ORIGINAL ARTICLE

Factors related to early dropout in psychoanalytic psychotherapy

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ABSTRACT

INTRODUCTION: The efficacy of psychoanalytic psychotherapy is well established in controlled clinical trials; however, some individual characteristics that predict better outcomes are yet poorly studied. This study aimed at evaluating the association of demographics data, psychiatric diagnosis, clinical impairment, quality of life, aspects of psychotherapy suitability, defensive style and dropout before 3 months. **METHOD:** A consecutive sample of 56 subjects was evaluated after psychotherapy indication through a standardized protocol, World Health Organization Quality of Life Bref (WHOQOL-Bref), Self Report Questionnaire, Defensive Style Questionnaire, Scale of Defensive Functioning of Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV-TR) and Global Assessment of Functioning, and followed for 3 months. **RESULTS:** Dropout rate was 12.5%. There was no difference between groups in respect to Global Assessment of Functioning, Self Report Questionnaire and Defensive Style Questionnaire scores. Dropout patients reported to be satisfied with their health, despite psychopathological severity, even when other variables were controlled (p < 0.0001). The group that remained in psychotherapy was better adjusted before treatment and had average or superior estimated intelligence (p < 0.05). More dropout patients presented lower levels of defensive style, by means of the Scale of Defensive Functioning of DSM-IV-TR. **CONCLUSIONS:** Psychopathology severity alone did not predict dropout. However, patients with

lower levels of insight and immature defenses (especially narcissistic) had higher dropout rates. Therefore, such aspects must be seriously considered, along with patients' expectations about the psychoanalytic method, and should be judiciously assessed before indication.

Keywords: Psychotherapy, psychoanalysis, patient dropout, treatment outcome, defense mechanisms, quality of life.

Introduction

After the advent of psychoanalysis, different therapeutic modalities have been developed to treat mental disorders and emotional problems. Among therapeutic options are other forms of psychotherapy and psychopharmacology. Efficacy of different methods has been systematically tested, so that treatment can be adjusted to patients' individual needs and to the health system. Studies comparing cognitive-behavioral therapy and brief or interpersonal psychodynamic psychotherapy found similar results in terms of general efficacy. However, variations in results have been pointed when considering patients' individual characteristics, such as time of disease, comorbid conditions, personality traits, symptoms severity, psychiatric diagnosis, existence of focus, quality of object relations, defensive style, marital status, among others. Such results, however, are still incipient, and there is no consensus allowing definition of the most suitable type of treatment for a particular patient based on scientific evidence.[1-9]

Several authors have been fighting the myth that all patients can be treated and cured through analytic psychotherapy, or analysis, a mistake that can discredit this technique and lead to unnecessary expenses and suffering.[10] The analytic method proposes a therapeutic tool aiming at symptom improvement through understanding of current functioning and unconscious aspects involved in a given conflict.

This process is not free from an "emotional cost" and may cause initial worsening of symptoms, by showing patient's characteristics contributing to the establishment and maintenance of his problematic aspects. In this sense, there must be a high motivation to improve through the analytic method, which often implies wider objectives, such as expanding mind capacity and the individual's possibilities of choice. Aspects such as the patient's capacity of symbolization and abstraction are certainly essential if one is thinking in suitability for analytic psychotherapy.

Consequently, indication of analytic treatment, by definition, demands consideration of psychological criteria that are not usually assessed in traditional models of clinical research. Concomitantly, adequacy of using the efficacy model, traditionally represented by randomized clinical trials, has been questioned in this area. Application of rigorous selection criteria with the aim of homogenizing sample and strict and systematic control of therapeutic modality make generalization of results impossible, since the treatment being tested is substantially different from that applied in "real life" and technical aspects that are essential to characterize a treatment as analytic are disrupted.[11] Effectiveness studies using some parameters of efficacy models (aiming to preserve internal validity), along with a naturalistic design, are more adequate.[10-15]

