therapeutic approach differs in its treatment objectives. For example, premature termination will be viewed differently in short-term crisis intervention work or brief psychotherapy, than in long term, open-ended psychotherapy. In each of these circumstances the expectations of the patient and therapist, as well as the criteria for success vary markedly; as such the definition of premature termination will be context dependent (Ogrodniczuk et al., 2005).

Discontinuation

In psychology the term 'termination' is widely used and interchanged with 'attrition', 'dropout', 'disengagement' and various other nomenclatures (Bischoff & Sprenkle, 1993). To avoid confusion between the technical phase of termination in psychoanalysis, and the termination that occurs prematurely during psychotherapy, the less complicated expression 'patient discontinuation' will be used here to describe the end of therapy. Discontinuation is not bound by any assumptions, it simply means that the patient left therapy. Due to waiting list pressures and funding issues, arbitrary institution-imposed time lengths on psychotherapy are common. Some therapies reach their natural conclusion prior to externally predicted time frames. In these cases the term patient

discontinuation is more appropriate than premature termination; the latter assumes there is more work to be done and the person is leaving prior to completing it.

It is also worth stating that while some patients discontinue therapy prior to the therapist's recommendation, they can still experience success, reach many of their goals, resolve some of their problems, improve their functioning, and are pleased with the service they receive (Ogrodniczuk et al., 2005). These authors note that some premature endings are quite appropriate because patients are required to move location, become physically ill, or their financial situation changes. Despite making genuine gains in therapy they are unable to continue. Discontinuation is thus a more inclusive description that captures all possible explanations that patients may have for leaving therapy early.

In psychotherapy, patient discontinuation is often a by-product of therapeutic failure. Hence, a thorough discussion of patient discontinuation needs to include an exploration this issue. The following section will outline the complex and contentious nature of therapeutic failure and therapeutic success, before turning to a more nuanced look at the current literature on patient discontinuation. The term 'psychotherapy' will be used to encapsulate all forms of psychological treatment from cognitive-behavioural right through to psychoanalytic therapies.

Therapeutic Success

What exactly are psychotherapists striving to achieve with their patients? The very word 'patient', which comes from the Latin word meaning 'to suffer', is suggestive of the aim to alleviate pain and distress. One aspect of psychotherapy is certainly about emotional pain relief, although what constitutes success has been widely debated since the birth of

psychotherapy. Initially Freud used the broad definition of promoting the patient's capacity to love and work, and securing the "best possible psychological functions of the ego" (Freud, 1964, p. 250). According to Gold and Stricker (2011), this is still very relevant one century later. They argue that a more specific definition of success is unfeasible due to its inherent subjectivity, and its dependence on context and theoretical standpoint. For example, Bion viewed success as the capacity to face emotional pain rather than avoid it, while from a Kleinian viewpoint success may be the integration of disavowed parts of the personality (Wittenberg, 1999). Most patients would agree they have succeeded in therapy if they feel better, get more from life, improve their functioning at work, in relationships, and increase their self-understanding (Gold & Stricker, 2011). In agreement with this view, Joyce, Piper and Klein (2007) contend that therapeutic success occurs when the patient and therapist both agree to end therapy because presenting symptoms have abated, therapeutic goals have been reached, and patient distress has been reduced to a manageable level. Traditionally, psychoanalytic therapies have been more concerned with increasing self-awareness, self-understanding, and bringing about characterological change through resolution of unconscious conflicts, while cognitive-behavioural therapies have been primarily focused on symptom improvement (Gold & Stricker, 2011). In psychoanalytic therapy, the therapist is not aiming solely for symptom removal, but is seeking to understand why patients may need their symptoms, and also explore what might happen if they were to relinquish them (Ivey, 1999).

The importance of the therapeutic alliance is heavily emphasised in the literature on therapeutic success. For example, Gold and Stricker (2011) propose that success is achieved when a strong, positive alliance is established very early in the relationship and

maintained throughout treatment. There is compelling evidence supporting the link between an early and strong therapeutic alliance with advantageous patient outcomes (Horvath, Del Re, Flückiger, & Symonds, 2011; Safran & Muran, 2000). The formation of a sturdy alliance that promotes respect, care and acceptance facilitates the patient's sense of safety and comfort, and therefore allows them to self-disclose personal information and explore parts of themselves that may otherwise be hidden or unrecognised (Watson, 2011). While therapists must have the right attitude and qualities to foster such an alliance, there are also certain patient factors associated with success and quick response in psychotherapy. Watson (2007) reported that patients are more likely to be successful if they engage easily in a productive therapeutic relationship, are ready for change, are action oriented, self-disclose readily, are self-focused rather than other-focused, use insights gained in therapy, practice what they learn in sessions, are cognitively flexible, and are able use social networks or resources. While the association between the therapeutic alliance and outcome in individual psychotherapy is the most robust predictor of therapeutic success, it only accounts for approximately 7.5% of the general variance in treatment outcomes (Horvath et al., 2011).

In psychoanalytic terms, the ultimate therapeutic success is associated with the resolution of our most basic conflict, which is not easily attained. Freud was somewhat pessimistic that one could reach this depth of resolution in therapy, and referred to psychoanalysis as the "impossible profession", because normality itself is relative and defined by intrapsychic conflict (Sandler, Person, & Fonagy, 1991). Freud argued that the possibility of success depended on the intensity of a person's drives, the severity of their early traumas, and the degree of ego distortion produced by their defensive structures (Sandler et al., 1991). In his paper, Bugental (1988) supports Freud's view that success and failure

in psychotherapy are open to interpretation and therefore ultimately do not exist in their pure form. Instead he claimed that "every course of therapy has some elements of success and some of failure" (p. 532).

If the concept of success is only an ideal, then it is possible that the concept of therapy completion is also an ideal. Perhaps a more appropriate assumption is that a natural and practical ending is essential at some point in psychotherapy. After this it is hoped that the patient's life is improved, though the improvement may be less than perfect. Despite the ambitious intentions of psychotherapists, some patient progress that may be considered success is very modest. For example, success may be as simple as keeping a patient in therapy beyond the initial assessment period. Regardless of how therapeutic success is measured, the key underlying factor in any definition is psychological change; change in the form of symptoms, behaviours, defences, maladaptive patterns, relationships, conflicts, or insight.

How many sessions is enough for therapeutic change? To determine a finite number of psychotherapy sessions or the duration of psychotherapy required to elicit change is extremely difficult, due to the individual manifestations of psychopathology, and idiosyncratic ways in which change can be measured and expressed in patients. Recent effectiveness research on a large sample of 10,000 patients found that in 50% of cases, 21 sessions were needed for patients reach criteria for clinically significant improvement (Lambert, Hansen, & Finch, 2001). Effectiveness research aims to understand patient change in real world clinical settings which is more generalizable than clinical trials research. In Lambert et al.'s study (2001), the criteria for clinically significant improvement was based on patient's self-reported change on a measure of subjective

discomfort, interpersonal relationships and social role functioning. This extensive research provided strong evidence for a dose-effect relationship in psychotherapy where the benefits increase for patients who stay longer in treatment. In support of this research, Nuetzel and Larsen (2012) established that patients who persisted with therapy for over one year had increasing levels of optimism, more positive affect, felt better, and were able to form a stronger therapeutic bond with their therapist. Despite evidence that patients do better if they are engaged longer, the average length of therapy is surprisingly short. Garfield (1994) estimated that the median duration of psychotherapy in the United States was about five to eight sessions. He reviewed studies that looked at outpatient clinic records, and large community samples asking whether people had engaged in psychotherapy, and if so for what length of time. Garfield (1994) reported that approximately 60% of people left by the tenth session, and under 10% of people completed more than 25 sessions. These findings highlight a serious discrepancy between the number of sessions required for therapeutic change and the average length of treatment. Finding ways to reduce discontinuation represents a significant ongoing challenge for psychotherapists.

Therapeutic Failure

Discontinuation is often the end result of therapeutic failure. If therapeutic success is associated with change in the patient's presentation, then therapeutic failure must be defined by either no change or further patient deterioration. Unfortunately, not all people benefit from psychotherapy, and one type of therapeutic approach does not suit everyone. There is a small cohort of people (5-10%) for whom psychotherapy is not effective and who actually get worse as a consequence of it (Lambert, 2011). There is also a group

often referred to as the "non-responders", who shift very slowly in psychotherapy and may not experience any change until after it has ended (Watson, 2011). Therapy 'fit' is dependent on personality style, personal history, ways of viewing the world, culture, values, and level of comfort with therapy (Watson, 2011). For example, some patients may not be capable of tolerating the lack of structure that is integral to psychodynamic psychotherapy, while others experience too much pressure in didactic and structured therapies. At the end of the day, not all patients respond as expected or hoped for. Despite psychotherapists beginning their careers with hope and optimism about changing people's lives, failure commonly occurs.

Once again this is an issue that is context dependent and subjective. By and large, if a patient is deteriorating or not responding, if their symptoms are not being alleviated, if their presentation does not fit with the type of therapy being offered and they are receiving no benefit from it, if a weak alliance is formed, or if the patient feels undervalued by the therapist, we must conclude that treatment is failing or has already failed. Discontinuation is a probable outcome in these cases.

What contributes to therapeutic failure? Research has linked therapeutic failure to a range of variables. Gold and Stricker (2011) have proposed a model identifying five main variables associated with failure in psychodynamic psychotherapy: those related to the patient, therapist, technique, relationship and third parties. Patient and therapist variables, and their impact on the therapeutic relationship, have been the most scrutinised, and are reported to have the most influence on outcome. For example, in the psychoanalytic literature it is well known that the analyst brings personal or human qualities to the analytic relationship that can detract from or facilitate their analytic

function, and these qualities make them a significant agent of change (Anastasopoulos & Papanicolaou, 2004). Given that discontinuation is a hallmark of therapeutic failure, these variables will be addressed in more detail because they are usually also implicated in patient discontinuation. A number of studies have demonstrated an association between hostility, negativism and therapeutic failure, which will also be looked at.

Therapist factors. It is crucial that therapist contributions to failure are discussed because they appear to have more influence than general technical variables (Blatt, Sanislow III, Zuroff, & Pilkonis, 1996) or theoretical orientation (Anastasopoulos & Papanicolaou, 2004; Bergin & Garfield, 1994), and contribute significantly to therapeutic change (Beutler, Machado, & Neufeld, 1994). Naturally, just as therapeutic success is associated with a strong alliance, a weak alliance is linked to therapeutic failure. Drawing from the literature on therapeutic failure and their own clinical experience, Gold and Stricker (2011) have formed a view that therapists who are not attuned to their patients, who fail to recognise problematic bond issues, or who are perceived to direct any form of hostility towards the patient, are likely to fail in their delivery of psychotherapy. The importance of the patient's perception of therapist attunement in creating a successful working alliance is well-known. For instance, in a small study on therapist-patient dyads, when therapists did not appear to commit and show the patient they were "caring, competent and concerned", the patient formed a negative perception of the therapist, which was linked to therapeutic failure (Strupp, Hadley, & Gomes-Schwartz, 1977). Although this study only used a very small sample, their controversial research findings suggest that patient perception alone may be more crucial than any therapist actions. They report that if the therapist displays signs of boredom, frustration, self-interest, detachment, or does not show sufficient empathy, this does not bode well for the

continuation or success of the therapy (Strupp et al., 1977). An absence of attunement is also associated with rigidity in therapeutic approach, which can itself lead to significant problems. When the therapist follows a manual-like recipe, with little room for movement or flexibility, it is not possible for them to adjust to and deal with issues that arise unexpectedly (Binder, 2003). A therapist who is not attuned to their patient will be hard pressed to notice alliance ruptures, let alone repair them when necessary. Likewise, in their review of the research on therapeutic failure, Ogrodniczuk et al. (2005) found that when patients detect a lack of empathy or feel criticised by their therapist it can result in therapeutic failure.

Based on his own clinical practice, Bugental (1988) formed a view that if the pre-conditions of respect, care and acceptance are not ensured, patients can be objectified and treated as diagnostic types, which impinges on the therapeutic alliance and subsequently causes therapeutic failure. Furthermore, Bugental argues that with a shallow alliance, when the therapist does not emotionally invest in the relationship, is not sufficiently active and challenging, misreads the patient's needs, times interventions poorly, or does not work with adequate sensitivity, the patient has poor outcomes. He asserts that therapeutic failure can result from a therapist who is perceived to be not "truly present" as needed by the patient, and not genuinely devoted to helping relieve their suffering. In support of this view, Watson, Goldman and Greenberg's in depth case-studies (2007) reveal that although some patients may agree on the tasks and goals of therapy, they often feel uncertain their therapist likes or values them, which results in negative outcomes.

Poor case formulating and misdiagnosis are also implicated in therapeutic failure. Summers and Barber (2009) assert that therapists who are unable to effectively reach a working formulation that focuses on the patient's core issues, particularly in time-limited

work, will be severely handicapped in alleviating their patient's distress. Gold (1995) also highlights that therapists often stick to their original formulations rather than keeping an open mind, leaving them closed to new information. Poor and inflexible formulating means the therapist has failed to "get completely inside the symptoms and pathology" of the person; what follows is often misdiagnosis or, worse still, misunderstanding of the depth of the patient's pain (1995, p.168).

Therapist burnout is an additional factor that can contribute to therapeutic failure. Burnout can lead to issues in identifying alliance strains, and increase the likelihood of therapists reacting in a hostile or rejecting way to the patient. Burnout becomes increasingly problematic when psychotherapists finish their training; they begin working more independently and are no longer consulting on every case. In this context, therapists are often less consistent or effective in reflecting on their own motivations and emotions, thus blind spots can develop (Gold & Stricker, 2011).

Patient factors. The patient factors outlined in Gold and Stricker's (2011) model of psychodynamic therapeutic failure are divided into fixed or variable characteristics of the individual patient. According to these authors severe and chronic psychopathology, in particular psychosis, poor impulse control, poor psychological mindedness, external attribution style, preference for excessive structure and direction, and unrealistic goal setting, act as barriers to success and increase the chance of therapeutic failure. Interestingly, Von der Lippe et al. (2008) reported that although diagnosis and symptoms were not associated with therapeutic outcome, patient scores on the Global Assessment of Functioning (GAF) were. When scoring the GAF a clinical judgement of the patient is made with respect to their psychological, social and occupational functioning. In this study, the group of patients who experienced no change or negative change from therapy

had lower GAF scores. This effect was large (d = -0.89) and suggests significantly lower levels of global functioning. These findings indicate that the psychiatric symptoms a person has are less important than the experienced impact of these symptoms on daily life. Having a history of trauma is related to therapeutic failure because these people generally have disrupted interpersonal attachments that cause bond and alliance difficulties with the therapist (Borden, 1994), despite often being most in need of therapy. This view is supported by Strupp's case study research (1980), which highlights how relatedness between patients and therapists differs based on early experiences; if people are not capable of forming relationships due to destructive early experiences, characterological problems can persist that prevent intimacy and increase the odds of therapeutic failure.

In his published case studies, Strupp (1980) demonstrates how the course of the therapeutic relationship can be fixed within the first few sessions, and how it is heavily influenced by patient qualities and therapist countertransference reactions that emerge in response to these. He uses two case examples from time-limited psychodynamic psychotherapy to illustrate how relatedness can affect the course and outcome of therapy: Eric, who was defined as a therapeutic success, was seen for 25 sessions, while Tom, defined as a therapeutic failure, was seen for 11 sessions (Strupp, 1980). What he reported is consistent with Gold and Stricker's (2011) findings outlined previously. Both patients presented with similar symptoms of anxiety, depression and social withdrawal, and both were treated psychodynamically, yet the quality of their interactions was profoundly different and this proved fateful. According to Strupp, Eric had a good social history, loving and supportive relationship with parents, he was sufficiently introspective and was not overly defensive. Strupp noted that Eric was cooperative, committed, and was able to

form a strong alliance in the first session. Eric was reportedly a pleasure to treat, he benefited greatly from the therapy and continued to have gains post-treatment. In contrast, Tom had a poor social history and marked personality deficits that resulted in an extremely stubborn, negativistic and resistant attitude. Tom apparently entered therapy with unrealistic expectations about the time-frame for resolution of his symptoms, had poor motivation, was experienced as provocative at times, and was completely passive during sessions. His presentation did not change over the course of therapy and he made no gains post-treatment. These two divergent cases exemplify how a person's early experiences, their capacity for relatedness, the maturity of their defences, and their personality development can impact on therapy. When there are multiple factors at play, such as in Tom's case, it is more likely that therapy will fail. Strupp also noted that when faced with a patient like Tom, therapists may react negatively towards them, which can be a trigger for adverse patient outcomes.

Hostility and negativism. The relationship between hostility or negativism and therapeutic failure has been investigated by a number of researchers (Henry, Schacht, & Strupp, 1986; Horvath & Symonds, 1991; Samstag, 1999; Strupp, 1980; Van Denburg & Van Denburg, 1992). For example, in Strupp's (1980) study described above contrasting two cases, he found that negativism and hostility from patients due to personality factors impacted on alliance formation and therefore increased the probability of therapeutic failure. He postulated that the cornerstone of therapeutic success or failure is related to the patient's capacity to form a working alliance, and personality factors that produced hostile interactions could make this an impossible task. In a hostile negative environment, a negative countertransference often emerges, exacerbating alliance issues (Strupp, 1980). In a follow-up study, Henry, Schacht and Strupp (1986) analysed therapist-patient

dyad interactions in session transcripts of psychodynamic psychotherapy. They reported that the presence of friendly interactions initiated by the patient, when reciprocated, was associated with therapeutic success. As expected, the presence of hostile interactions originating from the patient, when reciprocated, was associated with therapeutic failure. However, it is important to note that these two studies used very small sample sizes and therefore had small effect sizes. Some years later, a larger study by Samstag (1999) provided more compelling evidence of an association between negativity in the therapist-patient dyad and therapeutic failure. If hostility or negativism does impede the formation of a strong alliance, and the quality of the alliance is clearly connected to therapy outcome (Horvath & Symonds, 1991), then these factors may be a source of failure in psychotherapy.

A more recent study (Von Der Lippe et al., 2008) that examined patient-therapist interactions in successful and unsuccessful therapies using the structural behaviour analysis technique, found that in unsuccessful therapies the patient-therapist interaction styles did not match and were often marked with hostile complementarity. In this study, unsuccessful therapy was defined as the patient having no change or negative change as a result of engagement. Although therapists tried to be non-hostile and restore harmony in response to the hostility of their patients, they were often inadvertently more belittling and ignoring, which added to the hostile ambience. Freud alluded to these hostile transactions in his descriptions of resistance (Von Der Lippe et al., 2008); when negative transference dominates therapy and defensive conflicts are activated, it renders the patient "uncomprehending and inaccessible" (Freud, 1964, p. 239). The authors suggest two reasons for the "pull" of hostility. Firstly, it is human nature to act and react in corresponding ways in relationships. Von der Lippe and colleagues (2008) use

interpersonal therapy to explain this; if one experiences frequent rejection, one learns to expect it and consequently feels sceptical about the other person's genuineness. Secondly, when patients are sceptical, distrustful, defensive, and not open to influence, the therapist may begin to feel inadequate, which instigates their own subtle hostility. It is worth noting that in order to rule out therapist factors this study was conducted by the same group of therapists with a number of different patients. One of the most striking findings was that patients who were not successful in therapy repeatedly rejected the therapist's helpfulness, which again emphasises the gravity of patient personality factors in alliance formation and psychotherapy outcome.

Patient Discontinuation

One of the hallmarks of therapeutic failure, patient discontinuation, is a common and universal phenomenon (Phillips, 1995). There are various discontinuation rates quoted in the literature, some as high as 90% (Burstein, 1986; Owen & Kohutek, 1981), depending on the criteria and sample used. Some authors claim that most patients only attend a few sessions (Koss, 1979; Pekarik, 1996; Phillips, 1985; Whipple et al., 2003). For example, Phillips (1985) found that one third of patients leave therapy after the first session and half leave therapy after the second session. Other research indicates that approximately one third of depressed patients (Elkin et al., 1999) and over 50% of borderline cases (Waldinger & Gunderson, 1984) terminate early. Overall higher rates are reported for people with personality disorders (Ingenhoven, Duivenvoorden, Passchier, & Van Den Brink, 2012). Alarmingly, Scogin, Belon and Malone (1986) found that two thirds of patients receiving psychotherapy treatment dropped out in less than five sessions. Studies isolating dropout rates for individual therapy had similar findings; between 30 and 60%

left early (Baekeland & Lundwall, 1975; Garfield, 1994). Reported statistics from two very large study of university counselling centres provide strong evidence that the majority of students leave after only a handful of sessions (Draper, Jennings, Baron, Erdur, & Shankar, 2002; Lambert, Whipple, et al., 2001). However, another study that used a smaller university counselling sample cited between 17 and 50% as the termination rate, depending on the criterion used (Hatchett & Park, 2003), which is consistent with data collected more broadly. For example, an extensive meta-analysis of the literature on this topic, conducted by Wierzbicki and Pekarik (1993), reported 47% as the average rate of patient discontinuation for individual psychotherapy. This poor retention rate for psychotherapy could be seen as troubling, although it could indicate that many patients try therapy and self-select out if it they are not suited to it.

The range of scores reported in the literature, the assortment of definitions for discontinuation used, the different modes of therapy used, and the heterogeneous samples of patients studied, make these findings difficult to interpret. In a recent extensive meta-analysis of 669 studies, Swift and Greenberg (2012) contend the dropout rate to be between 18% and 38%, with a weighted mean rate of 20%. However, they did not distinguish between patient-initiated premature termination and therapist-initiated termination. In any case, discontinuation appears to be a pervasive problem regardless of therapeutic approach.

Premature termination is even more problematic in long-term psychotherapy because of the challenges associated with keeping people in therapy longer. Straker (1968) reported that the dropout rate for his clinic reduced from 62% to 32% when he changed the treatment from long-term to brief psychotherapy. In addition, Reder and Tyson (1980) reviewed the literature between 1930 and 1980 on patient discontinuation from

psychoanalytically oriented treatment and showed that 13% of patients receiving brief therapy dropped out in the first six months, while 41% of patients receiving long-term treatment dropped out in the same time frame. They consistently found that initial patient discontinuation, such as within the first few weeks of treatment, was commonplace. More recently, in their meta-analysis Swift and Greenberg (2012) used weighted effect sizes of 125 studies to determine that patient discontinuation was less common if the therapy was time-limited, regardless of whether the time-limit was brief or long. When a time-limit is imposed on the therapy there is usually a strong focus on specific patient problems rather than global goals (Swift & Greenberg, 2012), as well as an increased sense of urgency and emotional presence in both patient and therapist, which can fast-track the therapeutic process (Messner, 2001).

The discontinuation rate is also high with child and adolescent patients. Midgley and Navridi (2006) audited closed child analysis files from 1999 to 2003 from the Anna Freud Centre in London, and discovered that the proportion of discontinuation was around 60%. Discontinuation was defined as the child ending therapy at any stage prior to both parties agreeing. It was concluded that children or adolescents were more likely to cease therapy than remain in therapy. Equally high dropout rates have also been recorded in other types of child therapy such as family behavioural programs (40-60%) (Fleischman, 1981; Patterson, 1974), and psychiatric outpatient programs (58%) (Lazaratou, Vlassopoulos, & Dellatolas, 2000). The added complication with this group is that they are usually brought to therapy by a parent or guardian who must also be invested in the therapy.

Despite the significant barrier that patient discontinuation represents, Frayn (1995) argues that it is easier to find information about planned termination in psychoanalysis than on this issue. Moreover, there is inadequate training available to therapists on how to reduce

discontinuation, particularly for beginning therapists who do not have the skills to effectively manage this (Pekarik & Finney-Owen, 1987). In fact, most beginning therapists start their careers with an idealised view that patients attend therapy regularly and consistently, which the data suggests is simply not the case. Furthermore, therapists in general tend to underestimate the percentage of non-responders or failures, and focus disproportionately on successful treatment delivery (Lambert, 2011). In support of this, Tryon and Kane (1990) found that therapists' ratings on the Helping Alliance Questionnaire were not associated with patient ratings, indicating that they frequently missed alliance strains. Due to this incongruity, therapist's ratings were not predictive of premature termination.

Negative Outcomes of Discontinuation. In some cases early discontinuation is due to uncontrollable external factors. Patients need to cease therapy because they are required to move to a new location, their financial situation may change due to job loss, or they may be affected by physical illness that prevents them attending a clinic. It is also the case that many patients experience some benefit, satisfaction and real change from briefly engaging in therapy (Ogrodniczuk et al., 2005). Nonetheless, in the bulk of cases early discontinuation has negative consequences for patients and is a serious impediment to efficient deployment of limited mental health services (Ogrodniczuk et al., 2005). Not only is the time of therapists wasted when patients discontinue therapy, it also wastes resources due to missed appointments, invested time in therapy lost, and administrative costs (Bischoff & Sprenkle, 1993; Reis & Brown, 1999; Smith, Subich, & Kalodner, 1995). If a scheduled appointment is missed then this becomes lost time the therapist could have spent with another patient, which plays a part in the long waiting lists that

exist at many mental health services (Ogrodniczuk et al., 2005). Often it also means a loss of income for the psychotherapist. Discontinuation is a pervasive problem that extends to all aspects of the mental health care system (Pekarik, 1985a), impacting on outcomes for patients, administrators, and researchers (Ogrodniczuk et al., 2005).

Patient outcomes. When a patient discontinues therapy prior to goals being met or termination issues being worked through, they can experience a deep sense of failure and disappointment. Ogrodniczuk et al. (2005) suggest this experience can create negative self-perceptions, cause symptoms to resurface, increase the severity of symptoms and increase distress. Augmented symptom severity in this population has also been reported by other researchers (Bados, Balaguer, & Saldaña, 2007). Given the frequency of discontinuation, this may promote a negative perception of psychotherapy in the community (Ogrodniczuk et al., 2005), therefore reducing the likelihood of patients returning to a service in the future. Kazdin (1996) suggests that people who discontinue early are less likely to make meaningful gains in therapy, and post-treatment gains are also less likely (Pekarik, 1992). This population can be considered at risk and has poor outcomes in general (Lyons & Woods, 1991; May, 1984; Pekarik, 1992). According to a study by Carpenter, Del Gaudio and Morrow (1979), patients who leave therapy early tend to suffer from chronic mental health problems and need to re-engage with services multiple times across their lifespan. On average, patients who leave before resolving their issues make contact with services twice as often as other patients. This argument is supported by Reis and Brown (1999), who make a case that people who discontinue will overuse mental health resources, may require inpatient treatment in the long term and incur greater financial cost to the community. There is also a higher risk of eventual

suicide in people who prematurely terminate therapy (Dahlsgaard, Beck, & Brown, 1998).

Discouraging findings about patient discontinuation are paralleled in the group therapy literature. Individual discontinuers from group therapy have a negative impact on the group because they often trigger other group members to terminate treatment (Fieldsteel, 1996). Yalom and Leszcz (2005) contend that the phenomenon of patient discontinuation is more concerning in a group setting because of the effects it has on the functioning and continued success of the group as a whole. When studied six months later, individuals who had a negative group experience showed no evidence of a delayed gain; instead they remained disheartened and unsettled from the experience (Lieberman, Yalom, & Miles, 1972). Likewise, the literature on child psychotherapy indicates that children who discontinue have poor outcomes and suffer long term negative consequences (Midgley, 2003). Taken together, the research makes a clear statement about patient discontinuation being a significant problem in psychotherapy that needs to be addressed.

Therapist outcomes. Although there is more extensive research focusing on client outcomes, discontinuation also has an adverse effect on therapists. It is known to dampen therapist confidence and contribute to burnout (Joyce et al., 2007) or demoralisation, especially for beginning therapists (Garfield, 1994). It is not only beginning therapists who are affected; for any professional working in this field, when patients regularly discontinue, particularly prematurely, it can be experienced as an assault on professional self-esteem. Repeated over time, this can impact one's practice and motivation. According to Ogrodniczuk et al. (2005), therapists often feel that they have failed or wasted their time when patients leave therapy early, and may experience hurt, rejection or anger. The accumulative effect of these emotional responses can influence the personal

life of the therapist and create job dissatisfaction. For therapists whose self-esteem is strongly linked to helping others, some level of narcissistic injury is felt when discontinuation occurs, leaving them to seriously question their capacity as therapists (Ogrodniczuk et al., 2005). Strong emotions elicited in the therapist during one session may also be carried into the subsequent sessions with other patients. Therapists can become so fixated on keeping their patients engaged that they avoid challenging interventions, or stifle the emergence of negative transference feelings, due to fears of disrupting the therapeutic alliance. While this can help keep patients engaged, it can also lead to stagnation and may be counter-therapeutic.

Factors Associated with Patient Discontinuation

Patient discontinuation, like therapeutic failure, is a multi-faceted problem with various contributing factors. There is currently no replicable theory available to explain all instances of the phenomenon, and there is an absence of findings that can be generalised (Yu, 2011) or used to guide clinical practice. Issues pertaining to the limitations of the current research will be presented in detail in a later section. The following section will explore some of the patient-based and therapist-based factors associated with patient discontinuation, and will also address findings on how the phase of treatment, the therapeutic alliance, and transference issues, impact patient attendance.

Therapist factors. Understanding what therapist characteristics can influence a patient's choice to discontinue psychotherapy is important, yet it has not been widely studied. Therapist factors, such as experience, appear to be linked to lower rates of

discontinuation (Swift & Greenberg, 2012), while level of training and therapeutic orientation have been investigated with inconsistent results (Hamilton, Moore, Crane, & Payne, 2011). There is a strong evidence base that therapist style, particularly excessive confrontation is associated with higher rates of discontinuation (Chrits-Cristoph & Gibbons, 2001; Norcross & Wampold, 2011; Roos & Werbart, 2013). Other therapist skills such as the quality of empathic attunement, working alliance skills, engagement skills, flexibility in technique and goal setting, have been identified as qualities that may prevent patient discontinuation (Watson, 2011). This is unsurprising given the findings reported earlier about fostering a strong working alliance and how this acts as a protective factor against therapeutic failure.