Many treatment interruptions, as well as little effective outcomes, can be a consequence of improper initial assessments and imprecise indications. Freud (1913) states that "(...) regarding the psychoanalyst, if the case is unfavorable, the analyst made a practical mistake: he was responsible for unnecessary expenses and discredited his method of treatment."[10,16] By studying the phenomenon of psychotherapy dropout, Urtiaga et al. found that the risk of patient dropout over the first four sessions is very high and that after the tenth session the risk is significantly reduced.[17] In teaching institutions, factors such as need of periodic changes of therapist seem to explain a significant part of dropouts.[18]

Some psychopathologies, such as borderline personality disorder, have been particularly associated with high chances of dropout: two out of five patients abandon treatment, independent of who the therapist is.[19] Presence of major narcissistic traits also implies a higher chance of interruption, since it inhibits establishment of a relation that strengthens work alliance.[20] A study that followed 43 patients undergoing outpatient psychoanalytic treatment found that higher levels of insight

pretreatment were associated with longer psychotherapy duration, fewer chances of dropout and search for additional psychotherapeutic treatment over a 4-year follow-up.[21]

Other factors systematically associated with psychotherapy outcome are patient's motivation to the treatment, ability of thinking psychologically, psychic curiosity, level of initial suffering and level of personality organization (ego force, quality of object relations).[9,22] Initial quality of therapeutic alliance (or work alliance) has been especially considered, independent of the technique employed.[23-25]

Lack of evidence regarding patient's characteristics associated with higher effectiveness collaborates to absence of a general consensus in respect to indication criteria, an aspect that is particularly relevant when dealing with public health. Studies aiming to investigate the efficacy of currently used psychotherapy programs are needed, in order to contribute to refinement of criteria and decisions about resource allocation.[26] The aim of this study was to investigate, in a sample of patients admitted to the Program of Psychoanalytic Psychotherapy at the Service of Psychiatry of Hospital de Clínicas de Porto Alegre (HCPA), existence of an association between treatment dropout over the first 3 months and demographic characteristics, clinical severity, defensive functioning and criteria that are traditionally attributed to indication of psychoanalytic psychotherapy.

Methodology

Sample

A consecutive sample of 56 subjects that started attendance to the Program of Psychoanalytic Psychotherapy at HCPA, in 2005, was followed over a 3-month period, after indication of analytic psychotherapy. Early dropout was defined as treatment interruption (communicated or not) before 3 months. Choice of follow-up time was based on evidence indicating the initial period of psychotherapy is associated with higher dropout rates, which are drastically reduced after the 10th session.[17] In addition, 12 weeks (or 12 sessions in weekly treatments) can be considered minimum time to have changes obtained in an analytic treatment reflected in symptoms and improvement in functioning. Thus, there is reduced chance of dropout being a "discharge given by the patient," after reaching his objectives, independent of those established by the therapist. Although its importance in the establishment of an initial bond and in the correct method indication is recognizably fundamental, assessment interviews were not considered as treatment time, since they are not technically equivalent to sessions of psychoanalytic psychotherapy.

Indication and characteristics of psychotherapy

Evaluation of psychotherapy indication was guided by an evaluation protocol specifically developed for that purpose, based on literature review, meeting with experts and pilot studies. Twenty-one indication criteria were selected, comprehending data such as time availability, ego resources, existence of focus and motivation to perform an analytic treatment (Table 1). Criteria were evaluated through yes/no dichotomic responses, based on data obtained in assessment interviews.[27] The set of evaluated criteria was used to determine indications: an independent factor did not result in psychotherapy contraindication; all aspects were judged when considering suitability. Furthermore, sociodemographic data were evaluated, as well as diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR), focus of psychotherapy, aroused feelings (transference and countertransference), predominant defenses, preliminary psychodynamic hypothesis (current conflict, functioning and primary conflict), use of psychotropics, characteristics of psychotherapy (supervision and frequency) and detailed history of previous psychiatric treatment. All therapists were given 30 hours of theoretical-practical training about the protocol, which was filled based on assessment interviews (four in average) and performed by the therapist with the aid of his supervisor. Axis I disorders were evaluated by supervised clinical interview.