The current public health model in Australia encourages the practice of brief psychotherapy of approximately 10 to 12 sessions. In this climate, psychotherapists are under pressure to "fix" their patients, with the added expectation they will do it quickly. It is Gold's (1995) opinion that time pressures in psychotherapy lead to haste, which he warns can have a harmful effect on the patient. He remarks that the burden of haste can in some cases result in therapist forcefulness, where patients are pushed too vigorously and end up leaving therapy. When psychotherapy is performed with haste there is a tendency for the therapist to retreat into the expert role and resort to a prescriptive medical approach, which means they fail to fully understand the patient's psychic complexity and fail to ensure maximum benefit (Gold, 1995). Although time limits are known to accelerate the therapeutic process (Messner, 2001) and increase retention in some situations (Reder & Tyson, 1980), in Gold's (1995) view they can also reduce the capacity of the therapist and lead to worse outcomes for the patient. Moreover, this model has

permitted Australian patients to develop an expectation of therapy as brief, and they may therefore be reluctant to embark on long-term treatment, even when the latter is indicated.

Patient factors. A large amount of the early research on patient variables related to discontinuation focuses on patient demographics such as age, marital status, ethnicity and socio-economic status (Yu, 2011). A number of factors have been reported as significant predictors of early discontinuation, including ethnic minority membership (Kazdin, Holland & Crowley, 1997), racial status (Huey, 1999), educational attainment (Yu, 2011), and most consistently, socio-economic status (Warnick, Gonzalez, Weersing, & Woolston, 2011; Wierzbicki & Pekarik, 1993). Low socio-economic status is reportedly the only reliable patient factor associated with discontinuation (Yu, 2011). From his review of the research, Kazdin (1996) concluded that risk factors accumulate, so the more risk factors in a person's life, the more likely they will drop out of therapy. From his research in child psychotherapy, Kazdin claims that multiple diagnoses, delinquency and anti-social behaviour are potential risk factors. Most of the other factors Kazdin cites are demographic, including social and financial disadvantage, parental stress or psychopathology, lower maternal age, parenting practices, peer contacts and educational functioning. However, the relative contribution of each factor to discontinuation is unclear. It should also be noted that socio-economic status is not always a factor in discontinuation (Deakin, Gastaud, & Nunes, 2012). Nevertheless, these findings highlight the need to consider a person's external resources and cultural sensitivity when assessing for therapy.

A range of other variables have been identified in patient discontinuation. These variables can be categorised as personality factors, interpersonal factors such as transference and

the therapeutic alliance, goals and expectations, underlying psychopathology, symptom profile and duration, and patient theories of cure. In their review of patient-initiated premature termination, Ogrodniczuk and colleagues (2005) ascertained that factors such as anxiety about self-disclosure, perceived lack of improvement, disagreement on the nature and order of therapeutic goals, unrealistic goals, unrealistic expectations about therapy duration, and a strong negative transference, can all contribute to discontinuation. They also reported that discontinuation can result from a lack of motivation to do the work required in therapy, incapacity to reflect on emotional and intentional states, and excessive use of defence mechanisms, especially denial. Their review does not provide information about the magnitude or relative contribution of these various factors, but it does support earlier clinical research findings from Frayn (1992), who claimed that a lack of introspection and intrinsic motivation can negatively influence patient participation in therapy.

While Ogrodniczuk et al. (2005) determined that levels of defensiveness are key, other research implies that the type of defensiveness a patient engages in is also important in predicting discontinuation, such as primitive defence mechanisms of projective identification and splitting (Baker, 1980). In Midgley and Navridi's (2006) qualitative study of five child cases who prematurely discontinued analytic therapy at the Anna Freud Centre, they identified themes in the assessment phase of work with families that later discontinued treatment. The themes, which are similar to the abovementioned, concerned patients' motivations and expectations in relation to therapy process and outcome, and their capacity to think about emotions. Another relatively stable finding is that patient substance abuse interferes with therapy and frequently leads to discontinuation (Kelly et al., 1992; MacNair & Corazzini, 1994).

In support of the findings about defensive style and mentalisation capacity, Watson (2011) argues that patients who discontinue therapy are more likely to have complications in emotional processing. He contends that these people tend to be easily overwhelmed by emotion, prefer to discharge their distress, or escape feelings that are dangerous. In addition, they are more likely to have impoverished narratives because they lack reflective capacity and avoid self-awareness. In their in-depth case study research, Watson and colleagues (2007) concluded that when patients have no coherent personal history this can reduce therapist empathy and therefore supportiveness. Watson is also of the opinion that discontinuers tend to experience more shame and less agency, and have an expectation that they will be rejected and criticised, or a feeling they cannot or do not want to change (Watson, 2011). Based on his knowledge of the research in this area and his clinical experience, Watson (2011) proposed that patients who are not accepting of their own internal experiences and show little self-compassion will also have higher discontinuation rates. He believes this is usually more apparent in patients with a history of trauma. Furthermore, patient discontinuation is related to a negative patient attitude towards therapy and a lack of social support (Lambert, 2011; Watson et al., 2007), which is often a reflection of the severity of patient's symptoms and their capacity for relating (Watson, 2011).

In summary, there are a host of variables that have emerged from many years of research on this topic, some of which have been presented briefly here. The most prominent findings include therapist factors such as experience, professional style, empathic attunement, flexibility and alliance skills. Patient factors related to discontinuation are more varied and encompass personality, symptoms, ideas of cure, expectations, capacity to mentalise, defensiveness and interpersonal factors. However, the effect size and

relative contribution of these factor remains unclear, and there is no single coherent theory or model that accounts for the interaction of all of these variables.

Treatment phase. Trepka (1986) established that patients have different reasons for discontinuing therapy at different stages of the therapy process. For example, what triggers someone to leave treatment at the intake or assessment stage may be unrelated to what makes someone depart therapy after they have been attending regularly for three months. In Trepka's study, having a psychiatric history was predictive of non-attendance, low socio-economic status was predictive of non-engagement, while initially less severe presenting symptoms and lower levels of psychopathology was predictive of premature termination during therapy.

Trepka's findings were later supported by Richmond (1992), who found it was possible to predict with a statistically significant degree of accuracy, which patients would discontinue therapy from a dynamically oriented psychology training clinic, based on what stage of therapy they were in. In order to uncover new variables, Richmond controlled for demographics and psychiatric and diagnostic ratings in his study. Leaving therapy prior to commencing or following the first session was described as discontinuation at intake, leaving therapy after two or three sessions was described as discontinuation at evaluation, and leaving any time after the fourth session was described as discontinuation during therapy proper. High tension and low levels of guilt, as measured by the Brief Psychiatric Rating Scale (Overall & Gorham, 1962), as well as low educational levels, were consistently associated with discontinuation at all three stages, while hostility was significantly associated with discontinuation in the first one or two sessions (Richmond, 1992). It was postulated that people with low education level often

had a concrete thinking style and unrealistic expectations about the process of therapy. Aside from educational factors, these results suggest that personality factors and symptom factors are heavily implicated in the phenomenon of discontinuation. Having an Axis I diagnosis was not a significant predictor, while having an Axis II diagnosis of Cluster A (e.g., paranoid, schizoid or schizotypal personality disorder) or Cluster B (e.g., borderline, narcissistic, histrionic or anti-social personality disorder) was significant in the group of people who discontinued during therapy. Given these patients also rated highly on uncooperativeness, grandiosity and somatisation, Richmond (1992) reasoned that they were generally poor self-reflectors with limited insight and difficult interpersonal styles. This further emphasises the unfavourable influence of certain personality traits and structures on therapeutic engagement and persistence, which will be investigated in a later section. It suffices to say at this point that the influence of different factors on discontinuation is greatly dependent on the stage of therapy a patient is engaged in.

Therapeutic Alliance. The therapeutic alliance refers to the emotional bond between patient and therapist, and their agreed upon treatment goals and tasks (Bordin, 1979). The predictive value of the strength of the therapeutic alliance, in terms of discontinuation, has been examined for a number of decades. Research that has focused on the therapeutic alliance and its relationship to discontinuation has consistently yielded significant results, and provided strong evidence that patients are more likely to persist with therapy when they have a strong alliance with their therapist (Ran, 1973; Piper et al., 1999; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1993). To give an example of this research, Tryon and Kane (1990) studied the association between alliance robustness and the type of discontinuation in a sample of 102 counsellor-client dyads

from a university counselling service. They looked at whether patients discontinued prematurely or whether there was mutual agreement regarding their departure. The authors claimed that patients who discontinued therapy early and against therapist advice had a less robust alliance, according to the Helping Alliance Questionnaire. Their findings also highlighted the importance of therapists' openness and willingness to explicitly talk about expectations and therapeutic style for improved patient retention. Curiously, they discovered that therapist ratings of the alliance were not correlated with client ratings. The disconnection between what is observed by clinicians and what is experienced by patients emphasises how useful it can be to utilise outcome measures in clinical settings.

Ideas of Cure. There is some emerging evidence pointing to the influence of patient ideas of cure on early discontinuation, and this may have implications for patient selection. A study by Philips, Wennberg and Werbart (2007) assessed how patients' ideas of cure can have a bearing on outcome, early alliance and premature discontinuation, in a sample of 46 young adults undergoing psychodynamic psychotherapy. They hypothesised that patient's ideas of cure can be measured on a continuum, with approaching the problem at one pole, and distancing from the problem at the other pole. The authors concluded that patients who discontinued therapy prematurely were closer to the distancing pole, suggesting they were more avoidant of discussing their problems. Conversely, those who completed therapy were closer to the approaching pole in their conception of what brings about cure. According to the researchers, these patients were more likely to discuss problems, and are potentially better suited to psychodynamic therapy. This parallels earlier research on attribution and coping style that found patients who tend to internalise their problems may be more suited to insight-oriented therapies

such as psychodynamic psychotherapy, because of their introspective qualities (Beutler, Harwood, Alimohamed, & Malik, 2002). In contrast, people who externalise their problems are more likely to benefit from behavioural therapies as they can be more impulsive, externally and action-orientated (Beutler et al., 2002). Nevertheless, the study by Philips et al. (2007) used a small sample size, and further research is required to ascertain the contribution of patient ideas of cure to the phenomenon of discontinuation.

Transference. How particular transference reactions shape patient discontinuation is a vital consideration for therapists. Transference involves a patient unconsciously ascribing the qualities of a significant person from his or her childhood past to the person of the psychotherapist (Gabbard, 2004). Nuetzel (1991) holds the view that transference and countertransference issues play a significant part in developing the therapeutic alliance, which can be a key factor in early discontinuation when disrupted. Van Denburg and Van Denburg (1992) attempted to understand the potential impact of transference issues on patient discontinuation through various psychodynamic models. From a drive perspective, when transference themes are provoked and intensified, patients may try to escape therapy due to fears of their emerging fantasies about the therapist. From an object relations perspective, patients may be prone to discontinuation if their manic defences are mobilised because they feel happy, energetic, productive, and are more inclined to devalue the therapist. According to Van Denburg and Van Denburg, through a separation-individuation lens (Mahler, Pine, & Bergman, 1975) patients who have experienced early trauma around separations may expect, anticipate and fear rejection from the therapist, so they are likely to leave before this can occur. In a similar vein, they maintain that a patient with an immature defence system may project their internal hostility and anger onto their

therapists, view them as persecutors, and subsequently leave therapy to avoid further persecution. This is often seen in patients with primitive disturbances, such as borderline personality disorder. Patients with dependency issues or separation anxiety are also liable to take control and discontinue therapy on their own terms, to avoid feeling worse when the therapist decides the endpoint of therapy later on (Masterson, 1981).

Psychopathology. Type of psychopathology has frequently been reported as a predictor of discontinuation (Barrett et al., 2008; Garfield, 1994; Hamilton et al., 2011; Hilsenroth, Handler, Toman, & Padawar, 1995). In an extensive study conducted by Hamilton et al. (2011), diagnoses differed between those who left therapy early and those who persisted; patients with mood and anxiety disorders tended to persist, while patients with more severe diagnoses such as schizophrenia, other psychotic disorders, and substance use disorder, were more likely to discontinue psychotherapy. Personality disordered patients are also regularly cited in the literature as habitual discontinuers, due to their inherent interpersonal difficulties (Chiesa, Drahorad, & Longo, 2000; Gunderson et al., 1989; Hilsenroth, Holdwick, Castlebury, & Blais, 1998; Skodol, Buckley, & Charles, 1983). For example, Skodol, Buckley and Charles (1983) reported a 67% discontinuation rate for borderline personality disorder. Axis II disorders have been investigated in detail by some researchers, with Cluster A and Cluster B diagnoses being considered greater contributors to discontinuation than Cluster C diagnoses, such as avoidant, dependent, or obsessive-compulsive personality disorders (Shea, Pilkonis, & Beckham, 1990; Richmond, 1992). There are a number of possible reasons for these findings: firstly, there may be specific symptoms from these complex diagnostic categories that can contribute to the increased likelihood for discontinuation. Secondly,

there may be specific and identifiable personality traits within these categories of people that negatively influence therapy persistence. Finally, due to their more severe and early disturbances, and less integrated personality structures, these patients may resort to more primitive defence mechanisms and have less capacity for relationships, making them notoriously hard to engage.

One of the reasons that there are similar findings for personality disorders in terms of discontinuation, is due to hindrances with the *DSM-IV* classification system, which provides descriptive categories of these disorders that are very broad, overlap with each-other and give no practical information about aetiology or treatment (Higgitt & Fonagy, 1992). Some authors have argued that these discrete categories of personality disorders would be better understood and conceptualised as general personality traits, because of improved practical applications (Zanarini, Gunderson, Frankenberg, & Chauncey, 1990a). Rather than identifying which personality disorders are resistant to treatment, it may be more meaningful to determine particular personality traits and clusters of traits that are resistant to treatment, in order for there to be an augmentation of therapy retention rates. Some of these issues have been addressed in the *DSM 5*, with the introduction of a personality trait system of diagnosis, which includes the broad domains of negative affectivity, detachment, antagonism, disinhibition and psychoticism.

Rutler (1987) recommended thinking about personality disorders as a group of disorders in which the pathology comes from a pervasive problem in "establishing and maintaining adequate social relationships". According to Higgit and Fonagy (1992) this type of pathology generally corresponds to the Cluster B disorders in *DSM-IV* such as borderline, narcissistic, histrionic and anti-social personality; these patients are mainly borderline in their psychoanalytic personality structure, and are largely defined as difficult and

dramatic. Borderline personality structure is characterised by ego weakness, the use of immature psychological defences, identity diffusion, pathology of internal object relations, and a propensity to shift to dream-like thinking patterns (Kernberg, 1967; 1984). The adversity faced by therapists working with patients organised in such a way is linked to the patient's low achievement, manipulative suicide attempts, heightened affectivity, mild psychotic experiences, and disturbed close relationships (Gunderson, 1984; Gunderson & Zanarini, 1987).

One study examining a sample of patients with personality disorders attempted to elucidate the key factors that caused early discontinuation. The most prevalent diagnoses in the sample were from Cluster A and B: paranoid, borderline and anti-social personality disorder (Thormählen, Weinryb, Norén, Vinnars, & Bågedahl-Strindlund, 2003). The authors predicted that personality disordered patients with more hostility, less interpersonal distress, and more interpersonal rigidity, would discontinue therapy more often than those who displayed the opposite pattern. The results supported this hypothesis and also highlighted age as a predictive factor, with younger patients being more vulnerable to early discontinuation. An intriguing result was that the influence of hostility on discontinuation was not significant, except when combined with high levels of dominance. The combination of these two interaction styles appears to inhibit a person's capacity to succeed in therapy, probably because they create poor conditions for a robust therapeutic alliance. Thormählen et al. (2003) argued that people with high levels of hostility and dominance generally have interpersonal styles that dismiss intimacy and dependency. These findings are supported by earlier research by Horowitz and colleagues (1993), in which it was found that patients with dismissive attachment styles receive little gain from brief dynamic psychotherapy. In support of this, Hamilton et al.'s (2011)

extensive study of administrative records of over 400,000 patients, found that discontinuation rates were high for patients with relational diagnoses, which are traditionally treated with family therapy approaches. It seems that when relational capacity is affected, so too is a person's capacity to form a working therapeutic alliance, and therefore discontinuation is imminent. Taken together these findings provide a basis for investigating the impact of individual personality traits on discontinuation because of their correlation with interpersonal skills.

Personality Dimensions. Personality traits are known to be pervasive in nature because of their stability over time and across contexts; however, Miller (1991) suggests this area of psychology has developed independently and in opposition to clinical theory because of fundamental contradictions between the two. He contends that trait theories recognise a continuum of personality characteristics that are supposedly resistant to change, whereas in clinical theory there is a division between pathological and normal personality characteristics, which are thought to be changeable. Nevertheless, trait theories can be clinically useful for gaining an accurate picture of the patient's enduring interpersonal and affective style, motivations and needs, which can assist therapists in matching effective treatment, understanding the patient's presentation, anticipating behaviours, and predicting potential problems (McCrae, 1991; Miller, 1991). In fact, the idea that individual personality characteristics can disturb psychological treatment is a conventional belief amongst therapists, and some researchers have argued that it is the leading indicator of patient engagement in treatment (Coleman, 2006).

While some specific traits, such as hostility (Marziali, Marmar, & Krupnick, 1981; Richmond, 1992) and vindictiveness (Thormählen et al., 2003), have been reported as

potential predictors of premature termination when combined with other variables, the variance explained by these traits alone is not known. Interpersonal problems such as these, which are often present in patients with borderline personality disorder, are referred to by psychotherapists as a form of resistance, or non-facilitating factors (Frayn, 1992), as they are thought to reduce interpersonal competence, capacity for intimacy, and therefore interfere with the therapeutic alliance.

While hostility is one characteristic of borderline personality disorder, there are other characteristics of this diagnosis that can interrupt treatment. Given the high attrition rate of this population noted above, by extrapolating some of these characteristics we can ascertain individual traits that may be linked to therapy discontinuation. In their small naturalistic study of psychotherapeutic outcome, Horner and Diamond (1996) found evidence to suggest that sensitivity, impulsivity, narcissism and emotional instability are also traits contributing to the high attrition rate for this population. The largest effect was found for high narcissism scores, which predicted dropout in approximately 92% of cases. Impulsivity alone is reported to have a moderate negative correlation with length of treatment (r = -0.51) (Yeomans et al., 1994), and high levels of anger are usually the norm for this population, which can be problematic in therapy (Skodol et al., 1983), particularly if directed at the therapist. Despite these characteristics acting as potential barriers to treatment, it has been identified that when rapprochement themes are present, the chances of borderline personality disordered patients remaining in therapy may increase (Horner & Diamond, 1996). Rapprochement is a term used to describe the latter stage of an infant's individuation process, which involves a heightened state of conflict between the need for closeness and distance (Mahler et al., 1975). According to these findings, the impact of therapy interfering traits such as impulsivity and sensitivity, could be

compensated by levels of agreeableness. Analogously, Hilsenroth et al. (1995) maintain that interpersonal relatedness is a mediating factor in predicting discontinuation in this population, and this could also be linked to degrees of agreeableness.

A collection of studies on personality traits and discontinuation have used the scales from the Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway & McKinley, 1940) to ascertain predictor variables. One outpatient study found male discontinuers scored differently to males who remained in treatment on the MMPI scales of defensiveness, depressiveness and poor adjustment (Walters, Solomon, & Walden, 1982), although the correlations were relatively small. Overall, research using these scales has yielded mixed results. For example, Garfield (1994) and Hilsenroth et al. (1995) found no significant predictor variables for therapy discontinuation using the MMPI scales. Some researchers even controlled for symptom severity and personality disorder diagnosis to isolate personality traits measured by the MMPI-2 (Hathaway & McKinley, 1989) scales (Chisholm, Crowther, & Ben-Porath, 1997); although a relationship with therapeutic outcome was identified, there was no evidence of a relationship with discontinuation.

Some differences between patients who externalise compared to those who internalise their problems as a way of coping have been noted. Externalising patients may view their problems as more situational (Greenspan & Kulish, 1985), are liable to have a reduced capacity to self-reflect, be less psychologically minded, and are therefore less likely to persist with psychotherapy (Loffler-Statska, Blueml, & Boes, 2010). This is consistent with the view that patients who externalise are better matched with behavioural rather than insight-oriented therapies discussed earlier (Beutler, Consoli, & Lane, 2005).

NEO-PI Personality dimensions. Drawing on the findings from his own clinical case studies, Miller (1991) proposed a treatment model based on the five-factor model of

personality (NEO-PI) (Costa & McCrae, 1985), which can be used to predict the likelihood of retention or discontinuation in psychotherapy. The development of this model used information obtained from patient scores on the NEO-PI, combined with his own clinical experience and background research. The sample consisted of 119 patients from an outpatient clinic, comprising mainly blue collar workers with a range of psychological disorders, statistically high levels of neuroticism, and average scores on the other four personality factors of extraversion, agreeableness, openness and conscientiousness. Based on his findings, Miller (1991) put forward a set of patient typologies that could guide psychotherapeutic treatment.

Miller (1991) suggested that neuroticism motivates treatment compliance due to the patient's experience of emotional discomfort, yet patients with high scores on this trait may continue to experience a moderate degree of emotional discomfort in the long-term. Consistent with the notion that some stress actually improves motivation, perhaps there is an optimal level of stress as a result of emotional discomfort that corresponds to motivation for help-seeking and therefore therapy engagement. In comparison, patients with a low score on neuroticism may present as calm or well-adjusted individuals, with difficulties of a more situational nature due to dynamic stressors. According to this theory, there is a high probability that very neurotic patients would remain in therapy, whereas less neurotic patients may discontinue once their immediate problems are resolved.

Patients with high levels of extraversion who present as eager, highly sociable and talkative, generally have better outcomes according to Miller's (1991) theory. These patients are suited to a less structured therapeutic approach, although if they are particularly loquacious it can be challenging to remain goal-focused and move beyond a superficial alliance. Miller offered a less hopeful view of patients with low levels of

extraversion, who he described as verbally reluctant and overwhelmed in the presence of others. This type of patient would fit better with a structured treatment approach, may only interact minimally with the therapist, and would typically dread attending therapy. Based on Miller's findings, one might expect that very introverted patients will not persist with psychotherapy because of their level of discomfort with the process, which involves sharing their inner thoughts, feelings and fantasies with another person.

Conscientiousness is defined as the capacity to control impulses and resist temptations (Costa & McCrae, 1992b). High conscientiousness is thought to be associated with enjoyment of accomplishment, persistence and self-discipline, so these patients typically work very hard in therapy to achieve their goals and are willing to endure distress and frustration to do so (Miller, 1991). In fact, Miller asserted that very conscientious patients have almost no pitfalls in therapy. Comparatively, low conscientiousness in a patient can be seen in their apathetic commitment to goals, poor frustration tolerance and an investment of minimal effort towards change (Miller, 1991). It is also associated with social inhibition and negative affectivity (De Fruyt & Denollet, 2002). Patients with low conscientiousness seem prone to discontinue given therapy requires some level of emotional discomfort and tolerance of complex feelings. Once they have engaged, these patients may fail to work hard enough, not see any results and therefore discontinue. In addition, given these traits are so stable over time, they are resistant to most forms of challenging by the therapist (Miller, 1991).

From his research in this area, Miller (1991) postulated that a combination of high neuroticism, low extraversion and low conscientiousness in a patient, constituted a 'misery triad'. He argued that this type of patient was generally depressed, had experienced failure in many areas of their life, and had minimal capacity for well-being.

It could be argued that this triad of personality traits reflects a person who is unlikely to succeed in therapy. In addition, Sanderson and Clarkin (2002) contend that patients with a combination of low agreeableness and low conscientiousness generally respond inadequately to treatment, which may put them at higher risk of discontinuation.

The Agreeableness trait is associated with cooperation and interpersonal success (Costa & McCrae, 1992a). Miller (1991) reported that a therapeutic alliance is easily and quickly formed with patients who are highly agreeable. However, he found that these patients have a strong need to please the therapist because they usually fear disapproval and avoid conflict, which could interfere with open discussion of the transference. On the contrary, a patient with low levels of agreeableness can be overly competitive, envious and suspicious of the therapist, leading to hostility and scepticism in the therapeutic relationship (Miller, 1991). They may also exhibit a lack of empathy and have negative interpersonal experiences (Costa & McCrae, 1992a), which could explain why low levels of agreeableness are characteristic of patients with personality disorders where there are marked interpersonal difficulties such as paranoid, schizotypal, antisocial, borderline and narcissistic disorders (Saulsman & Page, 2004). It follows that patients who are less agreeable may find engagement in therapy challenging because of these factors, and could therefore initiate premature discontinuation. Miller suggests that further research to clarify this point would be helpful.

According to Miller (1991), patients with more openness demonstrate more curiosity, fantasize more readily, and are able to think in abstract and imaginative terms. Openness is related to inquisitiveness, broadmindedness, emotional awareness, and a desire to seek out new experiences; for example, high openness is associated with a preference to explore a new city without a map (McCrae, 1990b; McCrae & Costa, 1983a). Nuetzel and

Larsen (2012) draw a parallel between this and the experience of exploring one's own internal world in therapy, for which a high tolerance of ambiguity is required. Openness is analogous to suggestibility, which has been named as a protective factor for remaining in therapy (Frank, 1974). Openness may also be related to help-seeking behaviour such that being more open would result in being more willing to contemplate and try new ways of approaching personal problems. This could have implications for accepting offers of help from another person such as a therapist.

Patients with low levels of openness show the opposite trend; they are usually rigid, uncomfortable with the therapeutic process, typically adopt a concrete thinking style which reduces their capacity for free association, and are unable to understand basic psychodynamic interpretations (Miller, 1991). Miller advised that patients with low levels of openness respond better to psycho-education and supportive therapy because they are not interested in gaining insight and experiencing themselves in novel ways. Psychodynamic psychotherapy entails journeying into the unknown on a voyage of self-discovery, and sharing this experience with the therapist in an unhindered way. As such, Miller argued that patients who are open and extraverted are well suited to this type of therapy. One might therefore assume that an introverted, less conscientious, and less open individual would find psychodynamic psychotherapy particularly challenging.

In a recent study, Nuetzel and Larsen (2012) investigated whether there were differences between patients who discontinued from long term open-ended psychodynamic psychotherapy compared to those who persisted in a sample of adults, using measures of personality dimensions, symptom profiles and self-reported adjustment. In support of Miller's (1991) model, they found that the patients who persisted in therapy for more than one year had significantly higher scores on the personality trait of openness at baseline.

If patients had higher levels of optimism for the coming week, rather than a negative outlook, they were also more likely to persist with the therapy process. Optimism could act as a facilitating factor in therapy as it corresponds to the absence of negativity, a factor known to cause alliance problems. In accordance with this, Sanderson and Clarkin (2002) reported that patients with a combination of high agreeableness and openness were likely to form a strong therapeutic alliance.

A pilot study conducted at the Glen Nevis Clinic for Psychoanalytic Psychotherapy in Melbourne, Australia, has explored the influence of NEO-PI personality traits on patient discontinuation or continuation. The Glen Nevis Clinic is also the focus of the current research, which expands on this previous study, and is discussed in more detail in the Method section. Green (2009) initially found no association between personality factors and continuance or discontinuation of a two year course of psychotherapy. However, in a later study exploring clinic patients' decisions whether or not to proceed with psychotherapy after assessment, Green (2011) reported counter-intuitive findings. He ascertained that patients with low levels of agreeableness and conscientiousness were more likely to proceed with psychotherapy after assessment, rather than discontinue, which contradicts Miller's abovementioned model. Green (2011) argued that patients with low scores on the personality dimensions of agreeableness and conscientiousness were less interpersonally engaged in their lives, so the therapy relationship offered a unique experience for connecting with another person. Green also concluded that only patients with low agreeableness and conscientiousness, who are also motived to engage in therapy, would seek services from the Clinic. This is because the majority of patients are aware that the clinic offers long-term treatment of up to two years duration and twice weekly intensity, so there is no expectation mismatch. Importantly, Green's results were

only reliable for predicting patient continuation from the assessment phase into therapy, and he reported that no personality traits were able to reliably predict patient discontinuation after assessment.

In summary, high levels of patient agreeableness, extraversion, openness, and conscientiousness, are typically viewed as a recipe for therapy engagement and success, whereas low levels of these traits are generally thought to be problematic for psychotherapy and may be related to discontinuation. These traits are all positively correlated with the therapeutic alliance (Coleman, 2006). In contrast, high levels of patient neuroticism are arguably necessary for patient motivation and therefore engagement and continuation in therapy, whereas low levels of neuroticism may be linked to early discontinuation. However, in an outpatient sample with complex and severely unwell patients, agreeableness and conscientiousness were predictive of therapy engagement after assessment, but these traits did not have any predictive value for discontinuation. Overall there are mixed findings on the relationship between NEO-PI personality dimensions, and personality factors in general, on patient discontinuation.

Symptomatology. Common sense may suggest that the type and severity of symptoms a person experiences will affect their capacity to engage and persist in psychotherapeutic treatment. One might imagine that some symptoms present a barrier to the patient's physical attendance at a clinic, let alone their ability to undergo talking therapy. However, a review of the literature on symptomatology and patient discontinuation revealed inconsistent and contradictory results. Firstly, research is lacking on particular types of symptoms or symptoms profiles that influence discontinuation. Some studies link adult depressive symptoms to discontinuation of psychotherapy (McCallum, Piper, & Joyce,

1992; Persons et al., 1988), and there is also some research available from child psychotherapy in this regard. One small study of note, conducted by Deakin and Nunes (2009), found that children who remained in therapy were commonly females with internalising disorders, suffering from symptoms such as anxiety, insecurity, fear, depression and somatic complaints. The group who left therapy were mainly young boys with behavioural and attentional symptoms. These are only a handful of studies, and there is not sufficient evidence to assume that the type of symptomatology a person displays has a reliable influence on their likelihood of discontinuing therapy.