Table 1 - Indication criteria

1	Spontaneous search
2	Time availability
3	Professional activity
4	Intelligence
5	Good previous adaptation
6	Reality test
7	Significant person
8	Quality of object relations
9	Realistic expectations
10	Psychic suffering
11	Psychic curiosity
12	Psychological thinking
13	Tolerance to frustration
14	Identity diffusion
15	Conflicts with dependence
16	Lack of impulse control
17	Takes on responsibilities
18	Triggering factor
19	Identifiable focal conflict
20	Motivation for change
21	Therapeutic alliance

The patients were referred by other programs of the Service of Psychiatry Clinic (due to symptoms or residual suffering after optimization of drug treatment) or directly by the Screening Service, which receives patients from primary network. It can be said that, in case of indication according to psychological criteria, many patients diagnosed as Axis I that were already under drug treatment started psychotherapy (characterizing combined treatment) or were directly referred to psychotherapy when the nature of the disease implied evidence of equal effectiveness in relation to drug treatment (such as, for example, mild to moderate depression).

Once psychotherapy was indicated, its planning was based on preliminary psychodynamic hypothesis: current conflict, patient functioning, primary conflict and chosen work focus. Treatment manuals were not used to "prescribe" the script of the therapeutic process. However, a rigorous theoretical training, followed by systematic supervision, was used for technical training. The objective of not using manuals for psychotherapy was to maintain a "naturalistic setting," implying less rigidity and a treatment closer to the "real world."[22,29] For that same reason, patients with comorbidities were not excluded. Frequency of psychotherapy was once to twice a week, depending on indication and availability of schedules. The therapists were supervised by experienced psychotherapists (15-40 years of experience in analytic psychotherapy), through dialogue interviews.

Standardized instruments

Self Report Questionnaire (SRQ)

SRQ is a self-administered instrument, validated for Brazilian Portuguese, which evaluates clinical severity (symptoms) through 20 yes/no items, and is commonly used to screen presence of psychiatric disorder and evaluate severity in our country.[30,31] For classification into categories "high probability of psychiatric disease" and "low probability of psychiatric disease," the cut-off points defined in the validation study of the Brazilian version of SRQ were used.[32]

Diagnostic according to DSM-IV-TR

Diagnosis was performed throughout assessment interviews. The therapists who performed the interviews had at least 1 year of systematic training in diagnoses according to DSM-IV-TR, with supervision in psychiatric hospitalization and outpatient care, as well as experience with structured diagnostic instruments. Interview (considered, by definition, the gold standard) was chosen instead of standardized instruments due to raters' experience and to the significant number of assessment interviews, increasing time of contact with patient for proper performance of diagnosis.[28]

Global Assessment of Functioning (GAF)

It corresponds to Axis I of DSM-IV-TR. It is a scale in which the clinician assesses patient functioning as to presence of symptoms, social, occupational or school functioning, interpersonal relationships, behavior, self-care ability, risk of aggression or suicide, thinking and judgment ability, among others. The resulting score ranges between 1-100, zero being information that is inadequate for scale filling.[28]

Defensive Style Questionnaire (DSQ-40)

DSQ-40 is a self-administered scale, validated for Brazilian Portuguese, with 40 questions that verify degree of use of 20 defense mechanisms, generating scores for mature, immature and neurotic factor, which reflect the degree of use of mechanisms belonging to each category.[33]

Defensive Functioning Scale (DFS/DSM-IV-TR)

In this scale the therapist must choose, using a hierarchic score, the seven defense mechanisms more frequently used out of a total of 25. The patient's defensive mechanism is later classified into one of the following levels: high adaptive level, level of mental inhibitions (formation of commitment), level of mild image distortion, level of denial, level of major image distortion, level of action and level of defensive deregulation. A standardized glossary is used to homogenize conceptualization of each defense mechanisms, as well as of each defensive level.[34] In this study, the defensive level was determined by consensus between two raters, using defense scores and descriptions regarding psychic functioning that were part of the evaluation protocol.

Later, the seven levels were grouped into three categories, considering the degree of adaptation generated by predominant use of the set of defenses: a) category I - levels 1 and 2 of DSM-IV-TR; b) category II - level 3; and c) category III (less adaptation) - levels 4, 5, 6 and 7. It can be considered that the degree of egodystonic behavior, i.e., how much of his suffering the patient attributes to his defensive style or "way of being," tends to be lower in category III, since it comprehends defense groups strongly linked to denial, projection, dissociation, acting, etc.

World Health Organization Quality of Life Bref (WHOQOL-Bref)

Patient's perception of his quality of life was evaluated through the WHOQOL-Bref, a scale developed in 1998 by the World Health Organization Quality of Life Group and validated for Portuguese in 2000 by Fleck et al. It consists of a self-administered instrument, comprised of 26 questions, a short version of WHOQOL-100. The first two questions are about general quality of life and satisfaction with health. In this study, we chose to evaluate each of these two questions separately, since they deal with different aspects regarding how the patient sees himself and the world. The other 24 questions represent the four domains of the original instrument: physical, psychological, social relationships and environment.[35]

The protocol and DFS were filled by the therapist, with the aid of his supervisor, along the process of evaluating psychotherapy indication. Once indication was performed, each patient was contacted by a research assistant (medical or psychology student), and application of SRQ, DSQ-40 and WHOQOL-Bref (self-administered) was performed at HCPA, according to a convenient schedule for the patient.

Statistical analysis and ethical aspects

The groups were compared using Student's *t* test and Fisher's exact test, and correlations were investigated using Pearson's and Spearman's tests. Linear regression was performed to control presence of diagnosis in Axis III as to satisfaction with health. The project was approved by the Research Ethics Committee at HCPA (protocol no. GPPG-HCPA 05-160), and all patients and their therapists signed a consent term. Data analysis was performed using statistical software SPSS 13.0, with the help of Research and Graduate Group at HCPA.

Results

A total of 47 female patients and nine male patients were included. Mean age was 37.5±11.9 years; mean income was 3.3±2.8 minimum wages; and schooling was 11.8±3.1 years of complete study. Thirty-two patients were referred by other programs, and 24 came directly from screening.

Out of 56 patients included, one man (11.1% of men) and six women (12.8% of women) abandoned treatment before 3 months, in a total of 12.5% of the sample. There was no difference between this group (n = 7) and the group that remained under treatment for more than 3 months (n = 49) as to age (p = 0.32), marital status (p = 0.90), presence of children (p = 0.51) and practice or not of any religion (p = 0.14). As to baseline severity scores, there was no difference as to SRQ (10.71±3.5 vs.11.47±4.8; p = 0.69), GAF[36] (59.19±16.1 vs. 59.17±22.0; p = 0.99) and WHOQOL-Bref domains (physical: p = 0.56; psychological: p = 0.73; social relationships: p = 0.69; and environment: p = 0.84). There was no difference as to perception of general quality of life (p = 0.96). Although severity parameters had been similar, the patients who abandoned psychotherapy were more satisfied with their health (p < 0.01) in treatment onset, even when controlling presence of diagnosis in Axis III (p < 0.0001).

There was a tendency to lower personal income (3.6±2.9 vs. 1.50±1.4 minimum wages; p = 0.09) and lower schooling level (12.0±3.0 vs.9.7±2.8 years of study; p = 0.08) in the dropout group. The group that remained in psychotherapy had higher use of mature defenses in initial evaluation, according to DSQ-40 (4.5±1.5 vs.3.8±1.4), but this finding was not significant (p = 0.23).