Furthermore, there does not appear to be a good understanding of how symptom severity affects patient discontinuation. Pre-treatment symptom severity has been widely studied, and the general consensus is that patients who have lower symptom severity and lower distress before commencing treatment are more likely to terminate prematurely (Gunderson et al., 1989; Hansen, Hoogduin, Schaap, & De Haan, 1992; Kelly et al., 1992; Kutter, Wolf, & McKeever, 2004). Numerous studies have also determined that people who discontinue therapy are more assertive, independent and less distressed (Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003; Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010). According to these findings, patients who leave therapy are generally less affected by symptoms, know what they want, know what will work for them, and are active in finding alternative solutions. In contrast, in studies on antisocial children in outpatient therapy, it has been reported that discontinuation commonly eventuates when symptoms are more severe and chronic (Kazdin, 1990; Kazdin & Mazurick, 1994). The conflicting findings may be due to different factors being important in adult discontinuation compared to child discontinuation, different therapeutic

modalities being used in research, and the fact that none of these studies evaluated the phase of treatment in which discontinuation occurred.

To confuse matters, a collection of studies report no significant relationship between symptom severity and patient discontinuation (Horner & Diamond, 1996; Keijsers, Kampman, & Hoogduin, 2001; Nuetzel & Larsen, 2012; Smith et al., 1995). Nuetzel and Larsen (2012) used the Hopkins Symptom Checklist (SCL-R-90) to measure somatization, obsessiveness, interpersonal sensitivity, depression, and anxiety at regular intervals throughout psychodynamic psychotherapy treatment. Based on findings presented above on borderline personality disorder, one would assume that interpersonal sensitivity may be predictive of discontinuation. However, these authors found no difference between the group who stayed in therapy and the group who discontinued on any of these symptom dimensions. Similarly, Horner (1996) examined a small sample of patients with borderline personality disorder and found no differences on SCL-R-90 scores between those who terminated and those who completed psychodynamic psychotherapy.

Discrepancies in the literature are abundant when it comes to looking at how symptomatology affects patient discontinuation. This may be due to the variable nature of symptoms, which makes them challenging and elusive to measure. For example, in their study Nuetzel and Larsen (2012) noticed that participants who discontinued therapy early did not improve symptomatically, whereas the participants who stayed experienced significant symptomatic change after approximately three to four months, once a strong therapeutic alliance was properly established. Therefore, the initial symptom profile of each patient does not give a complete picture of how their symptoms fluctuate over time, and the time of measurement must be carefully thought through. Garfield (1994) contends

that symptoms are only related to discontinuation when measured during treatment, so pre-treatment measures will not be prognostic. Other researchers even claim that only symptoms measured just prior to discontinuation are likely to be significant (Chasson, Vincent, & Harris, 2008).

It can also be argued that the type and severity of symptoms is less critical than the level of distress caused by them; however, the idiosyncratic effect of symptoms is far more difficult to measure. Yu (2011) makes the case that patients' subjective experience of symptoms is a better predictor of discontinuation than the symptoms per se. This is in agreement with a large study by Hilsenroth et al. (1995) using Rorschach data, which concluded that a person's equilibrium of psychological resources verses demands has predictive value. They suggested that if a person's symptoms are too severe and they lack the psychological resources to manage, they are more prone to therapy disengagement. A person who finds their situation overwhelming and feels unable to cope would likely experience more subjective distress from their symptoms. These findings can be linked to research noted above on GAF scores, which reflect the functional impact of symptoms, and the connection of these to therapy outcome (Von Der Lippe et al., 2008). It might be hypothesised that the opposite is also true; that patients who experience a reduction in their symptoms and therefore a reduction in distress are more prone to premature discontinuation.

Qualitative Research Findings

Most of the research in the area of patient discontinuation has focused on patient variables and there are very few qualitative studies that have addressed the issue in more depth, particularly from the patient's perspective. In fact, the patient has usually been blamed

for therapeutic failures (Casement, 2002). Historically, psychoanalytic research has favoured the therapist's or the researcher's account of therapy, seen it as a superior view of reality, and habitually overlooked the second person in the therapeutic dyad (Hill, 2010). However, where both viewpoints have been investigated, contradictory reports between patient and therapist have been found. For example, Harty and Horowitz (1975) gathered data on patient and therapist ratings of patient satisfaction with treatment and level of goal attainment, and discovered that therapists over-estimated patient success. Similarly, Morley (2007) and Satran (1995) assert that patients and analysts have different agendas in therapy. In her book, 'What do patients want: psychoanalytic perspectives from the other side of the couch', Hill (2010) detailed a qualitative study of eighteen Australian adults who underwent psychoanalysis. She was interested in exploring the question of what patients want, by giving voice to the patient and discovering what enabled or encumbered therapy from their own perspective. Unfortunately, she reported some resistance to her research; one senior analyst considered it as more of a social study, others doubted whether patients could really know what they wanted or whether they had benefitted from analysis, and others were quick to explain the patient's dissatisfaction as transference. This provided Hill with real evidence of how the profession had come to subtly deny the voice of the patient.

In her journey into perspectives from the other side of the couch, Hill revealed that the personal and innate characteristics, or the personality of the analyst, had a very powerful impact on the quality of engagement and connection in the therapeutic relationship (Hill, 2010). For most patients, these innate analyst qualities were more important than the interpretations offered to them during the therapy. After all, the relational and human quality of Freud's interactions with his patients were thought to be curative (Roazen,

1985). Patients reported that therapy was successful when analysts stepped outside of a neutral stance and used their personal qualities in quite specific ways. According to Hill's research, some of the positive attributes that analysts held which made a great impression on the patient included gentleness, kindness, care, humanness, flexibility, playfulness, warmth, empathy and persistence. The negative analyst characteristics reported by patients included inflexibility, insensitivity, passivity, neutrality, authoritativeness and punitiveness, which were more frequently experienced by those who prematurely ended their analysis. Hill concluded that the person of the analyst played a bigger role in the outcome of psychoanalysis than the training, or theoretical framework, which is consistent with the research cited earlier by Anastasopoulos and Papanicolaou (2004).

Hill's (2010) work also highlighted the importance of analyst technique and the psychoanalytic frame in fostering a therapeutic process. The fit, flexibility, language used, and the delivery of interpretations, were all essential aspects of technique that either blocked or allowed deeper reflection in the patient. Additionally, the reliable and consistent nature of the frame enabled trust to develop in the relationship. Hill also noted the centrality of patient choice and agency in analysis, such that patients could assert their wishes and needs in the relationship and take the role of patient-partner rather than patient-victim.

Overall, Hill (2010) found that patients discontinued analysis because they were unable to develop a satisfactory relationship with the analyst. Alternatively, they got stuck and found that the analysis was inadequate or that it hindered them in some way. Hill recognised an interesting association between the process by which patients ended their analysis, and their future analytic journey: Patients who had positive and meaningful experiences also had a more mutually agreed upon termination period and were able to

properly prepare for this ending. Moreover, whether the ending was positive or negative was linked to how patients later recalled their overall experience of analysis.

Hill's (2010) research has provided a unique and rich insight into the patient's experience of therapy that has rarely been explored in such depth. She emphasised the need for future research to look at failed therapy and the patient's experience after termination, which is addressed in the current study. The voice of the patient is necessary for gaining a more comprehensive understanding of how and why patient discontinuation occurs.

Methodological Limitations

The literature on the phenomenon of patient discontinuation is in a state of "definitional chaos" (Armbruster & Kazdin, 1994). Despite the amount of research conducted, arbitrary, varied and subjective definitions and criteria for discontinuation have been adopted, and there is a focus on different phases of treatment (Corning & Malofeeva, 2004), not to mention different treatment approaches employed across different studies. In their meta-analysis, Wierzbicki and Pekarik (1993) established that when failure to attend a scheduled session was the criterion used, there was a low discontinuation rate. Alternatively, when the criterion was based on clinical judgement or the number of attended sessions, a high rate of discontinuation was reported. Essentially, smaller rates of discontinuation can be produced by using the non-attendance criterion. Deakin et al. (2012) contend that clinical judgement is the most reliable measure of discontinuation, while it is also the least objective. In any case, there seems to be ongoing disagreement amongst researchers about what criteria should be used. In addition, many studies on early discontinuation have used small clinical samples of patients with a single type of disorder, which has resulted in unreliable findings that are limited in their contribution to our

understanding of this issue. This is especially true for discontinuation research in psychodynamic psychotherapy, which is inadequate in volume and complicated by incongruous findings. Few studies have a psychotherapy duration of greater than one year (Perry, Bond, & Roy, 2007). Given that the rate of discontinuation changes depending on the definition used (Wierzbicki & Pekarik, 1993), a myriad of predictor variables are reported (Warnick et al., 2011) and these have been outlined in the previous sections. All these different factors need to be organised in a systematic and meaningful way. Although the current study does not set out to achieve this ambitious task, it is hoped that the data can be used as a stepping stone to accomplishing a more reliable theory.

Almost two decades ago, Kazdin (1996) argued that leaving therapy in the early stages was so dissimilar from leaving after a number of months, that these two events were not comparable, and needed different terminology applied to them. This idea has been advanced by Gastaud and Nunes (2010), who suggest that to reduce inconsistency and standardize research, discontinuation can be classified in three categories. The first category they propose is ‘non-adherence’; when a patient leaves during assessment or prior to setting any clear goals. The second category is ‘dropout’; when a patient has usually been coming to therapy for approximately one month, yet leaves for any reason before meeting any goals. The final category is ‘successful discharge’; when a patient meets some or all of their goals and either a bilateral or unilateral decision is made for them to be discharged from the service. The authors advise that this framework of definition and measurement needs to be applied in more research, so that replicable results can be obtained and psychotherapists can work towards improving engagement practices.

Rationale of the Present Study

As outlined above, research on patient discontinuation has found mixed results. There are certainly some indications that relatively stable personality features such as agreeableness, extraversion, openness, conscientiousness, and optimism may facilitate persistence in therapy. The research also points to enduring individual characteristics that may inhibit the therapeutic process, such as hostility, impulsivity, sensitivity and negativism, thus contributing to patient discontinuation. However, an investigation of these enduring characteristics using the *MMPI* scales had contradictory outcomes (Garfield, 1994; Hilsenroth et al., 1995). The literature to date implies that more fluid patient characteristics such as symptomatology, the level of distress experienced by individual patients as a result of their symptoms, and a person's current level of functioning, may also be contributing to discontinuation. Unfortunately, paradoxical findings about symptomatology that have been presented here raise more questions than they answer (Horner & Diamond, 1996; Keijsers et al., 2001; Nuetzel & Larsen, 2012; Smith et al., 1995).

Replicable results on patient discontinuation are not available because of the range of methodologies used and different types of therapeutic approaches studied. The majority of studies have focused on quantifiable patient variables, and there is a paucity of qualitative research. Nevertheless, the large body of research already established in the area of patient discontinuation, has certainly drawn attention to its prevalence, and therefore its relevance to the psychotherapy profession. It is necessary for psychotherapists to have better insight into this issue in order to improve retention rates and outcomes for patients. Clinical settings are thought to be an ideal environment in

which to study the phenomenon of patient discontinuation, determine risk factors and develop clinical guidelines that will assist in reducing it (Kazdin, 1996).

In light of this, the present study focused on the phenomenon of patient discontinuation from psychodynamic psychotherapy alone and employed a mixed methods approach. To achieve the aims outlined below, broad-based measures of patient functioning were used because of the inconsistent relationship between discontinuation and discrete individual factors, and because patient variables operate in complex and dynamic ways rather than in isolation. In view of methodological issues about the phase of treatment studied that have been raised (Corning & Malofeeva, 2004; Deakin et al., 2012; Nuetzel & Larsen, 2012; Richmond, 1992), the current study separated patients who discontinued during the initial assessment phase (Group 1) from those who discontinued during treatment proper (Group 2), and those who completed two years of psychotherapy (Group 3).

Aim of Phase 1

In keeping with the rationale of the study, the purpose in Phase 1 of this research was to illuminate individual patient characteristics associated with discontinuation from a low-fee clinic offering 24 months of psychoanalytic psychotherapy, by looking at differences between baseline measures of symptomatology and personality dimensions at different stages of discontinuation.

Hypothesis 1

Patients who discontinue psychodynamic psychotherapy at a low-fee clinic at different stages, will have different scores on measures of current global distress (as measured by

the CORE-OM), and psychiatric symptomatology and psychological distress (as measured by the BSI):

- *It is predicted that patients who discontinue therapy during the assessment phase (Group 1 – Early Discontinuation) will have:*
    - *Higher global scores on the BSI than Group 2 or Group 3*
    - *Higher scores on specific symptom dimensions of hostility and interpersonal sensitivity on the BSI than Group 2 or Group 3.*
    - *Higher global scores on the CORE-OM than Group 2 or Group 3.*
    - *Higher scores on the life and social functioning domain of the CORE-OM than Group 2 or Group 3.*
- *It is expected that patients who discontinue therapy during the treatment phase (Group 2 – Late Discontinuation) will have:*
    - *BSI scores that are lower than Group 1 but higher than Group 3.*
    - *Hostility and interpersonal sensitivity scores that are lower than Group 1 but higher than Group 3*
    - *Global CORE-OM scores that are lower than Group 1 but higher than Group 3.*
- *It is predicted that patients who complete 24 months of therapy (Group 3 – Completion) will have:*
    - *Lower scores on the BSI than Group 1 or Group 2.*
    - *Lower scores on the specific BSI symptom dimensions of hostility and interpersonal than Group 1 or Group 2.*
    - *Lower global scores on the CORE-OM than Group 1 or Group 2.*

- *Lower scores on the life and social functioning domain of the CORE-OM than Group 1 or Group 2.*

Hypothesis 2

A second hypothesis explored in the present study, is that patients who discontinue psychodynamic psychotherapy at a low-fee clinic at different stages will also have different scores on the five dimensions of personality, as measured by the NEO-FFI:

- *It is predicted that neuroticism will be higher in Group 1 compared to Group 2 or Group 3. In Group 2, neuroticism scores will be higher than Group 3 but lower than Group 1, and in Group 3, neuroticism scores will be lower than Group 1 or Group 2.*
- *It is expected that patients' extraversion, agreeableness, openness and conscientiousness scores will be lower in Group 1 compared to Group 2 or Group 3. In Group 2, these scores will be lower than Group 3 but higher than Group 1, and in Group 3, scores will be higher than Group 1 or Group 2.*

Aim of Phase 2

The purpose of Phase 2 of the present study, was to explore in more depth the question of why patients discontinued from psychoanalytic psychotherapy at a low-fee clinic. Phase 2 sought to clarify and extend our knowledge of what interferes with therapy and leads to discontinuation in this context, by analysing interview notes of patients who discontinued therapy.

Chapter 2: Method

The current study utilised data from a large longitudinal research project being undertaken by Monash University at the Glen Nevis Clinic for psychoanalytic psychotherapy in inner-city Melbourne, Australia. This section provides background information on the Clinic and how participants were initially selected and recruited for the research project. Following this is an outline of the method used in the current study. It details the overall study design, the current sample, data collection methods and procedures, and finally how the data was analysed.

Research Setting

The Glen Nevis Clinic. The Glen Nevis Clinic (GNC) was established by the Victorian Association of Psychoanalytic Psychotherapists (VAPP) to provide up to 24 months of low-cost psychoanalytic psychotherapy to adults otherwise unable to access such a service due to low income. The capacity for ongoing research and evaluation was explicitly built into the design of the Clinic as a condition of the philanthropic funding. The Glen Nevis Clinic Committee of Management and the VAPP Council have given their full support and collaboration to the research. The GNC is the first of its kind in Australia and provides a unique opportunity for research into psychoanalytic psychotherapy. This type of psychotherapy is generally intensive and long-term, and typically involves the exploration of complex historical and unconscious features relating to the patient's current difficulties. Patients are expected to commit to twice weekly sessions for up to two years if they wish to receive treatment at the GNC, and pay a fee

of $10 or $20 per session dependent on their income. The decision for a 24 month time-frame for therapy was based on funding availability. Potential patients can self-refer but they are usually referred by a general practitioner or mental health professional.

An advantage of the GNC as a research setting is that it has a clearly-defined treatment approach - namely psychoanalytic psychotherapy - which provides commonality in the service provided to patients (see Appendix 1 for the VAPP definition of psychoanalytic psychotherapy). This reduces the impact of variable treatment modalities and allows for research to isolate and focus on patient factors. The Clinic services patients from low-income backgrounds with a variety of presenting problems. Given the type of treatment available, the GNC patient population tends to present with more chronic psychological distress and complexity than a typical outpatient setting. Nevertheless, the Clinic is not designed to see high-risk patients or patients who require more intensive or inpatient psychiatric management.

Participants

Monash University research project. The current study was part of a broader longitudinal research project being conducted by Monash University that involved patients and psychotherapists from the GNC (see Appendix 11 for Human Ethics Approval Certificate). Psychotherapists were twenty-four Melbourne psychoanalytic psychotherapists who had worked as such for ten or more years. Twenty-two of these therapists were over 40 years of age and previously worked in Clinical Psychology (12), Psychology (2), Social Worker (4), Nursing (4), Psychiatry (1) and School Counselling (1). Seventeen of the psychotherapists were female and seven were male.

The aim of this research was to establish clinical outcomes, to identify process factors facilitating outcomes and to understand barriers to patient engagement in psychotherapy. The research study was introduced to all patients in their initial phone contact with the Clinic, in the patient application form, and subsequently all patients were briefed by the Clinic Psychologist about the research study at intake. If interested, patients and psychotherapists were given a copy of the Monash University Explanatory Statement (Appendix 2) and Consent Form (Appendix 3). Consenting patients and psychotherapists were interviewed at the Clinic at 8 months, 16 months and 24 months during the course of therapy. Patients were also interviewed at 8 months follow-up, or if they discontinued prior to 24 months of treatment.

Participant selection. All patients accepted as suitable to attend the GNC for psychotherapy were invited to participate in the research. Exclusion criteria for entry into the psychotherapy program, and thus the research, included active psychosis, a history of violence, and current substance abuse problems. Patients were also required to meet a low-income criteria. The current study used data from 188 participants aged between 18 and 70 years at intake.

Procedure

Clinic intake procedure. Patients seeking a service from the GNC filled out an application form. Once the Clinic received this form and were satisfied the patient met the low income and exclusion criteria, they were invited to attend an initial interview at the Clinic. This interview was completed by the Clinic Psychologist and took the form of

a semi-structured clinical interview. The appointment was used to get a general sense of the patient's presenting issues, any previous diagnosis, and to collect a range of information about their psychological functioning. The interview did not include a structured diagnostic assessment, but did include baseline administration of the *NEO Five-Factor Inventory* (Costa & McCrae, 1992b), the *Brief Symptom Inventory* (Derogatis, 1975) and the *Clinical Outcomes in Routine Evaluation* measure (Evans et al., 2000).

All patients who met the criteria of the Clinic were systematically assigned to the next available therapist. Patients then had four assessment sessions with their assigned therapist (once per week frequency), before commencing twice weekly sessions at the Clinic. The assessment process was an opportunity for therapists to assess whether patients were good candidates for psychoanalytic psychotherapy, and also for patients to make their own assessment about this approach so they could make an informed decision about proceeding. Patients who would be better suited for another service were identified during this process and an appropriate referral was made. Demographic information was also obtained and recorded as part of this routine data collection. For patients who consented to participate, data gathered during this intake procedure was made available to the researcher and was used for the current research project.

Phone interviews. Patients who left the Clinic before completing the two years of therapy were contacted via telephone to be interviewed. The phone calls were made by an independent consultant who was a clinical psychologist and experienced qualitative researcher assisting with the research, but who was independent of the main research team. At the beginning of the phone call the patients were asked if it was a convenient

time to answer some questions and informed that it may take up to 15 minutes of their time. Patients had the option of scheduling a more suitable time to undertake the interview, or to decline the interview altogether. Each interview began with a question about the patient's experience of the GNC. It then moved onto whether their expectations were met, and who made the decision to discontinue (therapist or patient). Finally, the interview aimed to explore what therapeutic support the patient currently received and, if they had commenced working with another therapist, how this was going (See Appendix 4). At the conclusion of the interview patients were encouraged to give any other details they believed were relevant about their experience of the GNC. Interviews were designed to be open-ended in order to facilitate discussion and elicit rich responses. Conversation was allowed to develop in a spontaneous and natural way, and the researcher asked further questions to clarify points made by the patients. Patient responses were recorded in short-hand during the conversation and the resulting interview notes used as data.

Materials

Formal psychological measures administered. The first phase of the research involved formal measurement of personality dimensions, symptoms and global distress at the point of intake into the GNC. Quantitative measures were all standardised self-report questionnaires, namely the *NEO Five-Factor Inventory*, the *Brief Symptom Inventory*, and the *Clinical Outcomes in Routine Evaluation* measure. Each of these tests is described in detail below, including information about their reliability and validity.

NEO Five-Factor Inventory (NEO-FFI). The *NEO-FFI* (Costa & McCrae, 1992b) is a 60-item self-report questionnaire that measures the five major dimensions of normal personality: neuroticism, extraversion, openness, conscientiousness, and agreeableness.

The *NEO-FFI* is a brief form of the full 240-item *NEO Personality Inventory – Revised (NEO PI-R)*, and the scales that measure these personality dimensions are derived from the five-factor model of personality structure that has been developed over decades of factor analytic research (Costa & McCrae, 1992b). There are 12-items on each of these five dimensions in the *NEO-FFI*, all with a 5-point Likert response format. Respondents are asked to reflect on their typical thoughts, feelings and behaviours that are consistent across time in answering the questionnaire. The test is usually completed in only 10 to 15 minutes. Example items for this test are located in Appendix 5.

The *NEO-FFI* scales are strongly correlated with the full *NEO PI-R* scales (between 0.88 and 0.94 for the five dimensions), and internal consistency ranges between 0.68 and 0.86 (Costa & McCrae, 1992b). Two-week retest reliability is also reported as high, ranging from 0.86 to 0.90 (Robins, Fraley, Roberts, & Trzesniewski, 2001). In longitudinal studies of up to six years, the test-retest reliability varies between .63 and .81 (Costa & McCrae, 1992d). When *NEO-FFI* scores were compared to convergent criteria such as adjective factors, and scores on the *NEO PI-R* self-report and observer rating forms, McCrae and Costa (1985b) reported correlations between 0.56 and 0.62 for the five personality dimensions. In these comparisons, divergent correlations did not exceed 0.20, indicating sound convergent and divergent validity. Despite being an abridged version of the full 240-item scale, the *NEO-FFI* accounts for approximately 85% of the variance in convergent criteria as the *NEO PI-R* (Costa & McCrae, 1992a).

The construct validity of the *NEO-FFI* is evidenced by its utility and success in predicting personality in a wide range of contexts, making it one of the most extensively used personality tools internationally (Pytlik Zillig, Hemenover, & Dienstbier, 2002). For example, the *NEO-FFI* has been used in research on personality trait heritability

(Riemann, Angleitner, & Strelau, 1997), personality change during adult development (Robins et al., 2001), and in the prediction of personality disorders (Brieger, Sommer, Blöink, & Marneros, 2000).

More broadly, the five factor model of personality has been effectively used to predict a host of psychological constructs, such as well-being (Costa & McCrae, 1984), coping style (McCrae & Costa, 1986b), interpersonal style (McCrae & Costa, 1989c), and therapy engagement (Miller, 1991). For example, Costa and McCrae (1986b) found that immature or neurotic coping styles, such as escapist fantasy, indecisiveness, sedation, self-blame and hostile reactions, were significantly associated with the dimension of neuroticism. Furthermore, the five factor model demonstrates good criterion group validity because identified groups of individuals who differ on the five personality dimensions also differ in predicted ways. It has been shown that clinical samples have high scores on the dimension neuroticism (Miller, 1991), low agreeableness, low conscientiousness, and low extraversion (Malouff, Thorsteinsson, & Schutte, 2005), and samples of patients who abuse substances have low scores on agreeableness and conscientiousness (Brooner et al., 1991).

Brief Symptom Inventory (BSI). The *BSI (ref)* is a 53-item self-report symptom inventory, a brief form of the *SCL-90-R*, which measures current, point-in-time psychiatric symptoms and psychological distress. Respondents are asked to rate their symptoms and distress in the past four weeks. The items on the *BSI* reflect nine symptom dimensions and three global indices of distress, examples of which are found in Appendix 6. The symptom dimensions include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The global indices include a global severity index, positive symptom total

and positive symptom distress Index. This study used all nine symptom dimensions to measure current psychiatric symptomatology, and the global severity index, for an overall measure of psychological distress within the sample.

Internal consistency coefficients reported by the author ranged from 0.71 (psychoticism) to 0.85 (depression) (Derogatis, 1993). Croog et al. (1986) reported coefficients between 0.78 and 0.83, while Aroian and Patsdaughter (1989) recorded internal consistency coefficients mainly above 0.80 in a smaller sample. The test-retest stability of the *BSI* over a two week period is purportedly very good, ranging from 0.68 (somatization) to 0.91 (phobic anxiety) (Derogatis, 1993). The test-retest coefficients for the global indices ranged from 0.87 to 0.90 (Derogatis, 1993).

The predictive validity of the *BSI* is well established. Studies have shown that it is predictive of psychological distress in a number of different populations: *BSI* scores in recently diagnosed cancer patients were predictive of current and future clinical symptoms (Zabora, Smith-Wilson, Fetting, & Enterline, 1990). *BSI* scores also correctly discriminated between varying levels of drug abuse and patient disposition in a sample of substance abusers (Royse & Drude, 1984). In an important study by Cohen, Test and Brown (1990), *BSI* scores were predictive of suicide in patients with schizophrenia from a community treatment centre. A number of studies have also demonstrated the convergent validity of the *BSI.* Derogatis, Rickels & Rock (1976) compared the *BSI* to the Minnesota Multiple Personality Inventory (*MMPI*) and found the clinical scales of the *MMPI* were correlated to all nine symptoms dimensions of the *BSI.* In particular the dimensions of interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism were clearly convergent. Although the magnitude of

correlations was smaller than for the *SCL-90-R*, the brevity of the *BSI* did not have a significant impact on overall convergent validity (Derogatis, 1993).

Clinical Outcomes in Routine Evaluation (CORE-OM). The *CORE-OM* (Evans et al., 2000) is a 34-item self-report instrument that measures global distress. It can be used as an initial mental health screening tool or outcome measure in a range of clinical settings. Respondents are asked to rate their distress levels in the past week. This brief instrument taps into patients' current distress by assessing four domains: subjective well-being, commonly experienced problems or symptoms, life and social functioning and risk to self and others (Barkham, Mellor-Clark, Connell, & Cahill, 2006). Examples of questions from each domain are listed in Appendix 7. Scores can be compared to normative data for clinical and non-clinical populations.

All of the domains of the *CORE-OM* have internal consistency α values between 0.75 and 0.95, representing suitable internal reliability (Evans et al., 2002). Test-retest stability of the *CORE-OM* is sound, with high test-retest correlations ($0.87 < 0.91$) (Evans et al., 2002). Evans et al. (2002) also reported that the *CORE-OM* is strongly correlated with conceptually close measures; the problems domain yielded the highest correlations, for example with the Beck Depression Inventory (0.78), the Beck Anxiety Inventory (0.68), the Brief Symptom Inventory (0.76), and the *SCL-90-R* (0.87). In addition the *CORE-OM* showed large and statistically significant differences between scores for clinical and non-clinical samples (Evans et al., 2002).

Analysis of the Data

For the purposes of the current research project, the participants were divided into three groups based on the point at which discontinuation occurred. These groups were as follows:

- Group 1 - Early Discontinuation (n = 84): *Patients who discontinued therapy during the assessment phase (sessions 1-4).*
- Group 2 - Late Discontinuation (n = 49): *Patients who discontinued therapy after the assessment phase but prior to 24 months.*
- Group 3 – Completion (n = 72): *Patients who completed 24 months of therapy.*

The rationale for using these three groups was based on previous research that found different predictor variables for discontinuation at different stages of therapy, particularly pre- and post- assessment, and recommendations that this be accounted for in the design of future studies (Corning & Malofeeva, 2004; Deakin et al., 2012; Gastaud & Nunes, 2010; Nuetzel & Larsen, 2012; Richmond, 1992).

Phase 1: Quantitative data analysis. Raw scores on the *BSI* and the *NEO-FFI* were converted to *T* scores based on standardised adult norms as per the test manuals. *T* scores are derived from a normal distribution of scores within a population. They have a mean of 50 and a standard deviation of 10, which allows for easy comparison between participants and between groups. The majority of scores in a whole population cluster near the mean, with less frequent scores falling at the extreme ends of the distribution.

Converting the raw scores to *T* scores allowed for comparison of the GNC patient population to other adult populations.

For the *NEO-FFI*, standardised adult norms were based on a non-clinical group. The reason for this is that adult psychotherapy patients usually display a similar variation in personality traits to the general adult population, with the exception of somewhat elevated levels of neuroticism (Costa and McCrae, 1992b). For the *BSI*, standardised adult norms were available for non-patients, psychiatric outpatients and psychiatric inpatients. Given the GNC patients were receiving a community-based psychotherapeutic service, normative data for psychiatric outpatients was used when converting GNC raw data to standard scores. The *BSI* manual provided normative scales for males and females independently, so different *T* scores conversions were used for each sex.

Raw *CORE-OM* scores from the GNC sample were compared to adult norms from a clinical population, as no standard score conversions were available. This group comprised people waiting for or receiving a wide variety of psychological interventions in various settings throughout Britain. There were different scales for males and females; however, the combined gender scale was used in order to compare adults in general. The *T* scores obtained from the sample data on the *BSI* and the *NEO-FFI,* and the raw *CORE-OM* scores, were then used in statistical analyses. Data were analysed using SPSS Version 22 (2013) and the probability value of $p < 0.05$ was applied throughout to ascertain statistical significance.

T-tests. Four separate one sample *t*-tests were used in Phase 1. The first *t*-test was conducted to determine whether mean *T* scores from the GNC sample of psychotherapy patients were significantly different to the general adult population scores on the *NEO-FFI*. The second *t*-test compared mean *T* scores from the GNC male sample to males in

the general adult psychiatric outpatient population on the *BSI*. The third t-test compared mean *T* scores from the GNC female sample to females in the general adult psychiatric outpatient population on the *BSI.* Finally, a one sample *t*-test was also conducted to determine whether raw *CORE-OM* mean scores from the GNC sample, differed significantly to scores from the clinical population.

Analysis of Variance. One-way Analysis of Variance (ANOVA) was used to investigate whether participants who discontinued therapy at different stages, differed in terms of their scores on the *NEO-FFI,* the *BSI,* or the *CORE-OM.* Three separate one-way between-groups ANOVAs were conducted in Phase 1. In each analysis the dependent variable was the patient's stage of therapy discontinuation: early discontinuation, late discontinuation or completion. The probability value of $p < 0.05$ was used throughout to determine statistical significance.

Prior to analysis the variables were screened to ensure they met relevant assumptions. The assumption of scores on each category of the independent variable being normally distributed with no significant outliers. Homogeneity of variance was assessed using Levene's statistic. Fisher's Least Significant Difference (LSD) statistic was used to ascertain the direction of any differences between groups. This statistic is recommended when group sizes differ (Heiman, 2001), which was the case in the present sample. The partial eta-squared statistic was used to measure effect size according to Cohen's guidelines (0.01 = small, 0.06 = moderate, 0.14 – large) (Cohen, 1988).

Phase 2: Qualitative data analysis. Interview notes used in the qualitative phase of data analysis were the short-hand notes recorded from phone interviews with patients who discontinued therapy at the GNC. Only a small selection of phone interview notes were

chosen from the pool of interviews to analyse, on the basis of descriptive detail in the participants' responses. Twenty phone interviews in total were selected (from a pool of forty), eleven comprising notes from patients who discontinued in the assessment phase (sessions 1-4), and nine comprising notes from patients who remained beyond assessment but discontinued prior to completing 24 months of therapy.

Thematic analysis was conducted because of its flexibility and potential to provide a complex and detailed account of the data (Braun & Clarke, 2006). The researcher applied a realist theoretical framework to the data and sought to report accurately on the experiences of participants, their motivations, and the meanings they attributed to discontinuation. In line with this framework, interview notes were analysed at an explicit surface level to ensure a faithful account of the data. The purpose of analysing the interview notes was to provide a more comprehensive account of the particular theme of discontinuation, rather than an overall rich description of the entire data set. As such, a more deductive approach was adopted, where the analysis was driven by the specific research question: "Why do patients discontinue therapy?"

Following the method of thematic analysis outlined by Braun and Clarke (2006), the researcher initially became familiar with the data by transcribing, reading and re-reading interview notes many times. Following this the researcher began generating initial codes, systematically reading each line of the transcribed notes and coding interesting features that pertained to the specific research question. A sample page of notes from one interview, showing how thematic codes were assigned, appears in Appendix 8. In the next stage the researcher searched for themes and patterns important to the description and understanding of the phenomenon of discontinuation. Codes were then collated into overarching sub-themes, then integrated into broader themes that captured salient aspects

of the data. These were reviewed and a map of themes was generated. In this way patients' stated reasons for discontinuing therapy at the GNC were systematically identified and categorised. A second member of the research team also read and coded a portion of the interview notes, then compared emergent themes, to ensure inter-rater validity. A matrix was constructed to display how codes were clustered into sub-themes and higher-order themes, as indicated in Appendix 9.

The frequency of emergent themes is displayed in another matrix in the Results section, where the interview data is presented along with quotes from interviews that illustrate particular themes. The insights generated from the qualitative analysis highlighted patients' experience of therapy at the GNC and stated reasons for discontinuing, which was used to further interpret the results from Phase 1.

To ensure the trustworthiness of this study, the data was collected by an independent qualitative researcher who set out to investigate and objectively establish reasons for discontinuation at the GNC. The data was then later interpreted by the author, who had no association with the GNC, no vested interest in the results, and therefore provided an independent perspective. The writer devised the original coding table, which was subsequently audited by the principal research supervisor and amended accordingly. Throughout the process of data interpretation, the writer regularly conferred with research supervisors on coding and generation of themes.

Chapter 3: Results Phase 1

Sample Characteristics

Participants in this study ranged from 18 to 70 years of age at initial contact, with a mean age of 36 years (*SD* = 11.76). The majority of the sample was female (68.1%) with only one third being male (31.9%). Overall, there was a discontinuation rate of 64.9% from the GNC, although this dropped to 40.5% when only people who stayed after the assessment phase were included. Twenty-one of the 226 participants in the study were still actively engaged in psychotherapy at the GNC, and thus did not fit into the categories of group membership outlined in the previous section. Consequently, their data could not be included in either phase of analysis. Of the 205 participants left in the sample, *BSI, CORE-OM* and *NEO-FFI* data were successfully collected for approximately 188 participants. Where there was missing data, analyses were conducted with the maximum number of scores available on each measure.

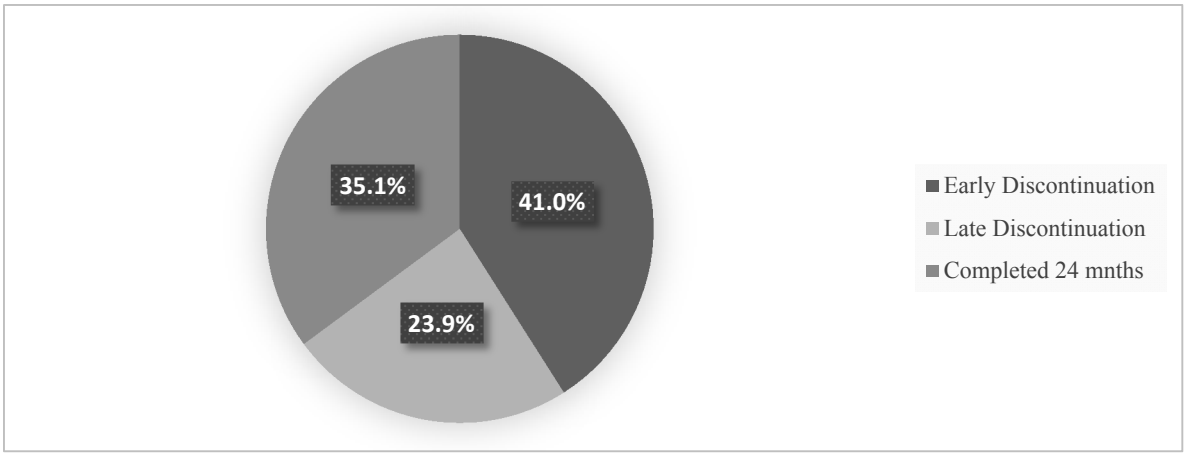

Figure 1. **The proportion of patients from the sample in each group.**

From the sample of 205 patients, 133 (64.9%) discontinued from the service at some stage, while 72 patients (35.1%) completed 24 months of psychotherapy. When these figures are broken down further in Figure 1, it is evident that more than half of patients who discontinued did so in the first four sessions. Eighty-four participants did not proceed past the assessment phase (41.0%), Forty-nine participants (23.9%) had some therapy and then disengaged with the service. Once participants completed the assessment phase the likelihood of discontinuation dropped to 40.5%

***NEO-FFI* scores.** Information about participant *T* scores on the *NEO-FFI* is presented in Table 1. The table shows that participants' mean *T* scores range from 38.36 to 61.90. Participants in the sample scored lowest overall on the personality dimension conscientiousness, and highest overall on the neuroticism dimension.

Table 1

Range, Mean and Standard Deviation of Participant T Scores on the NEO-FFI

***NEO-FFI* Dimension**	**n**	**Range**	**Mean**	**SD**
Neuroticism	187	30-75	61.90	7.54
Extraversion	188	25-71	41.98	11.59
Openness	188	25-70	50.00	9.79
Agreeableness	188	25-75	44.55	12.47
Conscientiousness	188	25-66	38.36	10.81

These *T* scores were then classified into categories Very Low, Low, Average, High or Very High. The Very High and Very Low categories represented more extreme scores (found in 7% of population), High and Low categories represent scores different to average that are less extreme (found in 24% of population), and the Average category represented the bulk of the bell curve (found in 38% of population) (Costa & McCrae, 1992b). Figure 2 below illustrates the spread of participants between these different categories on each personality dimension of the *NEO-FFI.* In the present sample, 81.3% of patients were in the High or Very High range for the personality dimension neuroticism. High extraversion was not very common within the sample, with 84.1% of patients being in the Average category or below. One third of GNC patients (29.8%) were in the Very Low range for extraversion. There was also an unusually large proportion of patients in the GNC sample with Very Low levels of agreeableness (23.4%). In general, the GNC patients had Very Low conscientiousness, with 67.5% of patients falling in the Low or Very Low category. The spread of openness in the sample mirrored that of a normal bell curve.

A series of one sample *t*-tests revealed that the mean *T* scores of participants in the sample on the *NEO-FFI* were significantly different to the mean of the general adult population on all personality dimensions with the exception of openness. These results are presented in Table 2 below. When compared to the general adult population, The GNC sample had significantly lower extraversion, agreeableness and conscientiousness scores, and significantly higher neuroticism scores. A conservative *p* value of 0.01 was used here to compensate for the potential family wise error generated by five *t*-tests.

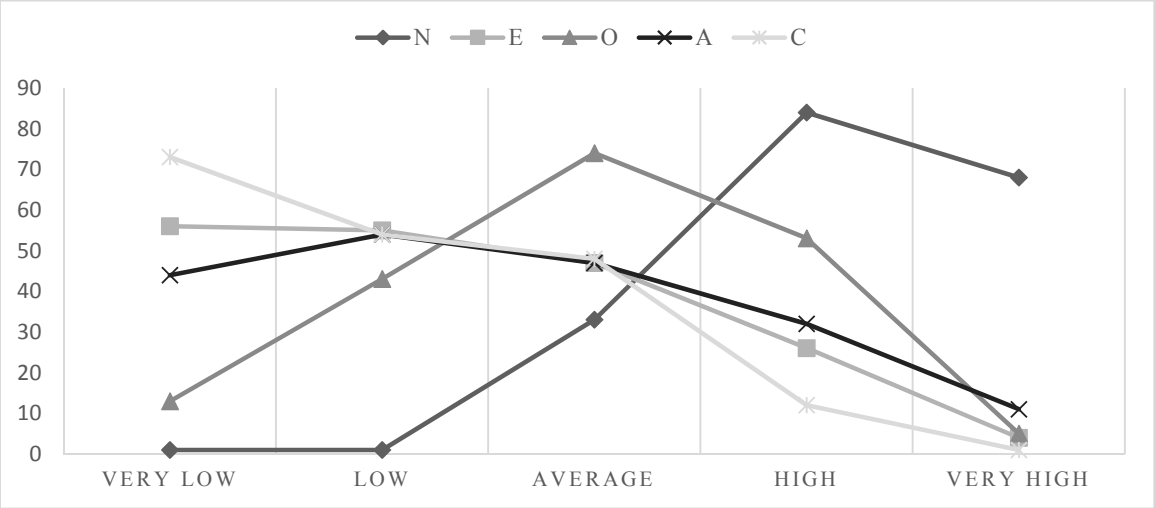

Figure 2. **The number of patients who scored in each category on each of the five *NEO-FFI* personality dimensions.**

Table 2

One Sample t-test Results for each NEO-FFI Dimension

***NEO-FFI* Dimension**	***t***	**df**	***p***	**Mean Difference**	**95% CI**	**Cohen's *d***
Neuroticism	21.60	186	**0.000***	11.90	[10.82, 12.99]	1.344
Extraversion	-9.49	187	**0.000***	-8.02	[-9.69, -6.35]	-0.741
Openness	0.00	187	1.000	0.00	[-1.41, 1.41]	0.000
Agreeableness	-5.99	187	**0.000***	-5.45	[-7.24, -3.65]	-0.482
Conscientiousness	-14.77	187	**0.000***	-11.64	[-13.20, -10.09]	-1.118

*p value is significant at 0.01 level

***BSI* scores.** Participant *T* scores on the *BSI* are presented in Table 3. The mean *T* scores obtained from the GNC sample range between 49.25 (depression) and 53.54 (obsessive-compulsiveness), with a global severity index score of 52.20.

Table 3

Range, Mean and Standard Deviation of Participant T Scores on the BSI

***BSI* Dimension**	**Range**	**Mean**	**SD**
Somatization	35-73	53.07	7.85
Obsessive-Compulsive	30-76	53.54	8.30
Interpersonal Sensitivity	4-80	52.34	9.56
Depression	30-76	50.46	9.04
Anxiety	30-77	49.25	9.01
Hostility	32-75	50.19	8.29
Phobic Anxiety	38-79	53.00	9.50
Paranoid Ideation	34-76	52.40	8.49
Psychoticism	33-75	52.31	8.78
Global Severity Index	**31-78**	**52.20**	**8.59**

One sample *t*-tests were conducted to compare each of these symptom dimension scores to the *T* scores found in the adult psychiatric outpatient population. These *t*-tests showed that the mean *T* scores of participants in the sample on the *BSI* were significantly higher than psychiatric outpatients on the symptom dimensions of somatization, obsessive-compulsive, interpersonal sensitivity, phobic anxiety, paranoid ideation, psychoticism,

and on the global severity index. These results are displayed in Table 4. Once again, a conservative *p* value of 0.01 was used to offset the potential family wise error generated by multiple *t*-tests.

Table 4

One Sample t-test Results for each Symptom Dimension of the BSI

***BSI* Dimension**	***t***	**df**	***P***	**Mean Difference**	**95% CI**	**Cohen's *d***
Somatization	5.35	186	**0.000***	3.07	[1.94, 4.21]	0.231
Obsessive-Compulsive	5.85	187	**0.000***	3.54	[2.34, 4.73]	0.385
Interpersonal Sensitivity	3.35	187	**0.001***	2.36	[0.96, 3.71]	0.239
Depression	0.70	187	0.484	0.46	[-0.84, 1.76]	0.049
Anxiety	-1.14	187	0.255	-0.75	[-2.05, 0.55]	-0.079
Hostility	0.31	187	0.759	0.19	[-1.01, 1.38]	0.020
Phobic Anxiety	4.33	187	**0.000***	3.00	[1.63, 4.37]	0.306
Paranoid Ideation	3.87	187	**0.000***	2.40	[1.18, 3.62]	0.259
Psychoticism	3.61	187	**0.000***	2.31	[1.05, 3.58]	0.246
Global Severity Index	3.51	186	**0.001***	2.20	[0.96, 3.44]	0.236

*p value is significant at 0.01 level

All of these differences were in a positive direction, indicating that the GNC sample had significantly higher scores on these *BSI* dimensions compared to adult psychiatric outpatients. Table 4 also shows that the mean *T* scores of participants from the GNC were

not significantly different to that of adult psychiatric outpatients on the symptom dimensions of depression, anxiety or hostility.

***CORE-OM* scores.** Information about the *CORE-OM* raw scores is presented in Table 5. The mean scores on this measure ranged from 0.34 on the clinical risk domain, to 2.09 on the well-being domain, with a global distress score of 1.54. The domains are problem scored, so the higher a person scores the more problems they have in that domain. For the well-being domain, higher scores mean the person has more problems with well-being.

Table 5

Range, Mean and Standard Deviation of Participant Raw Scores on the CORE-OM

***CORE-OM* Domain**	**Range**	**Mean**	**SD**
Well-being	0.25-4.00	2.09	0.95
Problems/Symptoms	0.33-3.92	1.92	0.85
Functioning	0.00-3.50	1.57	0.75
Clinical Risk	0.00-2.67	0.34	0.47
Global Distress	**0.29-3.35**	**1.54**	**0.68**

To compare these sample scores to scores obtained from a clinical sample, one way *t*-tests were conducted. The clinical sample comprised of users waiting for or receiving a wide variety of psychological interventions (often eclectic) in a wide variety of settings throughout Britain. These revealed that scores from the GNC sample were significantly different from a clinical sample on all of the domains measured: well-being ($t(186) = -$

3.98, $p < 0.05$), problems/symptoms ($t(186) = -6.24$, $p < 0.05$), functioning ($t(186) = -5.32$, $p < 0.05$), clinical risk ($t(186) = -8.65$, $p < 0.05$), and global distress ($t(186) = -6.41$, $p < 0.05$). All of these differences were in a negative direction. As such the GNC sample had significantly lower scores than a clinical sample on the domains measured by the *CORE-OM*, including the global score of distress. This is suggestive of fewer problems and less distress in the GNC sample. The results are presented in the Table 6 below.

Table 6

One Sample t-test Results for each CORE-OM Domain when Compared to a Clinical Sample comprising Users of Psychological Services throughout Britain.

***CORE-OM* Domain**	***t***	**df**	***P***	**Mean Difference**	**95% CI**	**Cohen's *d***
Well-Being	-3.98	186	**0.000***	-0.28	[-0.41, -0.14]	-0.290
Problems/Symptoms	-6.24	186	**0.000***	-0.39	[-0.51, -0,26]	-0.447
Functioning	-5.32	186	**0.000***	-0.29	[-0.40, -0.18]	-0.366
Clinical Risk	-8.65	186	**0.000***	-0.29	[-0.36, -0.23]	-0.472
Global Distress	-6.41	186	**0.000***	-0.32	[-0.42, -0.22]	-0.447

*p value is significant at 0.01 level

A conservative p value of 0.01 was applied here to compensate for the increased possibility of a family wise error created by multiple *t*-tests.

Findings in Relation to Hypothesis 1

The first hypothesis of this study was that patients who discontinue psychodynamic psychotherapy at a low-fee clinic at different stages, will have different scores on measures of current global distress (as measured by the *CORE-OM*), psychiatric symptomatology and psychological distress (as measured by the *BSI*):

- *It is predicted that patients who discontinue therapy during the assessment phase (Group 1 – Early Discontinuation) will have:*
    - *Higher global scores on the BSI than Group 2 or Group 3*
    - *Higher scores on specific symptom dimensions of hostility and interpersonal sensitivity on the BSI than Group 2 or Group 3.*
    - *Higher global scores on the CORE-OM than Group 2 or Group 3.*
    - *Higher scores on the life and social functioning domain of the CORE-OM than Group 2 or Group 3.*
- *It is expected that patients who discontinue therapy during the treatment phase (Group 2 – Late Discontinuation) will have:*
    - *BSI scores that are lower than Group 1 but higher than Group 3.*
    - *Hostility and interpersonal sensitivity scores that are lower than Group 1 but higher than Group 3*
    - *Global CORE-OM scores that are lower than Group 1 but higher than Group 3.*
- *It is predicted that patients who complete 24 months of therapy (Group 3 – Completion) will have:*
    - *Lower scores on the BSI than Group 1 or Group 2.*

- *Lower scores on the specific BSI symptom dimensions of hostility and interpersonal than Group 1 or Group 2.*
- *Lower global scores on the CORE-OM than Group 1 or Group 2.*
- *Lower scores on the life and social functioning domain of the CORE-OM than Group 1 or Group 2.*

Psychological distress. A one-way between-groups analysis of variance was conducted to explore the relationship between group membership, based on when discontinuation from the GNC occurred, and psychological distress, as measured by the global severity index scores on the *BSI.* Global severity index scores were not significantly different between patients who discontinued psychotherapy during the assessment phase, those who discontinued prior to 24 months of therapy, and those who completed 24 months of therapy, $F(2,182)= 2.02$, $p = 0.136$, $\eta^2_p = 0.022$. This result did not support the hypothesis that patients who discontinue therapy at different stages would have different levels of psychological distress.

Psychiatric symptoms. One-way between-groups analysis of variance was used to investigate the relationship between group membership and psychiatric symptoms, as measured by the nine symptom dimensions of the *BSI.* All of the symptom dimension scores used in the analysis followed a similar trend between groups, as Figure 3 illustrates. At face value, the early discontinuation group appeared to have consistently higher scores than the late discontinuation group on all the symptom dimensions. However, almost all of these differences were very small and did not reach statistical significance.

There was a statistically significant difference at the $p < 0.05$ level in scores on the symptom dimension of paranoid ideation between groups, $F(2,183)= 4.068$, $p = 0.019$. Despite reaching significance, the actual difference in mean scores between the groups was quite small. The effect size, calculated using partial eta squared, was only 0.043. Post-hoc comparisons using Fisher's LSD test indicated that the mean score for Group 1 ($M = 54.36$, $SD = 8.17$) was significantly different from Group 2 ($M = 50.04$, $SD = 8.96$), with a mean difference of 4.31 ($SE = 1.54$, $p = 0.006$). In other words, there were significantly higher levels of paranoid ideation reported by patients in the early discontinuation group, compared to patients in the late discontinuation group. However, Group 3 ($M = 51.98$, $SD = 7.97$) did not differ significantly from either Group 1 or 2.

There were no statistically significant differences between groups on any other symptoms dimension scores on the *BSI*. Scores on the hostility dimension or the interpersonal sensitivity dimension were not significantly different between any of the three groups ($F(2,183)= 2.18$, $p = 0.116$, $\eta^2_p = 0.023$, and $F(2,183)= 1.75$, $p = 0.176$, $\eta^2_p = 0.019$, respectively). The difference in phobic anxiety scores between each group, were very close to reaching significance ($F(2,183)= 2.90$, $p = 0.058$). This difference was between Group 1 and Group 3, with higher levels of phobic anxiety in Group 1. Once again the magnitude of the difference in mean scores between the groups was only small, with a η^2_p value of just 0.031, suggesting that patient levels of phobic anxiety were relatively similar regardless of when the patient discontinued therapy.

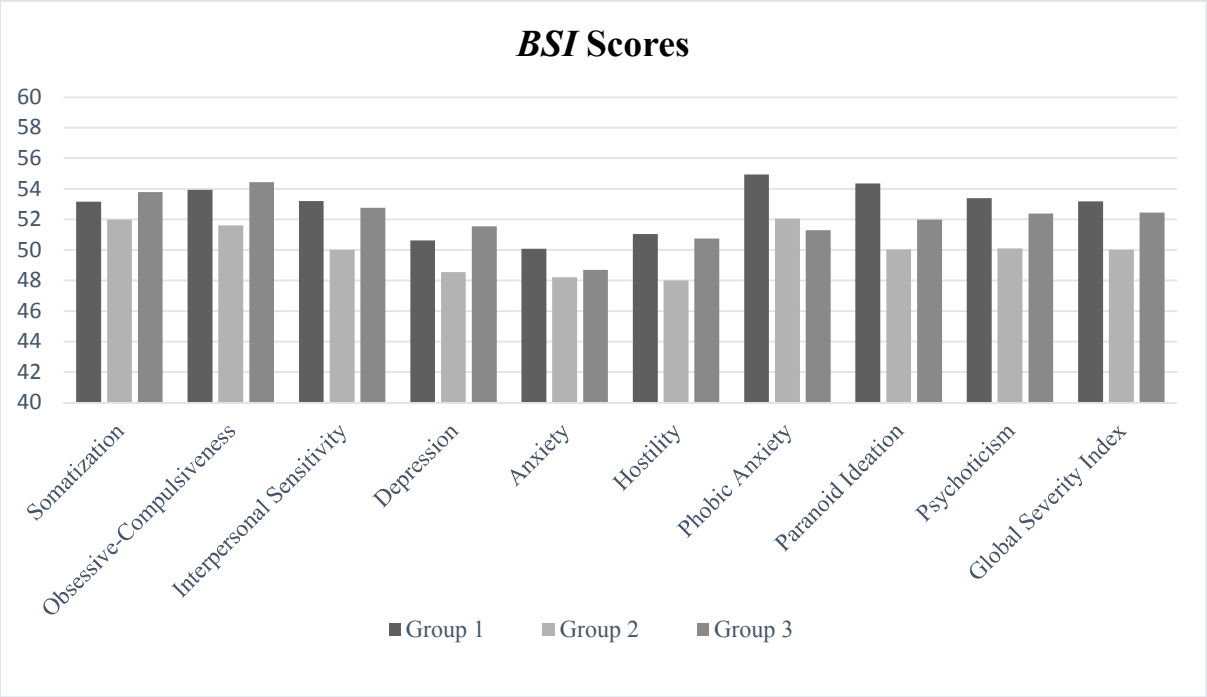

Figure 3. **Mean scores for each group on the symptom dimensions of the *BSI* and the Global Severity Index.**

Despite the fact that paranoid ideation appears to be higher in the early discontinuation group compared to the late discontinuation group, overall this result did not support the hypothesis that patients who discontinue therapy at different stages will have different psychiatric symptoms. In particular, the hypothesis that patients who discontinue therapy early will have high levels of hostility and interpersonal sensitivity was not supported.

Global Distress. A one way between-groups analysis of variance was performed to examine the relationship between group membership and global distress, as measured by the *CORE-OM* domains. In a similar fashion to the findings reported for the *BSI*, a trend emerged in the scores between each group, which is evident in Figure 4. The early

discontinuation group appeared to have the highest scores on all *CORE-OM* domains, followed by the completion group, and then the late discontinuation group. That is, the patients who left therapy during the assessment phase had higher levels of global distress compared to the other two groups, while the patients who had some therapy and then discontinue from the GNC had less global distress. However, only some of these differences reached significance.

The analysis found a statistically significant difference at the $p < 0.05$ level in scores between groups on the global distress index ($F(2,182) = 3.29$, $p = 0.039$, partial eta squared = 0.035). Post-hoc comparisons using Fisher's LSD test revealed that the mean score for Group 1 ($M = 1.66$, $SD = 0.72$) was significantly different from Group 2 ($M = 1.34$, $SD = 0.62$). The mean difference was 0.32 ($SE = 0.13$, $p = 0.011$). Group 3 ($M = 1.54$, $SD = 0.66$) did not differ significantly from either Group 1 or 2. This result supports the hypothesis that patients who discontinue at different stages would have different levels of global distress. However, counter to the hypothesis, there were no real differences in global distress scores in the group of patients who completed therapy, compared to the other two groups.

There was also a significant difference in scores between groups on the life and social functioning domain of the *CORE-OM* ($F(2,182) = 4.56$, $p = 0.012$). Post-hoc comparisons using the LSD test found that the mean score for Group 1 ($M = 1.72$, $SD = 0.77$) was significantly different to Group 2 ($M = 1.30$, $SD = 0.69$). The mean difference ($M = 0.41$, $SE = 0.14$, $p = 0.003$) represented a small to moderate effect size ($\eta^2_p = 0.048$). Group 3 ($M = 1.58$, $SD = 0.74$) did not differ significantly from the other two groups. This result provides evidence in support of the hypothesis that patients who discontinue therapy early will have poorer life and social functioning than those who discontinue therapy later.

These findings indicate there were no meaningful differences in life and social functioning scores in the group of patients who remained in therapy for 24 months, compared to the other two groups.

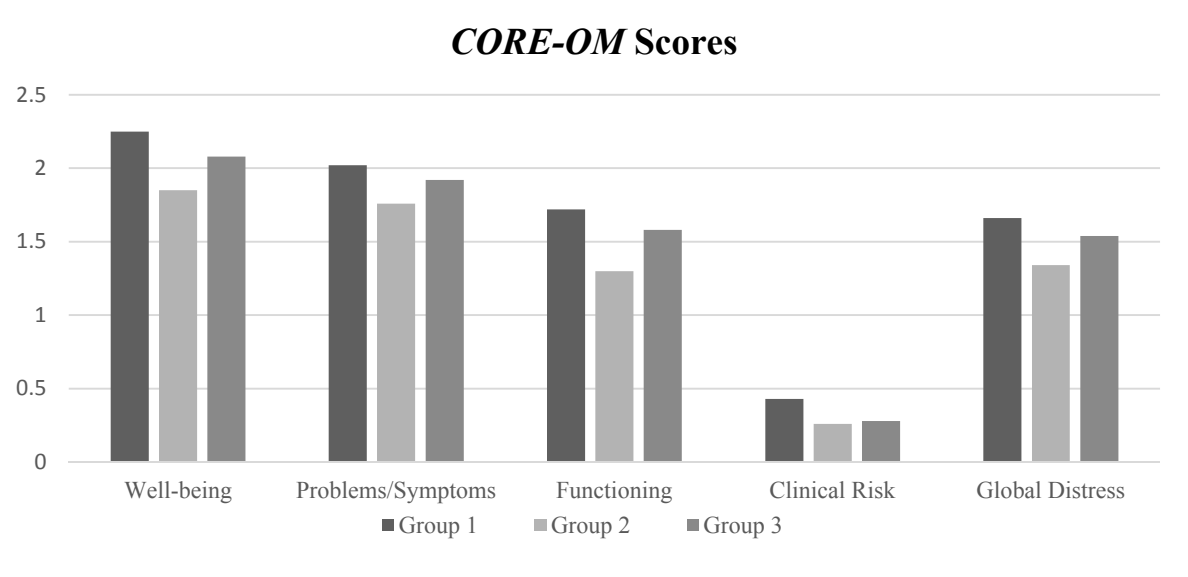

Figure 4. **Mean scores for each group on each domain of the *CORE-OM* including the Global Distress score.**

The analysis revealed no significant differences between groups on the well-being domain ($F(2,182) = 2.71$, $p = 0.069$), the problem/symptom domain ($F(2,182) = 1.35$, $p = 0.261$), or the clinical risk domain ($F(2,182) = 2.78$, $p = 0.065$) of the *CORE-OM*. The well-being and clinical risk domains had small p values, so effect sizes were calculated using η^2_p to determine the magnitude of any differences between groups. The values obtained were small; 0.029 and 0.030 respectively, indicating that the actual difference in mean scores between the groups was negligible. As such, the hypothesis that global distress would differ between groups was only partially supported.