With regard to criteria of psychotherapy indication, the group of patients who remained under treatment had higher proportion of individuals with good previous adaptation (81.6 vs. 42.9%; p = 0.04) and clinically average or superior intelligence (96 vs. 57.1%; p = 0.05). In the single case in which therapeutic alliance was evaluated as poor, the patient abandoned treatment.

One of the patients in the dropout group, when asked about the reason of interruption, alleged that he had already reached his objectives (despite the short time of treatment) and that he no longer felt it was necessary to remain in psychotherapy. When the statistical analyses were repeated, without considering this case, the lowest schooling level in the dropout group became significant (12.2±3.0 vs. 9±2.5; p = 0.036).

According to DFS,[34] a higher proportion of patients that interrupted treatment was classified as immature levels, particularly as negation level (Table 2). When grouped into three categories - I being higher adaptation and III being more maladaptive defenses and more ego-syntony - 55% of the patients who remained in treatment were classified into category III, whereas 85.7% of those who abandoned treatment were included in this category (p = 0.13). Whereas patients in category III that remained in treatment had a perception of their general quality of life worse than the other patients (37.0±25.9 vs. 51.1±19.3; p = 0.04), this did not occur with patients included in this category that abandoned treatment (51.1±18.8).

Table 2 - Defensive levels according to the Scale of Defensive Functioning of Diagnostic and Statistical Manual of Mental Disorders, fourth edition (SDF/DSM-IV-TR)

	No dropout (n = 49)		Dropout (n = 7)	
	n	%	n	%
Level 1				
High adaptive level	0	0	0	0
Level 2				
Mental inhibitions	12	24.5	1*	14.3
Level 3				
Mild image distortion	10	20.4	0	0
Level 4				
Denial	11	22.4	3	42.9
Level 5				
Major image distortion	7	14.3	1	14.3
Level 6				
Action	9	18.4	2	28.6
Level 7				
Defensive deregulation	0	0	0	0

* Analyzing defenses independently, defenses in the mental inhibition group were prevalent (isolation of affection, displacement), but concomitantly to an intensive use of acting, idealization, projection and dissociation.

[Table 2- Click to enlarge]

Using the cut-off point of SRQ to detect possible psychiatric disease in the Brazilian population, 85.7% of the patients who did not remain in psychotherapy had high probability of disease.

According to the classification of DSM-IV-TR,[36] all patients had at least one diagnosis in Axis I or Axis II (Table 3).

Table 3- Click to enlarge

Eight therapists were men and 10 were women; patient and therapist were of the same gender in 58.9% of pairs. There was no difference as to dropout rates in relation to those in which the therapist's and patient's gender was different (p = 0.99). All dropout cases were analyzed by supervision. Out of 24 patients directly referred from screening, 25% abandoned treatment, whereas only one patient (3.1%) of those referred by another programs did not remain in psychotherapy (p = 0.035). Any patient that interrupted treatment had undergone psychoanalytic psychotherapy in the past, whereas great part of those who remained (25 patients) had already undergone it at some moment in life (p = 0.01). Similarly, six out of seven patients of the dropout group had never undergone psychiatric treatment, except current psychoanalytic psychotherapy (p = 0.02).

Discussion

Dropout rate (12.5%) in this study is small when compared with that in the literature.[37] This can reflect a more judicious selection process for psychotherapy, which included 21 criteria taken from the literature and discussed in expert panels (Table 1). In addition, there was also careful clinical and psychodynamic assessment to plan psychotherapy. Such information implies one of the limitations of this study: the small number of patients in the dropout group, resulting in high probability of beta error. However, some findings were in disagreement with some aspects frequently discussed in the literature, justifying presentation of results. Another possible limiting factor is the fact that therapists were in their formation period; on the other hand, these therapists were submitted to rigorous technical training and systematic supervision, favoring internal validity.