Findings in Relation to Hypothesis 2

The second hypothesis was that patients who discontinue psychodynamic psychotherapy at a low-fee clinic at different stages, will also have different scores on the five dimensions of personality, as measured by the *NEO-FFI*:

- *It is predicted that neuroticism will be higher in Group 1 compared to Group 2 or Group 3. In Group 2, neuroticism scores will be higher than Group 3 but lower than Group 1, and in Group 3, neuroticism scores will be lower than Group 1 or Group 2.*
- *It is expected that patients' extraversion, agreeableness, openness and conscientiousness scores will be lower in Group 1 compared to Group 2 or Group 3. In Group 2, these scores will be lower than Group 3 but higher than Group 1, and in Group 3, scores will be higher than Group 1 or Group 2.*

A one-way between-groups analysis of variance was used to examine the relationship between group membership and personality traits, as measured by the five *NEO-FFI* personality dimensions of neuroticism, extraversion, openness, agreeableness and conscientiousness. In Figure 5 below, scores are plotted for each group. Mean scores on the dimensions of extraversion, openness, conscientiousness and agreeableness were consistently lowest in Group 1 and highest in Group 2. In contrast, mean neuroticism scores followed the opposite trend with the highest scores in Group 1 and the lowest scores in Group 2. Scores in Group 3 varied. Overall this group had lower scores on extraversion, openness, agreeableness, conscientiousness, and higher scores on neuroticism, than Group 2. However, scores for each of the five personality dimensions were not significantly different between groups.

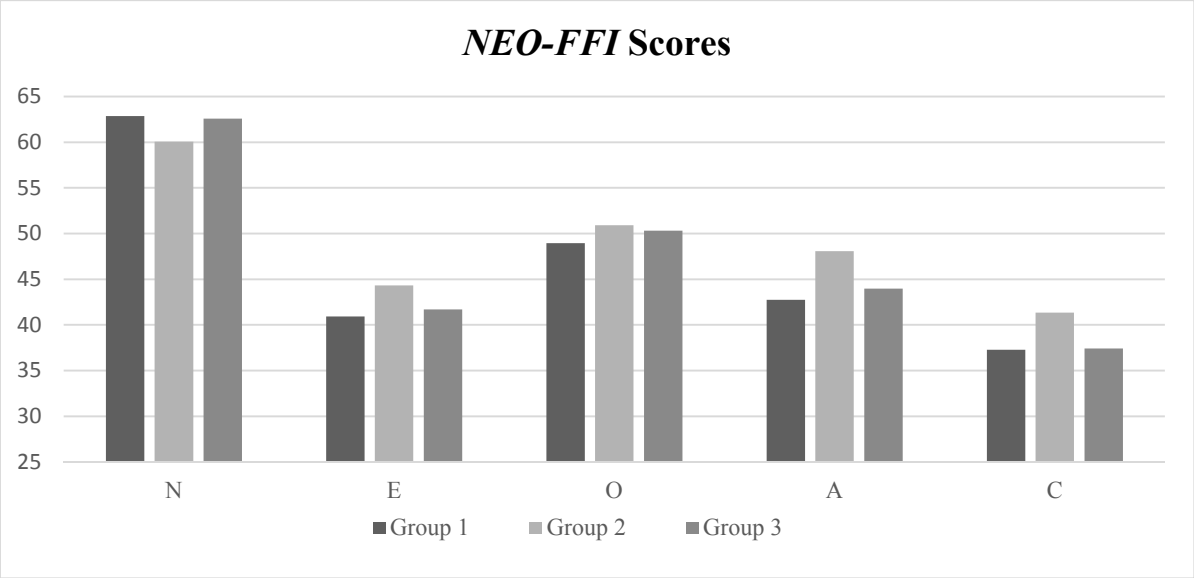

Figure 5. **Mean scores for each group on each personality dimension of the *NEO-FFI*.**

The only personality dimension that approached significance was agreeableness; $F(2,182)= 2.79$, $p = 0.064$. There were higher agreeableness scores in Group 2 compared to Group 1, with a mean difference of 2.82 (*SE:* 1.21, $p = 0.021$). However, the η^2_p value was only small (0.030). The results do appear to follow a pattern whereby Group 2 scores were consistently higher than the other two groups for all dimensions except neuroticism. However, with a sample size of 188, the current study had sufficient power, so if this pattern was meaningful it would have shown up in the analysis. These results did not support the hypothesis that patients who discontinue therapy at different stages would have different scores on the personality dimensions of neuroticism, extraversion, openness, agreeableness and conscientiousness.

Chapter 4: Results Phase 2

In this section, emergent themes and sub-themes from the thematic analysis of patient interview notes are presented with their corresponding frequencies in Table 7. The findings are then presented for each group of participants in more detail starting with the patients who discontinued psychoanalytic psychotherapy during the assessment phase, and moving onto the patients who had some therapy but discontinued prior to 24 months. In each of these sections, quotations are selected that exemplify typical patient comments in relation to each theme and sub-theme. An example of how interview notes were coded is contained in Appendix 8, and an example of how codes were clustered into themes can be found in Appendix 9.

Table 7

Themes and Sub-themes Emerging from the Interview Notes, and the Number of Participants Reporting these from Group 1 and Group 2

Emergent Theme	**Sub-theme**	**Number of participants**	
		Group 1	**Group 2**
Total number of participants		*11*	*9*
Clinic Factors	*Organisational Factors*	5	3
	Physical setting	4	6
	Negative overall perception	2	
	Distance to clinic	1	
TOTAL number of participants reporting this theme:		**9**	**8**
Therapist Factors	*Therapist style/technique*	5	5
	Individual characteristics	5	4
	Therapist Follow-up	3	
	Therapist competence	2	

TOTAL number of participants reporting this theme:		**8**	**7**
Patient Factors	*Lack of communication*	1	
	Scepticism	2	
	Ambivalence	1	1
	Unmet expectations	3	5
	Practical barriers	2	4
	Unable to recall	1	
	Individual characteristics		2
TOTAL number of participants reporting this theme:		**5**	**7**
Therapist-Patient Relationship Factors			
	Therapeutic Alliance	7	4
	Transference	1	
TOTAL number of participants reporting this theme:		**7**	**4**
Therapy Factors	*Termination Process*	2	
	Past Focus	2	
	Mental Health Industry	1	
	Challenges	2	
	Post-therapy feelings		2
	Commitment/Therapeutic Frame	1	3
	Poor Outcomes	1	3
TOTAL number of participants reporting this theme:		**6**	**6**
Positive Aspects of Patient Experience			
	Therapist characteristics	1	3
	Therapeutic Alliance	1	2
	Clinic factors		4
	Positive Outcomes		4
	Therapy experience	1	6
TOTAL number of participants reporting this theme:		**1**	**7**

Group 1: Early Discontinuation

This group comprised patients who discontinued psychotherapy during the assessment phase. From Table 7 it is clear that participants in Group 1 identified a range of factors

that may have contributed to them discontinuing therapy at the GNC in the first four sessions. The most prominent theme that emerged from these interviews related to the patient's negative perception of the clinic, followed by their negative experience of the therapist, the therapeutic relationship, and then problems pertaining to the therapy itself. The Group 1 interviews were consistently pessimistic and, therefore, positive aspects of the patient's experience was the least frequent theme in this group. Each of these themes will now be discussed in more detail.

Clinic factors. The most frequent theme from Group 1, which was observed in nine out of eleven participant interview notes, was Clinic factors. Participants reported four sub-themes relating to Clinic factors that included, in order of frequency: organisational factors, physical setting, distance to the Clinic and negative overall perception.

Five patients in Group 1 made negative comments about organisational factors. These comments covered aspects such as the Clinic eligibility criteria, the lack of patient choice of therapist, the long waiting list, ambiguity about what patient information was being used for research and what was being used for clinical purposes, as well a perceived lack of professionalism and ineffective Clinic communication. Three participants discontinued from the GNC because they were assessed as ineligible for a service. The news of Clinic ineligibility was unexpected and led to patient self-blame in one case, because they were allegedly informed by the therapist that they had "*too many issues*". One patient found the initial research questionnaire "*impersonal*" and felt that the difference between the clinical and research processes were not well explained during intake. Another patient remarked that the "*clinic assumed I knew more about the clinic than I did."* Furthermore,

one patient wanted more choice about the therapist they saw, which was not Clinic protocol, and this resulted in dissatisfaction.

Four out of the eleven participants in Group 1 described, in various ways, the negative impact that the physical setting of the GNC had on their overall experience. It is necessary here to mention that there is no formal waiting area or reception staff at the GNC. Patients are required to ring a doorbell when they arrive at the building and their therapist answers the door. If someone arrives early while their therapist is still seeing another patient, they must wait outside until the commencement of their session. In general, the participants from Group 1 spoke about the unwelcoming nature of the physical setting, which created anxiety for a number of people. One patient experienced the building as "*cold*" and "*austere*". Two patients made a specific comments about the absence of a waiting room, which they found "*inconvenient*" and *"confronting"*, or "*strange*" enough to be *"spooked"*. One patient commented about the 'secretive' nature of the entry process to the Clinic, which they likened to entering a "*brothel*". This person experienced the Clinic building as "*scary*" and felt "*exposed*" because of the large size of the therapy rooms. Some of the patients' perceptions of the Clinic also mirrored their perception of the therapist. For example, one patient experienced the Clinic as hostile and peculiar, and made similar comments about their therapist. Another patient described the Clinic and their therapist as rejecting, and another person, who felt the Clinic was cold, also experienced their therapist as lacking warmth.

Two participants from Group 1 talked more generally about their global impressions of the Clinic in negative terms. One patient described the Clinic as "*mysterious"* and doubted whether the service on offer would be useful, although they did not give specific reasons for thinking this. The other patient clearly highlighted how unfriendly and

unnerving the Clinic felt, and pointed out that with "*no hello, how are you*", the Clinic was "*not the kind of place for supportive work*." This perceived lack of support was a contributing factor in the patient leaving the clinic. Distance to the Clinic was a consideration for one patient who travelled a long way to attend therapy, and this resulted in discontinuation.

Therapist factors. The next most commonly reported theme for participants who discontinued in the early stages of therapy at the GNC, related to negative therapist factors, and this was described by eight out of the eleven participants. Comments relating to this broad theme fell into four different sub-themes: therapist style or technique, individual characteristics of the therapist, poor therapist follow-up, and perceived lack of therapist competence.

Almost half of the participants in Group 1 identified issues with the individual style or technique of their therapist. For example, three participants stated that the interpretations offered by their individual therapists were inaccurate. One participant observed that "*some comments were off the mark by the therapist"*, and this culminated in the patient feeling misunderstood, frustrated, and reduced their motivation to attend the Clinic. One patient said that the therapist's interpretations were unduly speculative ("*drew a few long bows*"), which made them question the effectiveness of the therapy. Another patient was seeking more complexity and depth, and experienced their therapist's "*basic*" interventions as too "*predictable*". They also disliked and were ultimately "*put off*" by certain therapist comments and mannerisms, particularly their therapist's excessively "*clinical*" approach. Another patient believed that their therapist was deliberately testing their tolerance, which was confronting. This patient felt challenged by the therapist's

"*rigid way of asking questions*", and use of silence. Therapist rigidity was picked up by another participant, who expressed irritation about their therapist's overt focus on maintaining the psychoanalytic frame, perhaps at the expense of the therapeutic relationship. The following is an extract from the interview of this participant:

> *"First time (I) came 5 mins late. (The therapist) made a very big deal (about this). Detracted from the session. Another session (I came) 3 mins early – a big deal made of this. (The) person is pedantic. (They) wanted to attach (something) to it…..Felt a little like therapist was digging. Made me less open, less willing to engage and develop a connection."*

Two patients referred to their therapist's lack of feedback or responsiveness, and how this affected their experience. In particular, one of these patients "*felt traumatised after every session*" because the therapist "*hardly responded*" to them. This situation was very difficult to cope with and ultimately resulted in their choice to discontinue from the GNC.

Another frequently cited issue in the interview notes was the negative impact of individual therapist characteristics, which was noted by almost half of the participants. Two patients identified therapist eccentricity as a negative factor, because this reduced their sense of safety with the therapist. One of these participants also described their therapist as hostile, while the other felt a lack of warmth that affected the therapeutic relationship. There were also two participants who experienced empathic failure from their therapist. For example, they *"didn't feel heard at all"* by their therapist, or their therapist was "*rude*" and "*disinterested*", so they "*didn't feel listened to, or that (the therapist) cared."* As a result, the patient left the Clinic and found a new therapist with whom they had a better connection. One patient found their therapist critical because personal matters they did

not consider issues *"all of a sudden were problematic."* Instead of feeling supported and validated by their therapist, these patients had the opposite experience.

The next most prominent sub-theme related to therapist factors, was poor therapist follow-up. There were three participants who spoke disapprovingly about the perceived lack of therapist follow-up after leaving the Clinic. One patient was waiting for a referral to another service but the therapist reportedly never contacted them. Another patient did not attend the session following the assessment phase but was never contacted by the therapist, while a third patient was told that they would not be accepted for treatment through a third party. This person expected to be contacted by the Clinic and was left feeling disappointed by the absence of direct communication. Instead, they heard the news from their treating psychiatrist. Another patient discontinued therapy because of distressing transference feelings they had towards their therapist that were not sufficiently addressed. Unfortunately, this patient was not contacted after leaving the Clinic which left them feeling "*abandoned*" and increased their emotional distress.

Perceived lack of therapist competence was raised as an issue by only one participant from Group 1. This patient felt that they had overloaded the therapist with their issues when they perceived the therapist responding with alarm during the session. The patient thus developed a view that the therapist could not handle their issues, which played a part in their decision to discontinue.

Therapist-patient relationship factors. Following on from Clinic factors and therapist factors, the next most frequently reported theme from participants who discontinued early was therapist-patient relationship factors. Seven out of eleven

participants raised this as a significant issue. Therapist-patient relationship factors were categorised as therapeutic alliance issues or transference issues.

All seven participants who mentioned this theme made reference to the poor therapeutic alliance that they had with their therapists. Patients reported feeling disappointed with the relationship, unsafe in the relationship, or a combination of both. Three participants pointed to a lack of rapport or the absence of any connection between them and their therapist. In one of these cases the therapist took a break which precipitated the patient's decision to discontinue therapy. In another case, the patient described having "*no positive feeling back*" when engaging with their therapist. This person was disappointed in their therapist's lack of reciprocity, failure to repair alliance ruptures, and failure to address the relationship at all, which led to feelings of being ignored. For example, the patient said there was "*not much conversation and when (they) did (they) totally missed the point."*

One participant was disappointed by the therapist's failure to engage with their dissatisfaction about therapy, despite trying to open the lines of communication:

> *"(A) couple of times I tried to raise the issue of whether the therapy was helping or not. (I was) told to give it time by (the) therapist."*

Three participants in Group 1 mentioned the lack of safety they felt in the therapeutic relationship, citing a variety of reasons. One person did not believe that their emotional distress was managed effectively by the therapist, another patient felt generally uncomfortable with the therapist, while a third person experienced their therapist as dismissive. In all of these examples, the therapist allegedly did not cultivate an environment that was conducive to the development of trust in the therapeutic relationship. As a result, these patients did not feel psychologically and emotionally safe

enough to proceed with therapy. Two participants talked about the lack of clarity around what was expected of them during sessions, or the therapeutic tasks and processes more broadly. This led to either confusion or anxiety for the patient.

One of the Group 1 participants experienced distressing transference feelings towards their therapist, who reminded them of an abuse perpetrator. This patient felt very upset about the therapist's non-engagement with this issue, and felt they were left to process the feelings alone. According to this patient's interview notes, it was not the transference feelings themselves, but rather the lack of response from the therapist after the patient's disclosure that created a sense of insecurity. This was cited as the main reason why this particular patient discontinued therapy.

Therapy factors. The fourth most prevalent theme that emerged from the analysis of Group 1 interview notes was therapy factors. Therapy factors were either related to therapy in general, or related to psychodynamic psychotherapy specifically. Sub-themes included the termination process, therapeutic frame, past focus, negative outcomes, navigating the mental health field and general challenges of undergoing therapy. Therapy factors were raised by six out of the eleven Group 1 participants.

In terms of general therapy factors, two participants were unhappy with the termination process. One patient wanted more time with the therapist to discuss why therapy was unsuccessful, and felt there was "*no space for this."* Two patients agreed that attending therapy was a challenging task because it felt unsettling and "*stirred up too many things*", and even though they described themselves as fully committed to the process it was still hard work. There was one participant in Group 1 who reported feeling confused about the

"*mental health industry*", with its myriad therapeutic approaches, and was unsure how to navigate it. Another participant reportedly experienced negative outcomes as a result of attending therapy, which they claim made them feel worse:

> *"(I) only attended a few times. Wasn't helpful for me. Made me worse. Having enough problems. Felt like the person was making problems out of (nothing)…not sure if it would ever have helped me? Feel like it made me worse."*

In terms of negative comments about psychoanalytic psychotherapy in particular, two patients disliked the focus on past relationships and events. One of these participants even said that bringing up issues from the past was "*traumatising*" for them. There was one person who did not like the strict therapeutic frame, which is a hallmark of psychoanalytic therapy, because they experienced it as too inflexible. This patient made the interesting observation that the therapist's rigid adherence to the session times created a "*combative dynamic*" between patient and therapist.

Patient factors. Patient factors were less frequently cited, but were still mentioned, by five out of the eleven participants in Group 1. Patient factors were divided into six sub-themes: lack of communication, scepticism, ambivalence, unmet expectations, practical barriers, and inability to recall reason for discontinuation.

The most common patient factor that was related to patient discontinuation in Group 1 was unmet expectations. That is, patients who entered into therapy at the GNC seeking a strategy-based treatment, or with a particular pre-conceived and fixed idea about how therapy would proceed, were left feeling unsatisfied or frustrated. There were two patients

who said that they were expecting to receive more feedback from the therapist and learn coping strategies. For example, one participant made the following comment: *"I need somebody/therapist to give me feedback. How do I deal with particular things. (I) didn't expect answers to big issues, (but) expected to find ways to manage (my) life situation and isolation."* In a similar vein, the other patient who hoped for strategies, and who explicitly said they would have preferred to engage in cognitive-behavioural therapy, made the following remark: *"(I) knew why I did things and where they came from. Needed to know how to deal with issues (such as) anger. Needed more strategies and learn to move forward in my life."* This patient was also expecting to have a more present and conscious focus in the therapy and consequently felt misled by the therapist. Another patient entered therapy with the very specific goal of returning to work as soon as possible. They were unhappy that the therapist did not immediately address these goals and eventually discontinued from the GNC because their needs felt too urgent to be dealt with via long-term psychoanalytic psychotherapy.

Practical barriers made a significant contribution to patient discontinuation for two participants. In both of these cases the patient travelled one hour or more to attend the Clinic. For one patient the time commitment was too great, particularly with the requirement of twice weekly attendance. For the other patient, the cost of long distance travel caused too much financial strain.

Patient scepticism about therapy also had a negative impact on the experience of therapy at the GNC. For example, one patient had studied Freud in the past and carried cynicism about this into their therapy. Another patient said that they "*didn't go in thinking it was going to work*." This fatalistic view of the therapy affected the patient's level of commitment. One of the participants from Group 1 simply did not communicate with the

therapist about their decision to discontinue, and another patient curiously could not recall the reason for leaving therapy. One patient expressed ambivalent feelings, stating that they felt unable to continue therapy and left; however, after some time had passed they regretted their decision.

Positive aspects of the patient experience. An uncommon theme to emerge from one participant who discontinued therapy early was positive aspects of the patient experience. This participant, who was excluded after assessment because of his financial ineligibility, commented on how the therapist's empathy led to the establishment of a strong therapeutic alliance. The patient believed that the therapist "*understood him*" and he felt "*rapport with him"*, which resulted in an overall positive, albeit brief, experience.

Group 2: Late Discontinuation

This group comprised patients who had some therapy and then discontinued later, prior to 24 months. The results presented in Table 7 show the emergent themes and sub-themes identified by participants in Group 2, which may have been a factor in their discontinuation from therapy. While the emergent themes are the same for each group, there were some differences in the relative importance of each theme, and some variations amongst the sub-themes, which will be explored in this section. The most prominent theme to emerge from the interview data for Group 2 was patients' negative perceptions of the Clinic, followed by negative experience of the therapist. This was the same for Group 1, indicating the salience of this theme regardless of when discontinuation occurred. Following this, Group 2 participants frequently mentioned patient factors that

were barriers to continuing therapy, while positive aspects of the patient experience was the next most frequent theme. Given that there was a high proportion of participants who talked about the positive side of their experience, the interview notes for this group were more balanced and optimistic when compared to the Group 1 interview notes. Negative aspects of the therapy itself and, finally, therapist-patient relationship factors, were the least prominent themes for Group 2, although they were still discussed by approximately 50% of patients in this group. This suggests that there were fewer negative interactions between patients and therapists in this group than in Group 1. The following section will discuss each of the emergent themes for Group 2 in more depth.

Clinic factors. The patients from this group described their dissatisfaction with the Clinic and the impact this had on them in a similar way to Group 1. The patients viewed the Clinic setting as the most important factor, followed closely by organisational factors like the lack of patient choice of therapist, ineligibility for treatment, and the Clinic waiting list.

Two thirds of the patients in Group 2 reported negative feelings about the physical setting of the GNC. For three participants this was directly related to the absence of a waiting room. One patient said they would prefer to be able to wait somewhere other than their car if they arrived early, one patient thought it was "*odd*", and the other patient felt "*unsettled*" by it. Two patients described the physical setting as unwelcoming and uninviting; both of these patients said that the colour of the Clinic played a role in this perception, and remarked that the Clinic might seem more welcoming if it was painted different colours. For example one patient said: *"(I) felt that (the) décor was very dark, impersonal, not homely (or) comfortable, more colourful would be good."* This patient

also referred to a picture of a "*skeleton man*" in their description of the Clinic. The 'skeleton man' picture was a bleak, monochrome print of a very thin figure hanging in one of the therapy rooms. Anecdotally, Clinic staff said that it was quite a confronting image and so it was replaced after a short time. In general, the descriptions from this group were similar to those reported by Group 1, although some of the Group 1 patients expressed feeling quite frightened, rather than simply unwelcome, at the Clinic. There was also one patient with chronic health problems in Group 2 who talked about their difficulty in climbing the stairs at the Clinic, which added to the challenge they faced of physically getting to the session.

One third of the participants who had some therapy before discontinuing raised organisational issues about the Clinic. One of the patients experienced a lack of fit with their therapist and was disappointed that they were not given the option of choosing their own therapist, or at least having some influence over the gender of the therapist they were allocated. This was cited as the reason for discontinuation after approximately six months of therapy. For another patient, being on the waiting list felt "*daunting*" and created anxiety. Finally, one of the patients who discontinued after a couple of months at the Clinic, discontinued because of the Clinic's eligibility criteria:

> *"(I) attended for a couple of months. (To) see if I was ready for the therapy. One of the criteria (was) no addiction - which I did have. I was kidding them & myself…(the therapist) said to me (you are) not ready for this work. (I) felt relieved and also like a failure."*

This man described himself as very motivated, but his daily heroin addiction prevented him from continuing at the Clinic.

Therapist factors. The patients in Group 2 described how factors relating to the therapist had a negative influence on their experience of the GNC. As in Group 1, individual style or technique, and individual therapist characteristics, emerged as sub-themes in the Group 2 data with almost identical frequencies.

Just over half of the participants in Group 2 disliked the style or technique of their therapist. Two patients found their therapist was not sufficiently active or interactive enough during sessions, which made one person feel anxious: *"(I was) hoping for a therapist that would ask me more questions. (Therapist) said not much. (I) feel like I was put on the spot. When I feel like that I just (get) nervous and can't talk."* The other patient, who only stayed for a few sessions beyond the assessment phase, was hoping for more feedback from their therapist and this may have contributed to a lack of rapport. One patient was seeking more confronting feedback from the therapist and was disappointed because they were not sufficiently challenged in the therapy. This patient wanted a "*stronger person*" as a therapist, "*someone who tells it like it is*". Another participant stated that they "*dreaded coming to sessions*" because of the therapist's use of silence. The same person communicated their frustration at the focus on meaning, and felt this was over-interpreted by the therapist. Another patient said that "*sessions were anxiety-provoking*" due to the therapist waiting and staring at them during sessions. One of the interviewees described their experience of feeling discredited by the therapist, as a result of the way the therapist engaged with their disclosure of a sexual assault trauma:

> *"(I) felt (my sexual assault disclosure) was questioned/invalidated (by) the way the therapist responded to bringing up this issue. (I) didn't feel heard – (I) felt questioned/challenged. (I) felt (that I) had to <u>prove</u>*

> *something terrible had happened (and) didn't feel therapist was hearing (my) distress".*

Overall, these comments from Group 2 were analogous to Group 1, particularly around therapist use of silence, perceived lack of feedback, response to disclosures, and the level of therapist confrontation being either excessive or minimal.

Four out of the nine patients observed that their therapists' individual characteristics were an obstacle in therapy. Two people felt misunderstood by their therapists and one of them perceived a "*wall"* between therapist and patient that impeded communication and halted progress. The other person said that the therapist frequently "*missed*" them, was not a good listener and cut them off during sessions. This patient still continued on with therapy for approximately six months, perhaps because they were able to air their feelings about this issue with the therapist. One patient in Group 2 described the therapist as mysterious because of their analytic stance. However, they were still able to form a workable relationship with the therapist and remained in therapy for 16 months. In comparison to Group 1 patients, those in Group 2 seemed to describe similar therapist-related obstacles but were more capable of working through them.

Patient factors. The participants' narratives revealed a number of key patient issues that contributed to discontinuation in Group 2. These various patient factors were more prevalent than in Group 1, even though they included a sub-set of the same themes: unmet expectations, practical barriers, patient ambivalence about therapy, and other individual patient characteristics such as motivation or poor communication.

The most common patient factor that led to dissatisfaction in Group 2, was unmet patient expectations, which was also the case for Group 1. Five patients regarded their experience as having failed their initial expectations of what therapy would be like or what it would provide. One of these patients reported disappointment because the therapy did not delve into their past history as much as they had hoped. The expectation for a cognitive-behavioural approach in therapy was more prominent in Group 1 interviews than in Group 2, although it was still mentioned by one participant. As a result of previous exposure to cognitive-behavioural therapy, this patient had developed an idea of the therapist as more active: *"Sessions were a bit awkward. Not used to this kind of treatment, where I had to do most of the talking. (I am) more used to CBT type".* The difference with this example from Group 2 is that, despite feeling this way, the patient persistently attended sessions, they "*slowly got used to it*", and stayed at the GNC for one year.

Just over one third of patients cited practical barriers to attending the Clinic, such as job commitments, travel plans, or physical health problems. Two interviewees pointed out that the frequency of twice weekly therapy interfered with their work commitments. This partially contributed to discontinuation for one person, and was the main reason for leaving the Clinic for the other. These practical reasons for leaving the Clinic were more frequently reported in Group 2 than in Group 1.

In two of the nine cases in Group 2, individual patient characteristics prompted discontinuation. For example, in one case the patient's motivation to attend therapy decreased because they reported positive treatment outcomes. Another patient failed to communicate their thoughts and feelings about the therapy with their therapist:

> *"(I) wanted to leave but didn't. (I) didn't raise it with (the) therapist. (I had) been thinking of it a few weeks before finishing. (I) told support*

> *worker from (another organisation) to advise (Clinic) of (me) not coming back."*

Accordingly, this issue could not be addressed and worked through by the therapist, so the patient ended therapy prematurely. There was also one patient who felt it was a battle to catch the train or drive to the Clinic due to their symptoms of anxiety, but despite finding it "*hard to come*", this was not the defining reason for discontinuation.

It is also worth noting that one patient who chose to discontinue therapy at the GNC described ambivalent feelings about their experience. After leaving the Clinic, they reported "*lingering*" thoughts about wishing they continued with therapy. This example contrasts the reports from Group 1 participants, who had a more negative and one-sided view of the Clinic and their experience in general.

Positive aspects of the patient experience. Patients in Group 2 reported significant positive aspects of their experience at the GNC, despite mentioning many negative aspects of the Clinic, the therapist, the therapeutic relationship and also the therapy itself. These positive facets will be addressed in this section and can be summarised as factors to do with the therapy experience, the Clinic, positive patient outcomes, therapist characteristics, or the therapeutic alliance. The prominence of this theme in Group 2 interview notes was a key difference from the Group 1 interview notes, where there was a paucity of favourable comments.

Two-thirds of the interviewees who continued beyond the assessment phase made positive remarks about their experience of therapy at the GNC. The majority of these comments were in relation to the overall experience of therapy being "*positive*" and

"*helpful*". For example, one patient said they were very depressed and anxious when they first arrived at the Clinic, and talking helped initially. One of these people asserted that their encounter with the Clinic was "*valuable*" and they would be keen to return in the future. There was also one person who described therapy as "*multi-faceted*", alluding to its richness and complexity.

Just over half of the Group 2 participants reported positive outcomes from therapy at the GNC. These positive outcomes included increased insight into patterns of relating to self and others, and a change in outlook on life. For example, one patient had a significant perspective shift due to therapy and cited improvements in her interpersonal awareness, self-awareness and assertiveness: *"(I) know myself, how I see the world, (I am) accepting of life and the wrongs in the world, more realistic….relationship improvements, more vocal/assertive, aware of (my) own mental processes."* Similarly, other patients claimed that therapy helped them articulate their inner experience, become more curious and self-aware, develop a stronger sense of self, or gain insight into their patterns of relating. One patient experienced a reduction in their suicidal thoughts because therapy helped them understand and cope with them. They were able to make a "*link with the past*" and understand "*where they originated from and developed*", so that the patient was less affected by them and consequently felt "*a lot more positive*". This patient asserted that therapy had improved multiple domains of their life including finances, career, and allowed them to make healthier relationship choices.

Another major difference in Group 2 interview notes, compared to Group 1, was that four patients made positive remarks about the Clinic setting. For example, one patient said they "*liked*" the building, while three others enjoyed the convenience of the Clinic's accessibility thanks to on-site parking and proximity to public transport.

Three participants in Group 2, all of whom remained at the Clinic for some time, spoke positively about the qualities of their therapist. For example, one patient who attended the Clinic for one year, spoke appreciatively of a "*calming*" and "*containing"* therapist who was "*patient*" and able to hold their level of distress and disorganisation. Another patient experienced their therapist as "*dependable and committed*", which likely contributed to their continuation in treatment for 16 months. One patient who stayed for approximately six months of therapy, said the therapist provided them with understanding, support and validation. Two of these patients also made reference to a positive working alliance with their therapist.

Therapy factors. There were six Group 2 participants who made negative remarks about the therapy itself at the GNC. The therapy factors identified by Group 2 were different from Group 1 and included therapeutic frame obstacles, post-therapy feelings, and also poor therapeutic outcomes.

One third of participants in Group 2 raised concerns about the therapeutic frame. The GNC required a commitment from its patients to attend twice weekly sessions, which is typical of psychoanalytic psychotherapy. These patients made comments about the frequency of twice weekly therapy being "*problematic*" or "*too much*", and it was not clear if they were also alluding to the intensity, rather than simply the frequency of sessions. One interviewee made specific reference to how the time they dedicated to travelling to and from sessions twice a week eventually impeded their work life.

One third of patients from Group 2 were unhappy with the lack of therapeutic outcomes from attending the GNC. For example, one patient said: *"(Therapy) helped (me) gain insight into where problems were coming from. But this didn't help (me) cope better."*

Another patient did not experience any change as a result of therapy, and could not identify any benefits of attending. A third patient did notice some changes but they believed this was due to antidepressant medication rather than therapy.

An interesting sub-theme that emerged from the interview data in Group 2 was that of post-therapy feelings, where participants provided some insight into their experience after leaving the Clinic. One of the participants described a feeling of "*relief*" when they finally made a decision to discontinue therapy because they found sessions anxiety provoking and difficult to physically attend. Another patient found therapy so unsettling that they felt the need to pursue further therapy outside of the GNC to process this.

Therapist-patient relationship factors. In comparison with Group 1, dissatisfaction with the therapeutic alliance was less frequently reported. However, four out of the nine participants from Group 2 reported alliance issues, and these invariably played a significant role in the patient's choice to discontinue therapy. Two patients communicated their experience of a mismatched therapist-patient relationship, stating, for example, that the relationship was not a "*good fit*". One of these people broached the issue of relationship incongruity with their therapist, hoping to open discussion about seeing another person, but this was never explored which may have strained the alliance. Subsequently, there was a break in therapy over a holiday period and when therapy resumed, this patient chose to discontinue from the Clinic. The second patient said there was no connection and a lack of communication in the therapeutic relationship, which they "*got sick of*" and resulted in them ending the therapy.

One patient expressed frustration about the therapist's alleged failure to assume responsibility for difficulties in their relationship, resulting in patient self-blame:

> *"(I) felt (he) didn't acknowledge his part-role in the process – it was always about (me). (It was a) difficult feeling when the therapist didn't acknowledge his part (patient saw this as being "non-relational"). (It) led to me blaming myself for not making sessions work."*

Another patient who had some therapy and then left the Clinic, stated that trust was initially absent and took a long time to build up before they felt safe enough to make a disclosure about a past sexual assault.

Summary of Phase 2 Results

In Phase 2, thematic analysis was conducted on the interview notes of eleven patients who had discontinued from the GNC during the assessment phase, and nine patients who had discontinued during therapy but prior to completion of 24 months. Guided by the specific research question, "Why do patients discontinue therapy?" the analysis sought to understand patients' experiences, motivations, the meanings they attributed to discontinuation, and to provide a more in-depth investigation of this phenomenon.

Clinic factors were referred to by the majority of patients in both groups in the interview notes. Most frequently, and almost equally in both groups, patients described organisational issues and negative impressions of the physical setting of the Clinic. In other words, the most ubiquitous finding from the Phase 2 analysis was that most patients who attended the GNC and then discontinued had negative experiences of the Clinic as an organisation, or did not feel comfortable at the Clinic due to physical aspects of the

Clinic. In particular, many patients were adversely affected by the absence of a waiting room, and although it was not usually a deciding factor as to whether the patient discontinued, it certainly did affect their overall perception and experience of the Clinic. For example, a number of patients used similar words to describe the physical setting and their therapist, especially in Group 1.

Negative discussion about therapist factors appeared in approximately half of the interview notes and was the second most prevalent factor for both groups. This mainly involved negative remarks about therapist style or technique, and also perceived therapist personality characteristics. Some patients talked about having negative reactions to therapist use of silence, a typical listening stance in psychodynamic psychotherapy, the extent of confrontation, the perceived lack of feedback and interaction during sessions, or feelings of invalidation after sensitive personal disclosures. There were a variety of individual characteristics mentioned by the patients, such as eccentricity, lack of warmth, hostility or criticalness, which contributed to them feeling misunderstood or uncomfortable with their therapist. Proportionately speaking, individual therapist characteristics were a prominent barrier in therapy for both groups, yet they appeared to have less of an influence on discontinuation in Group 2.

In interview notes from the late discontinuation group, patient factors and positive aspects of the patient's experience were as widespread as therapist factors. Patient factors were not quite as prevalent in the early discontinuation group but there were overlapping sub-themes in both groups, such as unmet expectations, often about the type of therapeutic approach, and practical barriers to attendance such as work, travel difficulties or distance to the Clinic. In general, interviews from the late discontinuation group were far more optimistic than the early discontinuation group because of the patients' overall experience

of therapy, the positive outcomes that impacted multiple life domains, and the Clinic's accessibility, reported by the patients in the group. In contrast, only one patient in the early discontinuation group spoke positively about their experience of the GNC, and this represented the least prevalent theme for that group.

Therapist-patient relationship factors were almost equally as prevalent as Clinic and therapist factors in the interviews of the early discontinuation group, and were predominantly related to problems with the therapeutic alliance. This was noticeably different to the late discontinuation group, where impediments in the therapeutic alliance were not referred to as commonly. Nevertheless, negative alliance issues were still noted by just less than half the patients in Group 2. In fact, regardless of group membership, relationship factors were consistently cited in patients' choice to discontinue therapy.

Finally, therapy factors emerged as important in understanding patient discontinuation from the GNC. Therapy factors were not quite as widely discussed by the patients as some of the other factors, although they still featured in a little over half the interviews in the early discontinuation group, and two thirds of the interviews in the late discontinuation group. There was a broad range of issues about the therapy that patients in both groups raised, the most common being rejection of the strict therapeutic frame, as well as the unfavourable outcomes that some patients reported as a consequence of insight-oriented therapy.

Chapter 5: Discussion

The present study had two aims; firstly, in Phase 1, it sought to determine whether there were differences between the symptom and/or personality profiles of patients who discontinued psychoanalytic psychotherapy at a low-fee clinic at different stages. The first part of the study sought to expand on Green's (2011) research at the Glen Nevis Clinic on the contribution of patient variables to discontinuation. The present study used patient scores on the *NEO Five-Factor Inventory* (*NEO-FFI)* of personality, the *Clinical Outcomes in Routine Evaluation* (*CORE*-OM) measure of global distress, and the *Brief Symptom Inventory* (*BSI*), from a sample of 188 patients at the Glen Nevis Clinic in Melbourne, Australia. These measures were used to establish differences between patients who discontinued therapy during the assessment phase, patients who discontinued after assessment but prior to 24 months, and patients who completed 24 months of therapy at the Clinic.

It was hypothesised that patients in the early discontinuation group (Group 1) would have higher scores on the *BSI* (psychological distress and psychiatric symptomatology), particularly on the dimensions of hostility and interpersonal sensitivity, and higher scores on the *CORE-OM* (global distress), particularly on the life and social functioning domain, than patients in the late discontinuation group (Group 2) or the completion group (Group 3). Likewise, it was hypothesised that patients in the late discontinuation group would have higher scores on these measures compared to patients in the completion group, who would have the lowest overall scores. A second hypothesis was that patient neuroticism, as measured by the *NEO-FFI*, would be highest in the early discontinuation group and

lowest in the completion group, while patient extraversion, agreeableness, openness and conscientiousness, would be highest in the completion group and lowest in the early discontinuation group. It was expected that the late discontinuation group would be somewhere in the middle of these two groups on all personality dimensions.

Secondly, in Phase 2, the study sought to answer the question of why patients discontinued psychoanalytic psychotherapy, by analysing a selection of twenty interview notes of patients who had left the Glen Nevis Clinic prematurely. Eleven of these patients were in the early discontinuation group, while nine patients were in the late discontinuation group. This section went beyond individual patient variables in an attempt to elucidate other factors that may be involved in the process of discontinuation. An exploration of the important findings from Phase 1 and Phase 2, along with possible interpretations, and a discussion of their implications and limitations, will follow.

Phase 1 Findings

The overall high discontinuation rate of 64.9% in this study was only slightly higher than other long-term adult psychoanalytic psychotherapy studies (Ingenhoven et al., 2012; Reder & Tyson, 1980), and some meta-analysis findings (Wierzbicki & Pekarik, 1993), and was more comparable to studies that used borderline personality disordered samples (Skodol et al., 1983). This discontinuation rate was also marginally more elevated than a recent and comprehensive meta-analysis by Swift and Greenberg (2012). In any case, the findings indicate that adults may be more likely to discontinue than complete long-term psychoanalytic psychotherapy at a low-fee clinic. It is concluded that this slightly elevated discontinuation rate is attributable to characteristics of the sample, such as their

personality trait configurations, and the intense long-term commitment required for this type of therapy. Each of these factors will be examined in turn.

It is important to note that the discontinuation rate dropped to 40.5% when patients who left the Clinic during the assessment phase were excluded. This disparity highlights the contested issue of how to report discontinuation rates in the literature. Once patients submitted their application forms to the GNC and met the criteria for the Clinic, the first four assessment sessions they had were conducted by their allocated therapist. For this reason, the assessment phase was essentially indistinguishable from therapy proper, and therefore should be included for an accurate estimate of the rate of discontinuation from the service overall.

The results did not support the first hypothesis, that patients who discontinue therapy at discrete stages would have different levels of psychological distress. The results did not substantiate the overall prediction that patients who discontinue therapy at different stages would have distinct psychiatric symptoms, as no symptoms were significantly different between groups, except for paranoid ideation. The individual symptom dimension of paranoid ideation was significantly higher in the early discontinuation group compared to the late discontinuation group, although the effect size was small ($\eta^2_p = 0.043$). The hypothesis that patients who discontinue therapy at different stages would have different levels of hostility and interpersonal sensitivity, was also not supported.

The hypothesis that global distress would differ between groups was only partially supported. As predicted, the early discontinuation group reported greater global distress compared to the other two groups, although the effect size was small ($\eta^2_p = 0.035$) and there were no other significant differences between groups on this measure. The results supported the hypothesis that the early discontinuation group would report greater

problems in living and social functioning, compared to the other two groups, with a small to moderate effect size ($\eta^2_p = 0.048$). Nonetheless, there were no meaningful differences between the late discontinuation group and the completion group in life and social functioning.

The results did not support the second hypothesis that patients who discontinue therapy at different stages would differ on the personality dimensions of neuroticism, extraversion, openness, agreeableness and conscientiousness. As predicted, agreeableness scores were higher in the late discontinuation group compared to the early discontinuation group, although the effect size was only quite small ($\eta^2_p = 0.030$). Each of these findings will now be examined in more detail.

Psychological distress and psychiatric symptomatology. Despite analysing the patients as three separate groups to ensure that variations between individuals who discontinued at different stages were accounted for, there was no evidence that levels of psychological distress, as measured by the *BSI*, could be used to differentiate the groups. It is also clear that in the main, psychiatric symptomatology could not be used to differentiate patients who discontinued therapy, except for paranoid ideation. One patient even reported in their interview that while their symptoms were a barrier to attending the Clinic because they caught public transport to their sessions, this was not the primary reason for discontinuation. The findings are consistent with other studies that report no significant relationship between symptom severity and patient discontinuation (Horner & Diamond, 1996; Keijsers et al., 2001; Nuetzel & Larsen, 2012; Smith et al., 1995). In particular, these results are comparable to other studies of long-term psychodynamic psychotherapy patients employing similar measures (Horner & Diamond, 1996; Nuetzel

& Larsen, 2012; Perry et al., 2007). It is important to note that the present study had a much larger sample size and more varied psychopathology features than these studies, and that it separated early from late discontinuers. Therefore, the results of this study may be more widely applicable. It has been argued that pre-treatment symptoms are not prognostic, and that symptoms really need to be measured during treatment to gain an accurate picture of their effect (Chasson et al., 2008; Garfield, 1994; Nuetzel & Larsen, 2012). However, Nuetzel and Larsen (2012) measured psychological distress and symptomatology throughout treatment and still reported results akin to ours, including non-significant differences on the dimensions of hostility and interpersonal sensitivity. Overall, the current findings suggest that the personal experience and impact of symptoms is more important than the type, number or severity of symptoms, and this will be explored further in a later section.

The findings are inconsistent with other research that cites hostility as a reliable predictor of premature termination (Gunderson et al., 1989; Skodol et al., 1983; Smith et al., 1995; Thormählen et al., 2003). However, these studies mainly examined hostility in patients with borderline personality disorder and factors that interfered with the therapeutic alliance. Although GNC patients were not diagnosed, so the prevalence of borderline personality disorder in the sample is unknown, differences here may be due to sample variability. It is also plausible that differences are due to the way hostility is conceptualised and measured between studies; as a stable trait or as a symptom. For example, Thormählen and colleagues (2003) used the inventory of interpersonal problems and *DSM* criteria as measures in their research, and found that hostile characteristics were only predictive of dropout when combined with a dominant interpersonal style. In our sample, hostility was measured as a symptom based on whether patients felt easily

annoyed, had temper outbursts, frequent arguments, or experienced uncontrollable urges to damage objects or people. These statements are tapping into a more state-based hostility rather than an enduring personality trait. Variation in baseline hostility may also be a factor in the contradictory results. For example, in our sample hostility symptoms were not very severe, and did not differ significantly from a normal outpatient group comparison. In contrast, it would be expected that baseline levels in a sample of patients with borderline personality disorder are substantially higher, and would therefore have more of a bearing on alliance problems and discontinuation. Given the results of the present study, it is likely that the symptom of hostility does not play a part in discontinuation, although if this symptom is extremely severe, or if hostility is more of a pervasive personality characteristic, then it may well impact on discontinuation. The fact that our results did not show statistically significant differences between groups on interpersonal sensitivity may be a consequence of similar issues. Previous findings about the association between sensitivity and discontinuation have likewise been reported in research on borderline personality disorder (Horner & Diamond, 1996), where interpersonal difficulties are presumably more severe and persistent. Once again, because patients at the GNC were not formally diagnosed it is difficult to compare the current sample with patients from other studies who were diagnosed with borderline personality disorder.

Paranoid ideation. The finding that levels of paranoid ideation are higher in the early discontinuation group compared to the late discontinuation group is consistent with research linking more severe and chronic symptoms with discontinuation (Kazdin, 1990; Kazdin & Mazurick, 1994). There were no specific predictions made about paranoid ideation, although the fact it was significant is not surprising. There is general consensus

in the psychotherapy profession that patients with paranoid symptoms are more challenging to engage and build rapport with. The degree of patient paranoia or mistrust is predictive of poor engagement and a weak alliance (Clarkin & Levy, 2004). From a psychodynamic perspective, a patient with paranoid features may project their own hostility onto the therapist, which results in them experiencing the therapist as hostile, thereby increasing their defensiveness. Consequently, paranoid patients can be very mistrustful of the therapist's intentions and feel unsafe in the therapeutic encounter. According to the *BSI* criteria, symptoms of paranoid ideation include feeling that others are to blame for one's troubles, feeling that most people cannot be trusted, that one is watched or talked about by others, that one will be taken advantage of, or not given proper credit for one's achievements. A patient who experiences these thoughts and feelings will inevitably find therapy confronting, anxiety-provoking, and will have difficulty developing trust, which is a necessary ingredient for the success of the therapeutic relationship. The patient will therefore be more likely to leave therapy in the early stages, in an attempt to avoid feelings of persecution (Van Denburg & Van Denburg, 1992).

Global distress. In the present study, global distress was higher in the early discontinuation group than the late discontinuation group. Hence, global distress can be used to differentiate between patients who discontinue during the assessment phase and those who persist with therapy beyond the assessment. These results suggest that if people are experiencing too much distress, they are unable to engage in psychotherapy to begin with, which may be especially true in the current study because of the high session frequency and long-term commitment required. This finding is consistent with Hilsenroth and colleagues (1995), who found that if people lack the psychological resources to

manage their symptoms, then they are naturally more prone to therapy disengagement. However, the findings are inconsistent; Perry, Bond and Roy (2007) reported that global distress did not predict attrition in a similar long-term psychodynamic psychotherapy sample. It does appear counter-intuitive that global distress should be significant in the present study, while psychiatric symptoms and the psychological distress associated with these is not. Then again, this reinforces Yu's (2011) findings that the patient's subjective experience of their symptoms is a better predictor of discontinuation than their specific symptoms.

A noteworthy finding from the current research was that psychological distress did not significantly differ between groups, yet global distress did. Psychological distress, as measured by the *BSI*, is not a self-reported measure of distress, rather it is an estimate of distress based on the number and severity of symptoms endorsed by the patient. The global score is calculated by summing all of the symptom domains, so if a patient has severe scores on six symptom domains, their global score of psychological distress will be higher than a patient with severe scores on only two symptoms domains. In contrast, the *CORE-OM* taps into the patient's personal experience of distress by assessing subjective well-being, commonly experienced problems or symptoms, life and social functioning, and risk to self and others. Therefore, this measure of global distress is more broad and inclusive, and does not just focus on patients' symptoms. To reinforce this argument, the problems/symptoms domain in the *CORE-OM* was not significantly different between groups, but the global *CORE-OM* measure was because it included additional and more expansive domains. The results of this study indicate that the global distress an individual patient experiences because of the impact of their psychological problems, is more important than the type, number or severity of their symptoms.

In contrast to what was predicted, the completion group did not have significantly lower levels of global distress than the other two groups who discontinued therapy. This finding can be linked to the motivational component of stress, which suggests that some distress is necessary to ensure continued engagement in therapy. This is particularly true of twice weekly long-term therapy, where increased motivation and commitment are prerequisites.

Life and social functioning. The finding that the early discontinuation group had poorer life and social functioning, compared to the other two groups, verifies that a basic level of functioning is needed for psychotherapy engagement to be possible. Very low functioning individuals may attend the Clinic but are unable to sustain attendance beyond the first few sessions, perhaps once they become cognisant of the level of commitment that is asked of patients at the GNC, or due to chaotic life circumstances. According to the *CORE-OM*, poor life and social functioning equates to feeling that one cannot achieve what one wants to in life, feeling unable to cope when things go wrong, and having minimal social connections or support. This finding highlights the need to assess patients' global view of functioning and is in line with research by Von Der Lippe and colleagues (2008), where patient scores on the Global Assessment of Functioning (GAF) were strongly associated with therapeutic outcome, rather than patient diagnosis or symptoms. It also bolsters other research that has demonstrated an association between lack of social support and discontinuation from therapy (Lambert, 2011; Watson, 2011). Once again, the results conflict with Perry, Bond and Roy (2007), who found that social functioning or GAF scores did not have predictive value in therapy dropout in a comparable sample, although they had a much smaller sample size. The present study indicates that the broad impact of symptoms on a person's everyday life is more central to this issue than the number, type or severity of their symptoms.

The results show that subjective well-being on the *CORE-OM* was not significantly different between groups. Patients with low subjective well-being reported that they often felt like crying, lacked optimism, or felt overwhelmed by their problems. Although this finding somewhat opposes Yu's (2011) proposition that patients' subjective experience is a critical element in discontinuation, it does support the argument that single and narrow measures of distress are not as essential as more global measures that consider the wider landscape of patient functioning in all life domains.

Personality traits. Contrary to what was hypothesised, and contrary to the belief held by many in the psychotherapy community, the present study found that individual personality traits could not be reliably used to differentiate between patients who discontinued therapy at different stages. Perry, Bond and Roy (2007) also reported no relationship between discontinuation and any of the five personality dimensions on the *NEO-FFI*. These findings are directly at odds with Green's (2011) research, despite both studies using a sample from the GNC. Green reported that patients with low levels of agreeableness and conscientiousness were more likely to proceed with psychotherapy after assessment than discontinue, yet this finding was not replicated here. Compared to the general adult population, the present sample had significantly lower scores on the personality dimensions of agreeableness, conscientiousness, and extraversion, and significantly higher neuroticism. This patient personality profile was almost identical in Green's (2011) research, except for openness scores, which were lower in Green's study, yet the difference in openness scores does not explain the disparity in these findings. However, Green had a slightly different focus where he concentrated on continuation in psychotherapy, rather than discontinuation. Even though he found predictors of therapy

continuation, he reported that no personality traits reliably predicted discontinuation after assessment, which is consistent with the present findings. In sum, the current results are in conflict with Miller's (1991) theory outlined in an earlier section, that personality traits can be used as a forecasting tool for patient discontinuation.

Another possibility is that the current results represent a statistical anomaly. However, the sample size was large enough for there to be sufficient confidence in the results. In addition, the GNC structure and protocols ensured that all patients were receiving a clearly defined therapy approach. Any differences in the variables measured should have been picked up in the statistical analysis. Green (2011) points out that the phenomenon of patient discontinuation is multi-faceted and may be the result of numerous variables interacting in multiple ways, although these variables may not independently reach statistical significance across the sample. For that reason, static individual traits may not be very useful in predicting patient engagement in therapy, or patient capacity and willingness to persist with twice weekly, long-term therapy. Instead, combinations of traits and personality profiles may provide more valuable information and statistical measures which incorporate this complexity could prove be useful in future. Freud also highlighted the importance of, not only diagnostic factors, but the whole personality of the patient, as likely indicators of therapeutic success (Berkowitz, 1998).

The personality profile of the current sample, constitutes what Miller (1991) described as a 'misery triad' (low A, low E, and low C), which is common in clinical samples (Malouff et al., 2005). These patients usually do not succeed in therapy, experience multiple life failures, have minimal capacity for well-being, are mistrustful and uncooperative, and disengage because they have difficulty establishing a therapeutic alliance (Miller, 1991). The presence of this misery triad of personality traits in the sample may explain the

elevated discontinuation in the present study. Green (2011) reported a high discontinuation rate of 59% in his sample, which could be a reflection of the similar personality profiles in both the samples. It was expected that a personality profile like this might exist at the GNC because clinical samples tend to have high scores on the personality dimension neuroticism (Miller, 1991), low agreeableness, low conscientiousness, and low extraversion (Malouff et al., 2005), compared to the general adult population. It is also not surprising given that the GNC attracts low-income patients with more chronic and severe psychological issues than the general adult outpatient population, because of the length, intensity and low cost of treatment on offer. Other measures, such as the therapeutic alliance and attachment style, which were not included in the present study, may identify factors playing a more significant role in discontinuation than originally supposed. Green (2011) argued that such measures may provide a far greater understanding of therapy engagement and discontinuation than individual traits, and the current results certainly point to this as a possibility.

In this study a high rate of discontinuation was observed, suggesting that even though many patients are assessed by the therapist and by themselves as good candidates for psychoanalytic psychotherapy, discontinuation can still occur. The assessment aims to identify patients who are inappropriate for psychoanalytic psychotherapy, which can be a more challenging modality because of the length of treatment, the intensity of twice weekly sessions, and the unstructured and expressive nature of the therapy. Therapists make an informed decision about whether patients' symptoms are likely to respond to the treatment, and that patients' individual characteristics enable engagement and use of the treatment (Gabbard, 2004). Assessment is a two-way process whereby patients are simultaneously deciding whether they are interested in pursuing the type of therapy on

offer and gauging their response to the therapist. The current findings indicate that potential reasons for patient discontinuation are not always obvious at the point of assessment, indeed they may not have sufficiently developed within the patient or the therapeutic relationship. It may therefore be unrealistic to assume, given its complexity, that the likelihood of discontinuation can be predicted during the assessment process. It is true though, that therapists need to provide as much clarity and preparation for the patient who chooses to embark on long-term psychotherapy (Hill, 2010), as this will minimise unnecessary discontinuation.

Summary of Phase 1 findings. The current findings from this research suggest that, in general, patient discontinuation is not influenced by specific types of symptoms, but rather the impact that individual symptoms have on a person's functioning. The only specific symptom that may differentiate between discontinuation at different stages is paranoid ideation. A patient who experiences paranoid ideation could find therapy more testing because of issues with trust and a perception of the therapeutic relationship as fundamentally unsafe. The results did not demonstrate a link between hostility or interpersonal sensitivity and discontinuation, perhaps because a measure of fluctuating symptoms rather than a trait-based measure was employed here.

As predicted, patients' ratings of global distress may be used to differentiate between patient discontinuation at different stages of psychotherapy. If patients experience very high levels of global distress they may be unable to engage in psychotherapy at all, particularly because of the intense and long-term commitment required from patients at the GNC. Ratings of global distress are more important than the severity and number of symptoms, or the type of symptoms in discontinuation, other than paranoid ideation.

However, some distress may be necessary to ensure continued motivation for therapy engagement beyond the assessment phase, especially with the greater intensity and frequency of sessions which provides additional containment. Poorer life adjustment and social functioning was found in the group of patients who discontinued from the GNC during the assessment phase, compared to the group who had some therapy and then left. In summary, discontinuation at different stages cannot be accounted for by a narrow measure of patient distress, such as distress related to psychiatric symptoms alone, or subjective well-being. Instead, a broader perspective of patient functioning needs to be adopted to understand discontinuation.

In contrast to previous research, individual personality traits could not be used to differentiate between patients who discontinued psychotherapy at different stages in this study. Having said that, the constellation of traits in the sample is typically problematic for therapy engagement (Miller, 1991) and may help explain the elevated discontinuation rate at the Clinic. The rationale for measuring traits in this study was informed by previous research on the impact that traits have on interpersonal functioning (Thormählen et al., 2003), and hence how they can affect the relationship between patient and therapist. The reason traits were not significant in this study is unclear, although in reality, personality traits are multi-dimensional and they may interact in subtle ways with numerous other variables to produce discontinuation. Isolating individual traits, or looking at nomothetic theories such as personality, can be overly reductionist (Green, 2011) and may only deliver unreliable results. If symptom and personality profiles do not differentiate between discontinuation at different stages, then what does? Are all-encompassing and more dynamic measures, such as the therapeutic alliance, which was not included in the

present study, more relevant? Why do patients discontinue from psychotherapy? This question will be examined in the next section, from the perspective of the patient.

Phase 2 Findings

In Phase 2, interview notes of eleven patients who discontinued therapy during the assessment phase, and nine patients who discontinued therapy after the assessment phase but prior to 24 months, were analysed using thematic analysis. Patients' negative perceptions of the Clinic and also of the therapist were the most prominent themes in interviews with patients who had discontinued from the GNC, regardless of when this occurred. Even though this study focused on patient factors, the findings indicate that non-patient factors, such as the physical environment in which therapy takes place, the organisational practices of the Clinic, and the characteristics and individual style of the therapist, appear to be far more influential in patient discontinuation. The absence of a strong therapeutic alliance was also a defining factor in patients' decisions to discontinue from the GNC. These results are comparable to other research arguing that patient factors alone are not sufficient to contribute to therapeutic success or failure, and that the therapist, the therapeutic relationship, the treatment modality, and the context of the Clinic, are all significant factors (Atwood & Beck, 1985; Norcross & Lambert, 2011). The following section will explore these qualitative results in more detail.

Clinic factors

The setting. Problematic Clinic factors were the most frequently reported theme in all of the interviews with patients who had discontinued from the GNC at any time. These

patients primarily made negative comments about organisational aspects of the clinic and the physical setting, which both appeared to be more significant than the distance travelled by patients to the Clinic. The GNC building, which is a restored two storey Victorian-era structure, was described by patients as "*cold*", "*austere*", "*mysterious*", and even "*unwelcoming*". Likewise, patients used words such as "*cold*", "*dark*" and "*impersonal*" to describe the décor inside and the paint colour of the building. There also seemed to be a consensus among the patients who discontinued at some point, that the absence of a reception and waiting area at the entrance to the Clinic, and the entry process as a consequence of this, had a major negative impact on patients' overall experience of therapy at the Clinic. Although this entry process is typical of other private clinics, it is different to most public mental health settings, which many of the GNC patients would have been familiar with. Patients communicated how confronting, inconvenient and unfriendly this felt, and how it shaped their view of the Clinic. Surprisingly, these issues were raised by patients more often than the therapeutic alliance across both groups.

In her qualitative research, Hill (2010) drew attention to the meaningfulness of the physical setting for patients undergoing psychoanalysis. She highlighted that the physical environment in which therapy takes place, which comprises the consistency of sessions over time, use of the couch, and the waiting area, offers a form of containment or holding, for the patient. Winnicott (1960) theorised that a safe physical and emotional environment provided by the primary caregiver was soothing, and also a vital foundation for healthy infant development. Adult psychotherapy patients who have not experienced adequate provision of a maternal holding environment in infancy tend to be particularly sensitive to the physical space in which their treatment occurs, which, according to Winnicott, has a specific symbolic meaning for them. Consequently, the absence of a physical 'holding'

space in the form of a waiting room and reception area may not simply be perceived as a minor inconvenience, but instead be experienced as failure of the 'clinic-mother' to provide an essential level of emotional attunement and care. For many GNC patients this spatial deficit thus may have communicated that the Clinic was not adequately welcoming, protecting or supporting them, despite the low-fee, twice weekly therapeutic care they received.