Similarity between both groups as to clinical severity (SRQ and GAF) suggests that, in this sample, clinical impairment (symptomatic) can be discarded as a possible cause of dropout. Nevertheless, apparently paradoxically, patients who abandoned treatment were more satisfied with their health at therapy onset, even when presence of Axis III disorders was controlled. On the other hand, when the psychodynamic variable "defense mechanisms" (DSQ-40 and SDF) is considered, the dropout group showed a more immature defensive functioning in many parameters, indicating a higher difficulty in getting into contact with reality and dealing with external and internal stressful agents. This is in accordance with other studies, which associated a lower level of insight and higher use of narcissistic defenses with a worse prognosis. Therefore, it can be inferred that patients who abandoned psychotherapy, in our sample, did not recognize themselves as having any disorder. Even if the objective of analytic psychotherapy is to increase ability of insight and improve reality test, depending on inexistence of more ego resources, very high levels of projection and denial can impair use of this method, avoiding a better use of interpretations and other interventions.

Awareness of the individual's responsibility over his current situation is exactly what allows changing it. Lack of motivation and persistent inability to recognize these aspects make the psychodynamic method unproductive, and increased perception over one self, others and the world is not feasible.

A tendency to higher schooling level, better socioeconomic level and clinically evaluated intelligence as mean or superior in the group that remained in treatment indicates importance of having a satisfactory intellectual condition to better benefit from psychoanalytic psychotherapy. It can be assumed that these variables reflect ability of abstraction and symbolization required to this process. Corroborating the importance of a minimal level of ego organization, we found, in the group that remained in treatment, a higher proportion of individuals with good previous adaptation, clinically average or superior intelligence, besides a tendency to a lower number of patients with identity diffusion. In the single case in which the therapist evaluated therapeutic alliance as poor, the patient abandoned treatment, which is in accordance with literature findings claiming that work alliance is essential for a good progress of psychotherapy.

In the present study, there were no dropouts due to change of therapist, since any dropout patient had previously undergone psychotherapy. It is important to stress this fact, since the literature presents it as one of the main reasons for treatment dropout in teaching institutions. Considering that any patient that interrupted treatment had undergone previous psychotherapeutic treatment (against more than 50% of those who remained), it could be inferred that this group was unaware of the real objectives of an analytic treatment. In addition, since the patients who came directly from screening had higher dropout rates, it is possible that indication of psychotherapy has been better analyzed by the psychiatrists of patients who were referred by other programs. On the other hand, those same patients had sought fewer treatments in general, despite their similar clinical impairment, reinforcing the hypothesis that perhaps they perceived themselves as less diseased, less needy or, due to present narcissistic characteristics, with more difficulty of searching for help. According to other studies, patients with higher insight level search more treatments and are more benefited from them.[20,21]

Considering that therapeutic alliance has been the variable most frequently associated with outcomes in psychotherapy, the findings in this study could be potentially involved factors in the ability of establishing a better quality alliance to perform a treatment of this type.[24] It is important to stress that, in this case, it is an alliance to perform a psychodynamic work, opposed to a treatment that offers fast and "magic" results. More ability of abstraction and symbolization, less use of immature defenses and fewer narcissistic characteristics allow searching for and receiving help more adequately and increase chance of having the patient better tolerate initial treatment stage. In the same sense, more critical sense, both about the patient's own condition of being diseased and about secondary impairments to his general functioning, collaborates to build an analytic work alliance. On the contrary, when immature defenses are prevalent (especially denial and projection), benefits from psychotherapy are affected.

These results suggest that, independent of the patient's psychiatric diagnosis, better definition of his objectives, of what is expected from the treatment, his motivation level and possibilities of thinking psychologically are essential factors that should be judiciously investigated in the assessment stage, when the best treatment modality to be indicated for that particular patient is being considered.

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