Bion's (1959) notion of containment is also relevant to the physical setting of psychotherapy. Containment involves the mother or therapist acting as a metaphorical 'container' for the infant or patient's projected, unwanted and overwhelming emotions, by tolerating them, holding them in mind and processing their as yet (for the patient) unthinkable qualities. The physical setting of the clinic, including the entrance and waiting area, can be thought of as an extension of the therapist or mother's mind and body, which also acts as a form of containment. Patients who attended the GNC may have felt metaphorically shut out of their therapist's mind when they encountered the locked door at the Clinic entrance, or the non-existent waiting area. The absence of a physical containing space at the point of entry may thus have resulted in patients feeling emotionally unsettled about attending the Clinic.

The setting or context in which therapy takes place plays a significant role in the patients' first impressions and overall experience. The setting is made up of the physical space, decoration, cultural beliefs or prejudices, and the emotional climate of the clinic (McLeod & Machin, 1998). The interactions that patients have with professionals in their various forms of contact with the clinic, starting with the referral process, are also of great consequence. During each of these interactions the patient is forming a first impression of the clinic, which in turn has a bearing on their choice to engage or disengage. Some of

the patients from the current study perceived the GNC as disorganised, unprofessional, and ineffective in its communication, which hindered the development of a positive and fruitful relationship with the service. The findings highlight how profound the quality of each interaction with the patient can be, and the service's obligation to maintain a high level of professionalism. At each point of contact, professionalism contributes to an overall perception of the service as reliable, competent and credible, which enables patients to trust that they are in safe hands on their therapeutic journey. According to the literature on the therapeutic milieu, all aspects of the therapy environment should contribute to the care and recovery of patients, including the interpersonal exchanges that take place between staff and patients (Thomas, Shattell, & Martin, 2002). These results are consistent with McLeod and Machin (1998), who argue that contextual factors can make a significant difference to the therapeutic relationship, the therapeutic process and outcome in psychotherapy settings. These authors suggest that therapists need to have a wider view of their service that extends beyond the therapeutic frame and the therapy room. They purport that by paying closer attention to the clinical setting as a whole, practitioners can increase the responsiveness and effectiveness of their clinics.

Aspects of the setting were frequently criticised by both groups of patients who discontinued from the GNC, even by some patients who stayed for approximately one year of therapy. As such, patients' negative impressions of the Clinic setting did not lead directly to discontinuation. In line with Hill's (2010) research, the data from this study shows that while the provision of a physical holding space may be beneficial for patients, it is not necessarily sufficient on its own, to prevent discontinuation. The qualities of the therapist and the therapeutic relationship have more of an impact on discontinuation and these will be discussed in a later section.

Reactions to Clinic. An interesting pattern that emerged in the data was that a small group of patients from the early discontinuation group had parallel feelings towards, and perceptions of, the Clinic and their therapists. It appears that these patients did not separate their affective reactions to the physical setting of the Clinic and their feelings about their individual therapist who conducted the treatment, instead developing a global impression of both. It is possible that the strong negative reactions that these patients described, such as feeling rejected, under hostile attack, or experiencing an absence of warmth, are partly a result of patients' own projected internal aspects and their transference to the therapist and Clinic. The phenomenon of transference involves the unconscious redirection of feelings from the patient's past to the psychotherapist and, by extension, to the building in which the therapist works. To illustrate this point, it is helpful to consider the case of one patient, who made a unique connection between the Clinic and a "*brothel*", and talked about feeling "*exposed*" during therapy sessions. This idiosyncratic perception suggests that the patient's experience of the Clinic and their therapy sessions may have been intimately linked to an internal conflict. Perhaps there was something sordid and shameful about attending the Clinic because of the association in her mind between one professional service and another. This finding corroborates a prediction from Van Denburg and Van Denburg (1992) that patients who fear the emergence of uncomfortable fantasies, potentially in this case disavowed shameful feelings, may leave therapy before these intensify further.

While transference reactions to the therapist are expected and their exploration is encouraged in psychodynamic psychotherapy, patients can also experience transference to the clinic itself. This has been observed in patients with poor interpersonal functioning,

who emotionally attach to an institution, such as a clinic, while simultaneously detaching from the individuals within it (Reider, 1953). Safirstein (1967; 1970) argued that this type of institutional transference is a primitive defence used by patients who lack autonomy, fear abandonment, and need to create interpersonal distance. Patients who present with institutional transference may have also come from settings, such as the public mental health system, where therapist rotation and absence is high, in which case the response is actually somewhat adaptive in protecting them from the loss of separation (Martin, 1989). However, this is not the case at the GNC where therapists commit for 24 months of therapy with their patients. In the present study, the emotional reactions to the Clinic that patients describe are mostly consistent with the emotional reactions they have towards their therapist. Therefore, patients' feelings about the Clinic could be an extension of their feelings towards the therapist, rather than distinct from them. As such, the level of detachment that might result in a purely institutional transference was not observed in this sample.

Patient Choice. At the GNC patients are allocated a therapist and are not involved in the selection process. The lack of patient choice in the therapist they work with was raised as an issue by two patients in the current study. These patients expressed their resultant disillusionment and vexation, due to challenges that could not be overcome in the relationship with their therapist. In this type of setting where there is a long waiting list and high demand for services, referrals are usually accepted when a vacancy arises, without emphasis on goodness of fit between therapist and patient based on their personalities and style. Hill (2010) advised that when a question arises about the compatibility of the patient-therapist dyad, and these issues cannot be worked through

openly, then a durable working alliance is unlikely and the therapist should discuss the option of referral to another person. The experience of one patient from the present study accentuated the significance of patients' perceptions regarding their having no choice in therapist. This woman had very distressing transference feelings towards her therapist because they reminded her of an abuser. She felt extremely unsafe in the relationship to the point where she was unable to attend the Clinic, and unfortunately the option of seeing another therapist was reportedly never explored with her. While this was clearly transference, some flexibility, given her specific circumstances, was probably warranted and may have prevented her discontinuation.

Giving the patient more choice in terms of who they see for therapy, is not a conventional practice in most clinical services, particularly in the public system. However, Hill (2010) asserts that patient choice in therapist can have a serious impact on engagement and treatment outcomes because it gives the patient a sense of personal agency in the therapeutic process. She argues that patient agency leads to a more positive therapy experience, where the patient can be a patient-partner rather than a patient-victim. In her psychoanalytic research, Hill (2010) contends that it is helpful to acknowledge limitations in the analytic relationship, or to entertain the possibility that another pairing may be more constructive and functional. In one study of psychodynamic psychotherapy (Perry et al., 2007) where patients could change therapists if they wanted to, the authors reported that only 23% of patients chose to do so and this did not prolong treatment duration. Most of these patients switched after 17.5 sessions, with only 25% of them choosing to switch in the first two months. While it is often regarded as highly impractical, giving patients the choice to change therapists can also be seen as good practice because it has the power to reduce attrition (Perry et al., 2007). In light of this, patient choice should be viewed as

important for successful psychotherapy, alongside the psychoanalytic emphasis on working through negative transference feelings and alliance ruptures.

Therapist Factors

Two prominent themes that emerged from interviews with patients who had discontinued from therapy at the GNC were that patients encountered difficulties due to the personal qualities and characteristics of their therapist, and also due to the individual style and technique of their therapist. The personal characteristics and personal approach of the therapist was far more crucial for the patient than the therapist's perceived competence, which was only mentioned by one out of eleven interviewees.

Therapist characteristics. Patients who discontinued at any stage from the GNC reported how the characteristics of their therapist were a major hindrance in forming a therapeutic relationship, and that this affected their motivation to continue therapy. Other research has also placed the personal and human qualities of the therapist at the heart of therapeutic engagement, persistence and success (Anastasopoulos & Papanicolaou, 2004; Hill, 2010; Simon, 1993). Even in the literature on therapeutic outcome the importance of therapist personality has been emphasised over and above accomplishment of therapeutic goals (Westmacott et al., 2010) and theoretical framework or training level (Anastasopoulos & Papanicolaou, 2004). Although there is less research on the link between individual therapist characteristics and discontinuation, negative patient attitudes towards the therapist have been associated with early discontinuation (Clarkin & Levy, 2004). Additionally, the present findings suggest that therapist competence is far less important in discontinuation than perceived therapist personal characteristics. Hill (2010)

argued that the innate qualities or personality of the analyst is critical because they form part of the patient's first impression of their therapist, which moulds their ongoing perceptions and ultimately their experience of therapy and therapist. Therapist characteristics have the power to enable or disable the engagement process, and it appears they can be potent enough to make or break the therapy.

The perceived empathic failure of the therapist was a consistent theme across both groups, where some patients felt that their therapists did not listen empathically, and did not hear or understand them on an emotional level. The significance of therapist empathy has been associated with continuation in therapy (Watson, 2011), therapeutic outcome (Bachelor, 1991; Strupp et al., 1977) and therapeutic engagement (Green, 1996) in other studies. For example, Strupp, Hadley and Gomes-Schwartz (1977) revealed that therapist empathy, conveyed through the therapist's care and concern, is more salient than any specific intervention used by the therapist. Hill (2010) also alluded to the containing function of empathy in her research. When the patients in her study felt supported, deeply understood and cared for, this had a transformative effect. She connected this to Bion's (1959) idea that when the mother responds to the infant from a place of empathy, where she is able to take in and understand, rather than push back and reject the infant's feelings, this has the potential to change the infant's experience. The present results suggest that perceived empathy plays a key role in preventing patient discontinuation.

Patients used a variety of words to describe the negative characteristics of their therapists, such as "*odd*", "*strange*", "*rude*", "*hostile*", "*mysterious*", or talked about feeling criticised when interacting with their therapists. These perceived characteristics are not conducive to creating a supportive, safe and trusting environment, or establishing a

genuine and collaborative working relationship. They also reflect Hill's (2010) finding about how detrimental therapist insensitivity can be to the therapeutic process.

In a number of cases, therapists' personal attributes were closely connected to therapists' treatment style. One example concerns a patient who reported that their therapist vehemently stuck to the psychoanalytic frame, and the patient consequently experienced the therapist as rigid, peculiar and unfriendly. One of the criticisms levelled at psychoanalytic approaches is that therapist detachment or aloofness often accompanies therapists' efforts to maintain a receptive and neutral listening space. The analytic attitude, which informs the implementation of the therapeutic frame or setting, was traditionally seen to require therapist neutrality, emotional abstinence and relative anonymity (Ivey, 1999). This attitude allows expression of the patient's unconscious conflicts, affords space for the transference to develop unhindered, for resistance to emerge and be interpreted, and ensures that the therapist seeks to understand rather than satisfy the demands or roles imposed on them by the patient (Laplanche & Pontalis, 1967). However, when this attitude is not applied with sensitivity and flexibility, it can produce an image of the therapist as cold and distant. For example, excessive neutrality is sometimes associated with indifference, disinterest, or lack of concern (Levine, 1996), while excessive abstinence can cross into emotional unresponsiveness, and can cause patient frustration because of the perceived denial of gratification (Meissner, 1998), usually resulting in alliance problems (Jacobson, 1993). Likewise, extreme therapist anonymity may be experienced as a lack of amiability and openness. Ivey (1999) points out that this caricature of the analytic therapist as cold and depriving contradicts the intended aim of the analytic attitude. The present study supports the notion that in their manner of relating to patients, therapists should strive to maintain a balance between

being appropriately analytic and sensitive to the impact that their attitude has on the therapeutic alliance and the patient's willingness to continue treatment.

While individual therapist characteristics were reportedly a significant barrier to therapy for both groups, they had more of an impact on discontinuation in the group who left therapy during the assessment phase. In this group, patients seemed more affected by therapist qualities such as perceived criticalness or rudeness. Similarly, Watson (2011) reported that discontinuers are more likely to have less agency, more shame, and expect to be rejected and criticised. However, the group of patients who remained in therapy longer appeared to be less personally affected by perceived undesirable therapist qualities, and did not react as negatively. In general, the second group were also more willing to speak openly, assert their needs, and raise these issues with their therapist. This is consistent with psychodynamic psychotherapy research on patients' ideas of cure, which found that patients who were more likely to approach problems rather than avoid them were better off in terms of therapy outcome, experiencing positive early alliance, and less prone to discontinuation (Philips et al., 2007).

The contribution of therapists' individual qualities to patient discontinuation is not given as much attention in the literature as patient variables. The current research verifies that perceived therapist qualities are central in discontinuation and validates the need for further research in this area. It is essential for these factors to be given adequate consideration because therapists often miss or undervalue patient dissatisfaction (Westmacott et al., 2010), so these issues are commonly not addressed. According to the present research, when patients have the opportunity to openly express their negative perceptions of and feelings toward their therapist, and explore the personal consequences of this in the therapy, discontinuation may be prevented or at least postponed.

Therapist style or technique. The results clearly show the importance of therapist style and technique in engaging patients, helping them to feel understood, safe, and promoting openness rather than defensiveness. Across both groups, patients expressed frustration concerning their perception that their therapists were too confronting, not confronting enough, did not provide sufficient feedback, were too inactive and non-responsive, dealt poorly with sensitive disclosures, or over-used silence as an intervention. When the therapist did not match their patient's need for a confrontational style or intervention, this was aggravating and discouraging for the patient. Conversely, when their patients needed a more supportive style or intervention, but this was not provided, it made patients feel more defensive. Some people who discontinued therapy reported feeling very anxious, even "*traumatised*', by the lack of responsiveness or feedback offered by their therapist. This was particularly troubling for two patients who made disclosures of abuse but did not feel they received the validation they needed. Some patients also felt challenged by, or "*nervous"* as a result of therapist silence. The current results are therefore in line with earlier research linking therapist style, including the level of therapist detachment, confrontation, or forcefulness, to patient discontinuation (Crits-Christoph & Gibbons, 2001; Gold, 1995; Hilsenroth & Cromer, 2007; Norcross & Wampold, 2011; Roos & Werbart, 2013). Hill (2010) has also demonstrated that patients dislike therapy when their therapist is too detached, excessively challenging, passive or neutral. This study once again highlights the need for therapists to be highly attuned and sensitive to their patients' ever-changing and evolving needs, and carefully balance confrontation with support.

A number of patients in the early discontinuation group remarked that the interpretations they received were inaccurate, which led them to feel misunderstood and question the utility of treatment. Hill (2010) argues that poorly delivered interpretations have the potential to block constructive work because they can be alienating, too forceful, authoritative, or disempowering. She found that patients judge interpretations based on a number of criteria, including their use of everyday language, delivery, fit, and flexibility. Other authors have also emphasised how slight differences in the delivery of interpretations can have a considerable impact on how they are received, and ultimately nurture or destabilise the alliance (Casement, 2002). Although inaccurate interpretations alone were not sufficient for someone to leave the GNC, they contributed to a lack of therapeutic rapport in the early discontinuation group, which subsequently resulted in discontinuation. These findings continue to illustrate how crucial it is for therapists to be patient, sensitive, and well attuned to their patients, so that interpretations are delivered appropriately and allow constructive work to take place.

The finding that therapist silence was intimidating and anxiety-provoking for some of the patients who discontinued, is not unusual. Patients in Hill's (2010) study also experienced silence as counter-productive because it shut down reflectivity rather than expanded it, and was even described as immobilising, persecutory or traumatising. Silence can be used therapeutically to create more space for the patient to freely associate and communicate without disruption. Nevertheless, if patients are not aware of the purpose of using silence, or if the alliance quality is weak, it is understandable that they may feel confronted, put on the spot, and uncomfortable with this process. It can potentially generate a view of the therapist as distant, uncaring, even hostile or antagonistic. Lane, Koetting and Bishop (2002) suggest that when used skilfully, silence can enhance the therapeutic encounter by

helping the patient feel safe and contained. However, they contend that silence not applied sensitively can undermine trust and safety and compromise the therapeutic relationship. Our results corroborate the need for therapist attunement, sensitivity, and relationship building as primary in minimizing discontinuation at any stage.

Therapists' rigid adherence to the psychoanalytic frame at the expense of the therapeutic relationship was also a problem encountered by some patients who discontinued from the GNC. When the purpose of this strict observance of the frame was not understood by patients, it resulted in patient irritation and a perception of being provoked. Hill (2010) also reported that if the therapist had a rigid focus on rules and maintaining the frame, this could take away from their ability to listen effectively to the patient. These current findings also stress the relevance of flexibility as a key therapeutic skill, which is consistent with previous work contending that flexibility in technique can prevent patient discontinuation (Watson, 2011). Clearly setting the frame and providing the patient with an unambiguous definition of their role in therapy, what is expected of them in each session, and what they can expect from the therapist, cannot be underestimated. With more clarity around this, it is likely that patients would experience less confusion, frustration and disappointment, in what is essentially a very challenging and uncomfortable process.

Therapist-Patient Relationship Factors

Therapeutic alliance. Regardless of group membership, problems with the therapeutic alliance were repeatedly associated with the patient's choice to discontinue therapy at the GNC. Approximately 64% of patients who left during the assessment phase,

and approximately 44% of patients who discontinued after some therapy, voiced alliance issues in their interviews. These problems included poor therapist-patient fit, poor connection or rapport with the therapist, lack of safety and trust in the relationship, lack of transparency around the patient's role and tasks in therapy, as well as inadequate awareness and management of alliance ruptures, such as when the therapist took a break or when the patient felt dissatisfied with treatment. Importantly, other factors that have already been discussed such as therapist characteristics, style and technique, are also linked to discontinuation because of the way they undermine the therapeutic alliance. This research confirms what has been widely reported in other studies; that the alliance is of prime significance in patient discontinuation (Hill, 2010; Ogrodniczuk et al., 2005; Piper et al., 1999; Samstag et al., 1998; Tryon & Kane, 1993; Yeomans et al., 1994). It corroborates previous research by Nuetzel and Larsen (2012) that highlighted relationship factors such as the emotional bond between therapist and patient, rather than patient personality factors, as critical in patient discontinuation. In addition, it provides support for the hypothesis proposed by Deakin and colleagues (2012) that poor capacity to form a robust alliance is associated with an increased likelihood of termination.

Therapist attunement is one of the central features of a strong therapeutic alliance, and has already been flagged as essential in preventing discontinuation in this study. A number of patients experienced their therapist as misattuned, and when this misattunement was strong enough for them to feel misunderstood, discontinuation usually followed. This result was unsurprising given that when attunement is lacking, it is not possible for therapists to recognise and rectify bond issues (Gold & Stricker, 2011; Summers & Barber, 2009). In her qualitative research on psychoanalysis, Hill (2010) also commented on the relationship between misattunement, failure of the therapist to notice

and deal with patient dissatisfaction, and subsequent therapeutic failure. She advised that recognising impasses and acknowledging the limitations in the therapeutic relationship are very helpful to both patient and therapist, and should not be avoided. Likewise, Ogrodniczuk et al. (2005) argue that problems in the relationship need to be addressed as they emerge in the here and now. Therapists' willingness to take responsibility for some of the interpersonal struggles that emerge in the therapeutic encounter, serves to validate the patient's experience (Rainer & Campbell, 2001), yet several patients in the current study were disappointed when their therapist seemed unable or unwilling to do this.

Ensuring the patient is aware of the tasks of therapy that will assist them in meeting their goals is vital to forming a successful working alliance (Bordin, 1979). In the current study, it emerged that one patient was unsure of these tasks and this created tension and unease for them during sessions, while another patient found the perceived lack of direction on how the therapy would proceed or what was expected of them, to be obstructive. This resonates with Hill's (2010) argument that when patients are poorly prepared for psychoanalysis, particularly around the process and structure of the therapy, they can be left feeling deterred and uncertain. To use Hill's terminology, the patient can more easily become a patient-victim as opposed to a patient-partner without adequate preparation and introduction to the therapy process. The expectations about the content, tasks and goals of therapy need to be developed collaboratively with both patient and therapist (Hatchett, 2004). Other authors also discuss the benefit of pre-therapy preparation whereby therapists outline the rationale, obligations, how the therapy will evolve, and common misconceptions or obstacles in the therapeutic process (Ogrodniczuk et al., 2005). The findings provide a strong argument that a proper patient role induction for psychoanalytic psychotherapy is essential and has the potential to prevent discontinuation.

A noteworthy finding in the present study, was that slightly fewer patients in the late discontinuation group reported obstacles in the therapist-patient relationship, when compared to the early discontinuation group. This suggests that people in the late discontinuation group were marginally more capable of forming workable relationships with their therapist, and as one would expect, this may have facilitated their perseverance with therapy beyond the assessment phase. In situations where the alliance between therapist and patient was especially strong, this may have promoted even lengthier engagement with the Clinic, although it is difficult to be clear about this because all late discontinuers were grouped together in this study, and no continuous measure of time in therapy was used. The present findings provide partial support for the assertion that patients are better placed to tolerate and push through painful times in therapy when the alliance is healthy (Gelso & Fretz, 1992), although future research using a reliable alliance measure and comparing it to time in therapy, would be necessary to verify this claim.

Overall, the current sample had low levels of agreeableness, conscientiousness and extraversion, so it is not surprising that a large number of patients had substantial problems in developing a sound alliance with their therapist. While this study did not investigate moderator variables, the results suggest that there are subtle and complex interactions between different variables that may all contribute to the quality of the therapeutic relationship, which is ultimately linked to patient persistence or discontinuation in psychotherapy. Even though the majority of patient factors investigated in this study were not significant on their own, it is likely that they have a moderating effect on relationship factors, which could be extrapolated in future research using more complex statistical methods such as structural equation modelling or cluster analysis.

Therapy Factors

Negative aspects of the overall therapy experience were frequently noted by both groups of patients who discontinued from the GNC. In terms of their experience of therapy in general, patients talked about their dissatisfaction with the termination process, the confusing mental health field, and also their disappointment with therapy outcomes. For example, one patient who attended therapy for just over one year, said that they gained insight but did not increase their coping capacity. Another patient sought more therapy after leaving the GNC to process their experience, while another felt that therapy created more problems rather than alleviated their distress. These results may be difficult to digest, especially because the patient's voice is often unheard in research on discontinuation, and therapists tend to underestimate the percentage of non-responders or failures (Lambert, 2011). Nevertheless, when the patient's voice is taken seriously, such as in Hill's (2010) work, it is evident that patient dissatisfaction can be widespread, often hidden, harmful to the therapeutic process, and sometimes causes more distress for the patient. For example, one of Hill's patients described his analysis as more damaging than the pain that originally led him to analysis.

It was foreseeable that patient dissatisfaction would be a dominant theme in the current study because the data was taken from two groups of patients who discontinued therapy prior to the expected time frame of 24 months, yet notably, the present study also highlights that patient dissatisfaction does not always lead to early discontinuation. In many cases the patients who felt anxious, disturbed, frustrated or annoyed with the process and the therapist, still continued with therapy, sometimes for close to one year.

Also, many patients experienced positive outcomes despite their dissatisfaction, which provided them with the motivation to persist in their therapy.

In terms of psychodynamic psychotherapy more specifically, several patients aired their frustrations about the strict therapeutic frame and sizeable commitment of twice weekly sessions. The time factor certainly contributed to discontinuation for some, but only in the group of patients who stayed beyond the assessment phase. Given these patients had attended the Clinic for several months, they would have had a fuller understanding of what it means to be dedicated to the therapy process, and what sacrifices they would need to make in order to continue. For some patients this level of commitment proved too difficult to maintain. One patient in the early discontinuation group talked about how the inflexibility of the frame, which is supposed to provide a form of containment for the patient, was felt to create a *"combative dynamic"* between patient and therapist. On the other hand, two patients expressed their gratitude for the strict frame and the sense of routine this provided. In Hill's (2010) study, there was a similar breadth of views about the therapeutic frame. For example, one of the patients in her study found the consistency and frequency of sessions extremely stabilising and therefore containing, yet others found it very challenging. It is likely that similar mixed views would have been reported by the patients who completed 24 months of therapy, which could be explored in future research. These differences may be due in part to patient resistance, or may be reflective of individual attachment styles.

Patient Factors

Patient factors such as expectations about therapy, scepticism, poor communication, motivation, ambivalent feelings about therapy, and also practical barriers to attendance,

were reported by the patients from both groups who discontinued from the GNC. Despite the predictions from this study, other patient factors such as symptomatology or distress did not emerge as themes in the interview data. Patient factors noted above were prevalent in both groups, but more so in the late discontinuation group. Unmet patient expectations was the most prominent sub-theme, which was equally common across both groups and contributed significantly to patient dissatisfaction. Patients' expectations, especially in the early discontinuation group, seemed to be shaped by previous exposure to different therapeutic approaches where the therapist was more active and directive, such as in cognitive-behavioural therapy. Despite having psychoanalytic psychotherapy explained to them throughout the intake process, there was quite a fixed expectation from some patients that they would receive strategies to manage their symptoms, and they were thus disconcerted when these were not supplied by the therapist.

Mismatched or failed patient expectations have been associated with premature discontinuation in other research (Hansen et al., 1992; Nock & Kazdin, 2001; Reis & Brown, 1999; Swift & Callahan, 2008). Expectations refer to the anticipatory beliefs that patients carry with them into therapy about the process, content, structure or length of therapy, which can influence both attendance and outcomes (Nock & Kazdin, 2001). In the vast majority of cases, patients in the present study expressed unmet or only partially met role expectations, as opposed to outcome expectations. Role expectations are related to patients' pre-conceived ideas about the internal structure of therapy sessions and the behaviours that occur within them (Dew & Bickman, 2005). When patients are not given a thorough induction into their role in psychotherapy, or provided with explicit details about what to expect from each session, from therapy as a whole, and how this differs from other treatment modalities, they can be left feeling confused, anxious, frustrated,

dissatisfied and eventually choose to discontinue. Under the current public health model in Australia, cognitive-behavioural therapies are quite prolific, and there is a community expectation of brief, evidence-based psychotherapy treatment. People often believe that if they seek therapy they will be offered practical strategies that they can use to cope in their daily lives. Consequently, outlining the patient's role and clarifying their expectations of therapy, is even more imperative for a therapist providing psychoanalytic psychotherapy in this environment.

Many patients mentioned practical barriers to attendance at the GNC, such as job commitments, travel plans, physical health problems, distance to the Clinic, or inability to continue with the twice weekly commitment. Usually these practical barriers led directly to discontinuation, and were slightly more prevalent in the late discontinuation group. It is fair to assume that practical barriers would have a greater influence on discontinuation for this type of long-term and intensive therapy. However, only two patients from each group cited the frequency of sessions as their reason for discontinuation. The GNC is unique in that patients are often made aware by the referrer of the commitment that will be expected of them, even before making contact with the Clinic, and if not patients are informed of this at their first point of contact and at several points throughout the intake process. It may be for this reason that only such a small proportion of those interviewed left the Clinic because of the twice weekly format. Lack of patient motivation also prompted discontinuation when the patient began experiencing positive outcomes, or in one case, ambivalence about therapy. This was foreseeable given the research on the influence of motivation in therapy (Frayn, 1992; Midgley & Navridi, 2006; Ogrodniczuk et al., 2005). Scepticism, which reflects a particular quality of patient

attitude, was talked about by one patient in this study, although it did not directly impact on their decision to discontinue.

The findings indicate a possible connection between deficiency in patient communication and discontinuation. For example, one patient plainly talked about their decision not to share negative feelings about therapy with their therapist, thus denying the therapist an opportunity to engage with their dissatisfaction. Although it was not always explicitly identified by interviewees, unwillingness to communicate negative feelings with their therapist, was a pattern in the group of patients who discontinued early. These inhibitions potentially made this group more vulnerable to acting out their frustrations. This finding supports other research linking termination likelihood to difficulty expressing negative emotions (Oei & Kazmierczak, 1997), and linking patient assertiveness to more successful analyses (Hill, 2010). It also supports Ogrodniczuk and colleagues' (2005) view that therapists need to actively encourage patients to voice their doubts, fears and questions, and facilitate exploration of the negative transference, in order to help patients integrate and tolerate negative affect.

Positive Perceptions

An intuitive finding from the current study was that patients who left the GNC during the assessment phase had an overwhelmingly pessimistic view of the Clinic, compared to the more positive view of patients who engaged initially but discontinued prior to 24 months. In fact, only one out of eleven patients who discontinued early spoke in a positive way about their experience. Nuetzel and Larsen (2012) found a similar result in their study, where people who remained in therapy for more than one year, had more positive affect and optimism. However, the patients from the current research who had some therapy

before discontinuing were not overly positive in their appraisal of the Clinic. In fact, they reported mixed feelings about their experience of therapy and cited a similar number of problems to the other group, despite remaining in therapy for up to and over one year in a few cases. This result speaks to the demanding and confronting nature of therapy and reinforces the level of persistence and dedication, as well as the tolerance of negative affect, such as frustration, required, particularly in long-term therapy of twice weekly intensity. It is important to note that patients who did stay beyond the four initial assessment sessions were more willing to work through the difficulties they encountered in the relationship with their therapist. Frustration tolerance is imperative for psychodynamic psychotherapy to be successful (Berkowitz, 1998), and those who decide to engage in therapy often see it as an arduous but necessary part of the process (Parissis, Whitley, & Ward, 2006). Moreover, patients who have more adaptive defences can manage distressing affect and weather ruptures in the alliance that might result in discontinuation for less adaptive patients (Perry et al., 2007). To give an example from the present study, one patient who stayed in therapy for a number of months was better able to cope with a therapist they perceived as critical, and was better equipped at openly resolving these issues with their therapist. On the other hand, patients who discontinued during the assessment phase did not appear to manage these challenges as effectively. As a result, patients who discontinued later were less affected by negative therapist qualities, style, and negative aspects of the Clinic setting, and more of them reported a positive therapeutic alliance.

It is also plausible that patients remained in therapy beyond the assessment, and were more inclined to endure frustration, because they simultaneously experienced the benefits of therapy. These positive effects may have provided enough motivation to push beyond

their threshold of emotional discomfort. In the present study, patients who stayed in therapy beyond the assessment phase used a variety of words to convey their positive experiences of therapy; *"valuable"*, *"multi-faceted"*, *"helpful"*, and their therapist; *"calming"*, *"containing"*, *"dependable and committed"*. Patients in this late discontinuation group, said that therapy increased their interpersonal awareness, self-awareness, self-curiosity, assertiveness, and improved their understanding of and management of their symptoms. These reported therapeutic gains are consistent with the expectation of change in psychoanalytic therapies (Gold & Stricker, 2011), and are highly motivating for patients.

The possibility that therapy may have reached a natural conclusion for some patients prior to the 24 month period offered by the GNC, was considered. However, there was no indication from the patient interviews that this was the case. All of patients interviewed who mentioned some positive aspects of their experience, discontinued from the service due to dissatisfaction, discomfort, or for reasons external to the therapy such as being unable to manage the time commitment.

Implications

The results of this study have a number of implications for the GNC, for psychodynamic psychotherapy, and for clinical practice in general, about reducing the likelihood of patient discontinuation. In order to identify patients who are more likely to discontinue from psychotherapy, symptom checklists and personality measures do not appear particularly reliable or useful. It is more relevant to use a broader measure of global distress and assess life and social functioning, to obtain a picture of the impact that symptoms have on the individual. Patients who are identified as having high levels of

distress and poor life and social functioning, appear to be more at risk of disengagement in the assessment phase of therapy and may therefore need to be approached in a more sensitive, flexible and supportive way. Having said that, the present study does indicate that patients with elevated paranoid ideation are prone to discontinuation, so this could be reduced through early identification with the use of a formal measure or less formally during thorough clinical assessment, and early intervention. Patients who have paranoid thought content may feel unsafe with the therapist so the focus should be on creating safety in the relationship at the outset with these patients, in order to lessen the rate of discontinuation.

To reduce discontinuation, attention needs to be paid to the setting in which psychotherapy takes place. Our results show that many patients prefer to have a waiting room or reception area to use prior to the beginning of their sessions, perhaps because it may function as a metaphoric container for their psychic distress. A waiting area has the potential to welcome, support and comfort, people as they embark on an emotionally demanding journey. This first point of entry into a clinic, along with interactions with clinic staff during the referral process, forms part of patients' first impressions of the service. Where patients do not experience a clinical service that is well organised and professional, or where the staff are reliable, competent and credible, this can adversely impact on patients' overall impressions of both the clinic, the therapist and the therapy. In the early stages of therapy when a strong alliance has not yet been established, negative impressions of the clinic can be a serious impediment to patient engagement. Despite these findings, setting factors are not sufficient on their own to result in patient discontinuation. Once an alliance has been formed, or once the patient is benefitting from

therapy, the setting appears to have less of a bearing on a patient's decision to leave therapy.

Individual therapist characteristics have the power to enable or completely disable psychotherapy engagement and should be the focus of future research on this topic. According to the findings from this research, individual therapist characteristics are more influential than perceived therapist competence in discontinuation. Patients are typically seeking a therapist who can show empathy, otherwise they feel misunderstood and uncontained in the therapy. The therapist needs empathic qualities to fully receive, deeply understand and transform the patient's experience. Patients are also seeking a therapist who feels human, who they can connect with, and can be easily put off by perceived rudeness, criticalness, hostility, and eccentricity. When the patient perceives these characteristics in the therapist, it can preclude the formation of a trusting bond. In such cases, discontinuation can still be minimised by ensuring that patients feel comfortable raising their concerns and talking openly about these issues in therapy. The results provide evidence that patients who feel unsafe due to either a strong negative transference, or excessive paranoid ideation, should be regarded as more likely to discontinue. This does not mean that these patients should be excluded from services such as the GNC, but that they demand more focused attention from the therapist early on to avoid discontinuation. These patients require a sensitive and attuned therapist to create a safe therapeutic space where they can express their negative affects rather than act them out.

Therapist attunement, the sensitive and flexible application of technique, and clear setting of the therapy frame, are all potential antidotes to patient discontinuation according to the results of the present study. Therapists must be patient, attentive, and responsive to the ever-changing needs of their patient so that interventions are pitched at the appropriate

level. Discontinuation may be reduced if interventions such as silence or interpretations are not employed in a rigid fashion, but applied flexibly depending on the amount of confrontation that each individual can cope with. When therapists have a style that involves a high level of attunement, sensitivity and flexibility, rapport is easier to establish, and patients are more likely to continue with therapy. Additionally, therapist attunement is critical to noticing alliance ruptures (Summers & Barber, 2009) and ensuring a robust alliance. Discontinuation may also be avoided if therapists spend the time to clearly outline the therapeutic frame at the commencement of therapy. That is, provide an explanation of the patient's role and tasks, and clarify the expectations of both the patient and the therapist. It is clear that a lack of transparency around these issues can result in frustration, confusion or anxiety for patients, and often impacts on the therapeutic alliance.

The therapeutic alliance is considered central to the issue of patient discontinuation so it seems reasonable that any activity that boosts the alliance should simultaneously improve retention rates. Discontinuation could be avoided if therapists are adequately attuned to their patients to notice and engage with their negative reactions or dissatisfaction, and repair any alliance strains. If these issues are not recognised and discussed as they emerge, they can lead to an impasse or rupture in the relationship and ultimately result in discontinuation. Therapists also need to consider their own contribution to these issues for patients to feel validated and supported. There is some evidence from this study to suggest that where a strong alliance exists, the patient is more able to tolerate painful experiences and negative affect in therapy, and remain engaged for longer. It is suggested that many of the factors linked to discontinuation that have been discussed, may have a moderating effect on the therapeutic relationship, which in turn affects discontinuation.

Most discontinuers interviewed in this study found therapy unpleasant and challenging, despite some remaining at the Clinic for approximately one year. This demonstrates that discontinuation does not always eventuate from patient dissatisfaction. In fact, mixed feelings and ambivalence about therapy is expected. Patients should be encouraged and given opportunities to talk candidly about their dissatisfaction and disappointment with the therapy or therapist. This involves keeping on the lookout for a lack of disclosure, unusual pauses, defensiveness, general non-responsiveness (Watson, 2011), and emboldening the patient to voice doubts, concerns, aggravations or questions (Ogrodniczuk et al., 2005). Some authors have recommended systematically and regularly eliciting feedback from patients through formal measures (Shimokawa, Lambert, & Smart, 2010), to ensure adequate feedback is being sought and necessary adaptations can be made in a timely manner. If an opening to talk about issues with the therapy or therapist is provided, it can help patients to tolerate these and continue treatment rather than act out their frustrations by terminating prematurely.

Findings from this study suggest that patients at risk of discontinuing from therapy have a very pessimistic view of the service, and potentially have a lower threshold for frustration. Even though patients who continue for some therapy beyond the assessment phase have a mixed view rather than a unilaterally positive view of therapy, they usually also report positive outcomes and benefits of therapy attendance. This more positive experience serves to keep them motivated for a period of time, buffer their negative experiences and ease their vexations. Therefore, low frustration tolerance should be considered a probable risk for early discontinuation, because these patients are likely to be more affected by negative experiences of the setting, the therapy, therapist, or relationship. When there are no beneficial outcomes for the patient beginning therapy,

they may struggle to maintain motivation to persist, especially at times when therapy is more demanding. Hence, discontinuation could be minimised by regularly addressing patients' frustrations, and always working towards attainable goals in order to decrease discontinuation.

Some patient factors were identified in this study that could be used to identify patients at risk of discontinuation. Patients with mismatched expectations about therapy, those who are unwilling to communicate how they feel, or those who face practical barriers to attendance, tended to discontinue early. A number of the patients who left the Clinic were expecting to receive strategy-based treatments and were disappointed when this was not the case. As such, their departure from the GNC was timely and appropriate, and they could go on to seek a more suitable service. This highlights that carefully assessing patient expectations and ensuring that they are realistic, and also providing adequate role induction, are important steps in preventing discontinuation. The findings suggest that a small number of people stopped coming to therapy when they could no longer manage the frequency of sessions, so to avoid discontinuation, this issue may need to be addressed at the commencement and throughout therapy. Practical barriers to attendance are usually an issue outside the therapist's control, but therapists can engage in discussions about the emotional and practical challenges of twice weekly psychoanalytic psychotherapy as early as possible. Although at the outset it is impossible to predict exactly what will emerge for patients during their therapeutic journey, it is important that therapists introduce the idea that patients will certainly face challenges during the process. Recognising and discussing these adversities could help contain the patient's frustrations and provide them with enough hope to sustain their motivation.

Limitations and Suggestions for Future Research

The current study has a number of limitations which may limit the generalisability of findings. The most notable of these is that no distinction was made between patient-initiated or therapist-initiated discontinuation. The study did consider different phases of treatment, which was an important improvement on previous research, but essentially still analysed various forms of discontinuation together. In the post-discontinuation interviews, the researcher tried to ascertain who initiated discontinuation by asking the patient directly, but this information could not be gleaned from the interview notes with certainty. At times people did not specify, and often discontinuation was initiated by a combination of the therapist and patient. In any case, even when patients did specify who initiated discontinuation, this information was still subjective and was not corroborated by the therapist. Discontinuation is such a dynamic process that it may never involve only one party. The present results therefore do not distinguish between discontinuers who themselves chose to cease therapy, and those who were assessed by the therapist as unlikely to benefit from psychoanalytic psychotherapy.

Additionally, no distinction was drawn between discontinuation as a result of outside issues or issues internal to the therapy, which is often a complex distinction to make. For example, in most cases it was not clear whether people ceased therapy because of new work or travel plans, or whether they stopped because of therapy-related issues such as a lack of rapport with the therapist. The study also did not differentiate between those who discontinued because they were making an informed decision that psychoanalytic therapy was not the right treatment for them, or those who discontinued due to dissatisfaction. It was apparent that many patients who discontinued actually had a mix of reasons, both

conscious and unconscious, for doing so and this complexity was often not captured in the interview data. Future researchers could attempt to tease apart these different forms of discontinuation from therapy such as those that were patient-initiated, therapist-initiated, or externally imposed, by exploring in greater depth the circumstances of the decision to cease therapy, ideally from both the therapist and the patient's perspectives.

A second limitation to this study is that interview data used was written in the form of short-hand notes, and was at times difficult to interpret. This came about because the original researcher who interviewed the patients kept brief notes of the phone conversation which were transcribed by a second researcher some time later. Unfortunately the interview notes could not be expanded upon or fleshed out in any great detail, and sometimes the intended meaning of sentences could not be clarified. It is therefore necessary to be cautious about over-interpretation of this material. Ideally recording and transcribing of patient interviews would result in richer data for analysis. However, the use of this type of data is common in ethnographic research, where unstructured notes containing key dialogue or phrases are jotted down to capture the essence of interactions or observations (Mulhall, 2003). In this tradition, the lack of detailed accounts such as verbatim transcripts are not viewed as problematic if the researcher is seeking to understand broad patterns in the dialogue, and articulates how their focus has affected the direction of analysis (Mulhall, 2003), as in the current study.

Factors previously associated with early discontinuation from therapy such as diagnosis, cultural factors, socio-economic status, gender and ethnicity, were not measured or controlled for in this study. As such, their influence on the findings are not known. In particular, not having information about patient diagnosis makes it difficult to contrast the present findings with other research. It was beyond the scope of this project to

examine the average number of therapy sessions that patients had at the GNC. However, this would be useful information because it could be compared to the previously reported dose effect for psychotherapy (Lambert et al., 2001) to determine whether patients remained in therapy long enough for therapeutic change to take place.

It is possible that the inclusion of an alliance measure in the data analysis would afford more meaningful information about the potential moderating effect of patient factors on the therapeutic relationship. The conclusions that have been drawn about the therapeutic alliance can only be tentative because a formal measure of this was not utilised. It is therefore recommended that future research includes relationship variables rather than focusing on isolated patient variables. The focus of this research was on discontinuation, so patients who completed 24 months of long-term psychoanalytic psychotherapy at the GNC were not included in the sample. Analysing these patient interviews and comparing findings on similar variables will be and valuable next step for future research.

Given these findings have emanated from a sample of patients at a clinic offering long-term psychoanalytic psychotherapy, their generalisability to other kinds of therapy may be limited. The current sample is not representative of a normal outpatient clinic because the GNC services more severe and chronic patients who are seeking intensive treatment. The sample also has significantly lower levels of agreeableness, conscientiousness and extraversion when compared to other outpatient groups. Likewise, caution needs to be exercised if applying these findings to cognitive-behavioural or other short-term therapies. In spite of this, these results can be applied with confidence to other similar settings where psychodynamic psychotherapy is the primary treatment modality.

Conclusions

The findings presented here did address some of the methodological limitations of previous research and make an important contribution to the literature on patient discontinuation. This study focused on all forms of patient discontinuation from twice weekly psychoanalytic psychotherapy, using a large sample of adult patients from a low-fee clinic in Melbourne, Australia. The length of treatment offered was 24 months, which differentiates it from other studies published on shorter term therapies. Building on earlier research on patient variables conducted by Green (2011) at the same Clinic, the present study used symptom and personality profiles of patients to explore the phenomenon of discontinuation. It sought to determine differences between patients who discontinued at different stages based on Gastaud and Nunes' (2010) model, thus separating discontinuation during the assessment phase from discontinuation during therapy proper, and completion of therapy. In addition to baseline quantitative predictors, this research also included thematic analysis of interview notes from patients who had discontinued from the Clinic, which elucidated reasons for discontinuation from therapy prior to the available 24 months of treatment. This qualitative adjunct to the study allowed for deeper exploration and provided a unique perspective on this issue.

Overall the GNC had a high, but not untypical, discontinuation rate of 64.9%, which is a reflection of the chronicity and severity of referrals, and the requirement of twice weekly session frequency. Forty-one percent of patients discontinued during the assessment phase, while 35.1% completed 24 months of psychotherapy. Counter to what was hypothesised and commonly reported elsewhere, the results suggest that patient factors may not be foremost in explaining discontinuation. The only significant patient factors

found were high levels of paranoid ideation, global distress, and poor life and social functioning.

Non-patient factors, such as perception of the Clinic setting, individual characteristics of the therapist, therapist style or technique, the therapeutic alliance, or the therapy itself were frequently reported by patients who discontinued from the GNC, and appeared to have more of a bearing on their decision to cease treatment. The bulk of patients who left during the assessment phase had a predominantly negative experience of therapy at the clinic, with those who stayed for approximately one year of treatment expressing mixed sentiments about their time in therapy. The findings indicate that discontinuation is not always a product of patient dissatisfaction, especially if it is directly engaged with by a sensitive therapist, or tempered by perceived therapeutic benefits. Strupp (1980) talked about how patient qualities and relatedness could shape the course of the therapeutic relationship, however, the present study demonstrates that therapist qualities are also implicated in this process and cannot be ignored. Nonetheless, the present study did confirm Strupp's view that multiple factors occurring in conjunction with one another can amalgamate to make discontinuation more probable.

Valuable recommendations for clinical practice in addressing patient discontinuation have emanated from the current research. Firstly, that broad-based measures of global functioning are more useful than lengthy symptom and personality checklists in identifying people at risk of discontinuation from long-term psychotherapy. Secondly, discontinuation could be minimised if therapists are aware that the presence of paranoid ideation can increase the risk of discontinuation, and that a focus on rapport building may reduce this risk. Thirdly, priority must be given to the wider clinic environment of the waiting room, the clinic setting and the interactions between clinic staff and patients, so

that a therapeutic space is established where patients feel supported, welcomed and held. Fourthly, patient choice in therapist where appropriate could reduce unnecessary discontinuation.

Additionally, therapist qualities of empathy, attunement, flexibility and sensitivity are highly valued by patients and assist in the creation and upkeep of a workable alliance, where patients' negative emotions such as frustration can be openly discussed. It is clear that without a robust therapeutic alliance discontinuation is very likely to occur and any attempt to strengthen the alliance will likely reduce patient discontinuation. Finally, explicit setting of the therapeutic frame, where roles, tasks and expectations are clarified, is vital to minimising discontinuation.

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Appendix 1

The VAPP Definition of Psychoanalytic Psychotherapy

The VAPP Definition of Psychoanalytic Psychotherapy

For the purposes of membership qualifications and training in the Association, psychoanalytic psychotherapy is defined as an approach to the treatment of emotional problems which:

- stems from and takes place within the broad conceptual framework of psychoanalytic theory of human behaviour and mental life;
- regards the individual as an ever-changing dynamic system in which each part or aspect relates to, affects, and is affected by all others;
- assumes that many emotional and cognitive functions and experiences take place in the unconscious;
- assumes that the processes which govern admission to and exclusion from conscious awareness can be modified by insight or self understanding;
- assumes that therapy takes place within a relationship which involves commitment and responsibility from both therapist and patient;
- recognises and utilises the development of transference as an important vehicle for the achievement of insight and therapeutic change;
- regards counter-transference as an inevitable component of the therapeutic relationship which can be controlled and productively utilised only by virtue of the therapist's own self understanding;
- undertakes, within the theoretical framework provided, constantly to assess the therapeutic progress of each patient and evaluate and refine the techniques employed as well as the theory itself.

Appendix 2

Monash University Explanatory Statement

Explanatory Statement for Patients

Glen Nevis Clinic for Psychoanalytic Psychotherapy

Research Study

This information sheet is for you to keep.

My name is Dr Celia Godfrey and I am a Clinical Psychologist at the Glen Nevis Clinic. I am also a Research Fellow at Monash University. The Centre for Developmental Psychiatry and Psychology at Monash University is supporting the Glen Nevis Clinic to conduct research during its first 4 years. We are asking all patients attending the Glen Nevis Clinic, and all Psychotherapists, to participate in this research study.

What is the aim of the research?
The aim of the research is to document the service offered by the Glen Nevis Clinic, and to understand patients' experience of their psychotherapy. This research is the first of its kind to be conducted in Australia and is expected to contribute important knowledge to the health-care field internationally. It is also expected to assist the Clinic in reviewing and improving its service so as to be more helpful to patients attending the Clinic.

What does the research involve?
Participation in the research will involve 1) giving the researcher written consent to your participating in the overall study; 2) giving the researcher permission to access your Clinic file, specifically, administration information and the questionnaires you originally completed, but not the notes your therapist keeps; and 3) participation in up to four confidential research interviews, each taking approximately thirty to forty minutes. With your permission, the interviews will be audio-taped to ensure accuracy of recording. The Research Fellow will check with your therapist as to the suitability of the exact timing of the interviews, but the first two are likely to occur approximately 8 and 16 months into your therapy. Following this, there will be one interview at the conclusion of your therapy, and then another six months after you have finished therapy. The interviews will not interfere with your regular therapy appointments, and will be conducted at a separate time that is convenient to you.

Possible inconvenience or discomfort
As mentioned above, interviews would be arranged to take place at a time convenient to you. It is not anticipated that participation will entail any discomfort. Indeed, it is possible that you may find some benefit from reflecting upon your experience of attending the Clinic. Obviously you could discuss with your therapist any issues that are important to you that may arise in the interviews. In the unlikely event that any discomfort should arise during the interviews, the researcher can, after discussion with you, let your therapist know.

Confidentiality
The interviews are confidential, and for research purposes only. This means that only the researchers would have access to the transcripts. Your therapist will not read the interview transcripts. You are, of course, free to discuss the interviews and any thoughts you have about the research in your therapy, if you wish.

Storage and reporting of information
Storage of the research information collected will adhere to the University regulations and kept in a locked filing cabinet at the Glen Nevis Clinic for 5 years after any publication involving the data. After this time the data will be shredded. Written summary reports of the findings will eventually go to the Glen Nevis Clinic management. Summaries of findings may also be presented at professional conferences or in professional journals. In any written report, group findings will be summarised, and individual participants will be anonymous and not identifiable. After transcribing is completed the recording of the interview will be erased.

Payment
There is no payment for participation in this research.

Can I withdraw from the research?
Choosing to participate in the study is completely voluntary and you are under no obligation to consent to participation. Deciding not to participate will not affect your attendance at the Clinic for psychotherapy in any way. Further, you may withdraw your participation in the research at any time without consequence to you.

Results or findings
If you would like to be informed of the overall research findings, please contact Dr Celia Godfrey at the Glen Nevis Clinic on 9429-3387. The findings will be available once the research study is completed, in approximately 2012.

Thank you

Dr Celia Godfrey
Clinical Psychologist
Glen Nevis Research Fellow

If you would like to contact the researchers about any aspect of this study, please contact one of the Investigators:	If you have a complaint concerning the manner in which this research <insert your project number here, i.e. 2006/011> is being conducted, please contact:
Dr Celia Godfrey Research Fellow Phone: 9429-3387 Email: celia.godfrey@med.monash.edu.au Chief Investigators at Monash University Centre for Developmental Psychiatry and Psychology: Associate Professor Suzanne Dean Phone: 9429-3387 Email: suzanne.dean@med.monash.edu.au Professor Bruce Tonge Phone: 9594-1354 Email: bruce.tonge@med.monash.edu.au Ms Jeanette Beaufoy Phone: 9594-1300 Email: jeanette.beaufoy@med.monash.edu.au	Human Ethics Officer Standing Committee on Ethics in Research Involving Humans (SCERH) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 1420 Email: scerh@adm.monash.edu.au

Appendix 3

Consent Form

PATIENT CONSENT FORM

Glen Nevis Clinic for Psychoanalytic Psychotherapy

Research Study

NOTE: This Consent Form will remain with the Monash University researcher for their records, and you will also receive a copy

I agree to take part in the Monash University research project entitled "Glen Nevis Clinic for Psychoanalytic Psychotherapy Research Study". I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that consenting to take part in the research means that:

1. I agree to be interviewed by the researcher ☐ Yes ☐ No

2. I agree to allow the interviews to be audio-taped ☐ Yes ☐ No

3. I give the researcher permission to access information in my Clinic file ☐ Yes ☐ No

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any information from the interviews used in reports or published findings will not, under any circumstances, contain names, and will not identify individual participants.

Participant's name:_____

Signature:_____

Date:_____

Dr Celia Godfrey, Research Fellow

Signature:_____

Date:_____

Appendix 4

Interview Questions after Discontinuation

Interview Questions

1. What was your experience of coming to the GNC?
2. Did it meet your expectations?
3. So obviously you're not in therapy at the Clinic now. How did that come about – was it your decision or the therapist's decision not to go ahead / to finish up?
4. Have you linked in with another service/therapist since then?
5. Is there anything else you would like to add about your experience at the Glen Nevis Clinic?

Appendix 5

Example Items from the *NEO-FFI*

Dimension	Facet	Example items
Neuroticism	Anxiety	*I am easily frightened*
	Angry Hostility	*At times I feel bitter and resentful*
	Depression	*I have a low opinion of myself*
	Self-consciousness	*I often feel inferior to others*
	Impulsiveness	*I have trouble resisting my cravings*
	Vulnerability	*I often feel helpless and want someone else to solve my problems*
Extraversion	Warmth	*I am known as warm and friendly person*
	Gregariousness	*I enjoy parties with lots of people*
	Assertiveness	*Other people often look to me to make decisions*
	Activity	*When I do things I do them vigorously*
	Excitement-Seeking	*I like to be where the action is*
	Positive Emotions	*Sometimes I bubble with happiness*
Openness	Fantasy	*I have a very active imagination*
	Aesthetics	*Certain kinds of music have an endless fascination for me*
	Feelings	*I find it easy to empathize - to feel what other people are feeling*
	Actions	*I often try new and foreign foods*
	Ideas	*I have a lot of intellectual curiosity*
	Values	*I consider myself broad-minded and tolerant of other people's lifestyles*
Agreeableness	Trust	*I think most people I deal with are honest and trustworthy*
	Straightforwardness	*I'm not crafty or sly*
	Altruism	*I go out of my to help others if I can*
	Compliance	*When I've been insulted, I just try to forgive and forget*
	Modesty	*I'd rather not talk about myself and my achievements*
	Tender-Mindedness	*I would rather be known as "merciful" than as "just"*
Conscientiousness	Competence	*I pride myself on my sound judgement*
	Order	*I tend to be somewhat fastidious or exacting*
	Dutifulness	*I pay my debts promptly and in full*
	Achievement Striving	*I strive for excellence in everything I do*
	Self-Discipline	*I am a productive person who always gets the job done*
	Deliberation	*I think things through before coming to a decision*

Appendix 6

Example Items from the *BSI*

Dimension	Characteristics	Example symptom descriptor
Somatization	Distress arising from perceptions of bodily dysfunction	*Feeling weak in parts of your body*
Obsessive-Compulsive	Unremitting and irresistible thoughts and behaviours	*Feeling blocked in getting things done*
Interpersonal Sensitivity	Feelings of personal inadequacy and inferiority	*Feeling that people are unfriendly or dislike you*
Depression	Dysphoric mood, lack of motivation and loss of interest in life	*Feeling hopeless about the future*
Anxiety	Nervousness, tension, panic and terror	*Nervousness of shakiness inside*
Hostility	Angry thoughts, feelings or actions	*Tempter outbursts that you could not control*
Phobic Anxiety	Pathognomonic and disruptive manifestations of phobic anxiety	*Feeling afraid in open spaces or in the streets*
Paranoid Ideation	Projective thought, hostility, suspiciousness, grandiosity, delusions	*Feeing that you are watched or talked about by others*
Psychoticism	Mild interpersonal alienation to dramatic psychosis	*The idea that someone else can control your thoughts*

Appendix 7

Example Items from the *CORE-OM*

Dimension	Example item
Subjective Well-being	*I have felt like crying* *I have felt optimistic about my future*
Problems/Symptoms	*My problems have been impossible to put to one side* *I have felt totally lacking in enthusiasm and energy*
Life Functioning	*I have been able to do most things I needed to* *Talking to people has felt too much for me*
Risk/Harm	*I made plans to end my life* *I have been physically voilent to others*

Appendix 8

Sample Interview Transcript with Coding

Transcripts of patients who left therapy during assessment phase (Group 1)

ID: 79

What was your experience of coming to the GNC?

Pt found therapist interventions basic

About 1 year ago attended for 3-4 sessions?? Ax + Exp?? Have been seeing a psychologist for 10 yrs now. Much of the treatment was basic – frustrated as I knew where she was going.

↳ Pt found predictability of therapist frustrating

Did it meet your expectations?

↳ Pt found therapeutic approach misleading

Pt was expecting CBT

Aware of psychoanalytic treatment but felt misled and not what I was expecting. Said I wanted to see a clinical psychologist and have CBT, but when arrived didn't get this. Told this to [redacted]

So obviously you're not in therapy at the Clinic now. How did that come about – was it your decision or the therapist's decision not to go ahead / to finish up?

Pt unable to recall reason for discontinuation

Can't really recall. Spoke to her and said I couldn't continue. She went on a break for 3 weeks. Before holidays. Couldn't.

↳ Therapist break preceded/coincided with pt discontinuation.

Have you linked in with another service/therapist since then?

- felt connection with therapist

Clinical Psychologist Private Practice. 6-8 months. CBT approach. Not re-living, but focus.

Pt prefers CBT due to its focus on the present

Is there anything else you would like to add about your experience at the Glen Nevis Clinic?

↳ Pt travelled long distance to clinic. ↳ Pt experienced no waiting room as confronting/inconvenient

A long way to drive. Parking at. No waiting room – inconvenient/confronting if early. More awareness of clinic in the public. Better if offered clinical psychologist eg:CBT. An amazing clinic in terms of low cost therapy across a long period of time. CBT would have been more suitable for me. Wasn't really happy with the therapist. Didn't feel connected to the therapist. Understood the where and why of my problems. Didn't want to bring more up re the past. This therapy can be traumatising. Statements were quite basic. Beyond this level – needed something – knew why I did things and where they came from. Needed to know how to deal with issues eg anger. Needed more strategies and learn to move forward in my life. Spoke to therapist about this and believe said I wasn't benefiting. Things she did or said that put me off. Didn't feel helped, put on her work hat. Used checklist re suicide.

Pt thought CBT was more suitable for their issues

focus + past was experienced as traumatising

Pt was seeking a strategy-based tx

↳ Pt felt put off by therapist comments + mannerisms.

↳ Pt found therapist statements / interpretations basic.

Therapist use of suicide checklist was experienced as unhelpful + impersonal by patient.

Pt was able to raise issue of dissatisfaction in therapist.

Appendix 9

Matrix of Codes, Sub-themes & Themes

Emergent theme	Sub-themes	Example codes	Example quotation
Clinic Factors	Negative impression of physical setting	Patient found clinic dark, impersonal and unwelcoming.	"Felt that décor was very dark, impersonal, not homely, comfortable, more colourful would be good. Skeleton man picture."
Therapy Factors	Negative experience of past focus	Focus on past was experienced as re-traumatising.	"Didn't want to bring more up re the past. This therapy can be traumatising."
Therapist Factors	Empathic failure	Patient experienced therapist as uncaring.	"Didn't feel listened to, or that she cared."
Patient Factors	Patient scepticism of psychodynamic therapy	Prior knowledge made patient sceptical of psychodynamic therapy.	"(I was) a bit sceptical of whole process due to study of Freud. Carried this into the therapy."
Therapist-Patient Relationship Factors	Relationship incongruity	Mismatched patient-therapist relationship.	"It was pretty much didn't feel it was a good fit with the therapist. "
Positive Aspects of Patient Experience	Improved perspective on self and world	Therapy improved patient self-awareness and changed patient perspective.	"Know myself, how I see the world, accepting of life & the wrongs in the world, more realistic..."

Appendix 11

Monash University Human Ethics Approval Certificate

MONASH University

Standing Committee on Ethics in Research Involving Humans (SCERH)
Research Office

Human Ethics Certificate of Approval

Date:	**28 October 2008**
Project Number:	**CF08/2193 - 2008001059**
Project Title:	**Glen Nevis Clinic for Psychoanalytic Psychotherapy Research Study**
Chief Investigator:	**Prof Bruce Tonge**
Approved:	**From: 28 October 2008 to 28 October 2013**

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained and a copy forwarded to SCERH before any data collection can occur at the specified organisation. **Failure to provide permission letters to SCERH before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research.**
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by SCERH.
4. You should notify SCERH immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to SCERH and must not begin without written approval from SCERH. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. SCERH should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by SCERH at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Ben Canny
Chair, SCERH

Cc: Assoc Prof Suzanne Dean; Ms Jeanette Beaufoy; Dr Celia Godfrey

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