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Patient-reported Reasons for Discontinuing Psychotherapy in a Low-Cost Psychoanalytic Community Clinic

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Abstract

Using data from an outcome study of adult individual psychoanalytic psychotherapy, conducted in a low-cost Australian clinic, a mixed methods approach was employed to investigate patient discontinuation. This paper addresses the qualitative component of the discontinuation study, which explored patients' reasons for leaving the clinic service upon assessment or in treatment proper. Of 205 patients commencing clinic contact, 41% discontinued during or shortly after the four-week assessment period, while 40.5% of patients beginning psychotherapy withdrew before reaching the two-year treatment limit. Across these two groups, former patients were interviewed about their therapy experience and decision to discontinue. Thematic analysis of 20 interview transcripts generated five descriptive categories of discomfort or dissatisfaction prompting discontinuation: clinic factors, therapist factors, patient factors, therapist-patient relationship factors, and therapy factors. Findings

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suggest that experience of the clinic setting itself, together with negative patient perceptions of therapists and therapist interactional style, were significant influences and that dissatisfaction with the psychotherapy process and outcome was more relevant than problematic patient factors in treatment withdrawal. A number of patients, mainly late discontinuers, reported positive experiences of psychotherapy and significant treatment gains. Implications of the findings, with specific emphasis on psychoanalytic treatment settings, are discussed.

Keywords: psychotherapy discontinuation; psychoanalytic treatment; thematic analysis; community clinic.

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Patient-initiated premature treatment discontinuation, which occurs when patients decide to end psychotherapy before agreed upon treatment goals have been reached (Kazdin, 1996; Ogrodniczuk, Joyce, & Piper, 2005), is considered a major challenge for psychotherapy practitioners of all orientations (Roseborough, McLeod & Wright, 2016; Swift & Greenberg, 2012). Despite considerable research into the phenomenon over five decades, patient discontinuation is still poorly understood and difficult to prevent (Barrett, Chua, Crits-Christoff, Gibbons, & Thompson, 2008; Kegel & Fluckiger, 2015). Furthermore, there appear to be no significant differences in discontinuation rates when comparing psychotherapy treatment modalities, settings, patient types and therapist characteristics (Wiersbicki & Pekarik, 1993).

The term ‘discontinuation’ is often used interchangeably with ‘termination’, ‘attrition’, ‘dropout’, and ‘disengagement’ (Bischoff & Sprenkle, 1993; Van Denburg & Van Denburg, 1992). Discontinuation, however, is a more inclusive and non-pejorative term that accommodates all possible explanations that patients may have for leaving psychotherapy earlier than anticipated. ‘Patient discontinuation’ is thus used here to describe patients ceasing contact before treatment proper has commenced or before an agreed-upon treatment time-limit has been reached.

The definition of discontinuation is also necessarily context-dependent (Ogrodniczuk et al., 2005), taking its significance from the meanings and motives of early endings in specific therapeutic circumstances. Patients may cease treatment because they are resistant, dissatisfied or, alternatively, feel that they are well enough to manage life without further professional help. Indeed, while possibly contrary to their psychotherapists' assessment of their readiness, some early leavers may experience treatment success, reach their goals, resolve some of their problems, improve their functioning, and be content with the service they have received (Ogrodniczuk et al., 2005). Other premature endings are less psychologically motivated and occur because patients relocate, become physically ill or can no longer afford treatment.

Patient discontinuation is also an indication of unyielding resistance, patient or treatment unsuitability, therapeutic dissatisfaction, or irreparable alliance rupture (lambert & Ogles, 2004; Roos & Werbart, 2013), so it is of interest to psychotherapists and psychotherapy researchers alike.

There are widely varying discontinuation rates cited in the literature, some as high as 90% (Burstein, 1986; Owen & Kohutek, 1981). Some authors have claimed that most psychotherapy patients typically attend for

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only a few sessions (Pekarik, 1996; Phillips, 1985; Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003). Phillips (1985), for example, found that one third of patients commencing treatment leave after the first session and that half do not proceed past the second session. Others have found discontinuation rates of between 20% and 60 % (Garfield, 1994). Alarmingly, Scogin, Belon and Malone (1986) found that two thirds of psychotherapy patients dropped out after less than five sessions. An extensive meta-analysis conducted by Wierzbicki and Pekarik (1993), reported 47% as the average rate of patient discontinuation for individual psychotherapy. In a more recent meta-analysis of 669 studies, Swift and Greenberg (2012) cited a rate between 18% and 38%, with a weighted mean rate of 20%.

Meta-analytic research publications have addressed discontinuation in specific contemporary therapeutic orientations, including dialectical behaviour therapy (Dixon & Linardon, 2019), acceptance and commitment therapy (Ong, Lee, & Twohig, 2018), mindfulness-based therapy (Swift & Greenbert, 2012), interpersonal therapy (Linardon, Fitzsimmons-Craft, Brennan, Barillaro, & Wilfley, 2018), and cognitive-behavioural psychotherapy (Fernandez, Salem, Swift, & Ramtahal, 2015; Linardon, Hindle, & Brennan, 2018). However, fewer research efforts address discontinuation rates in psychoanalytic or psychodynamic psychotherapy (Gold & Stricker, 2011; Hill, 2010; Ingenhoven, Duivenvoorden, Passchier, & Van Den Brink, 2012; Neutzel & Larsen, 2012; Perry, Bond, & Roy, 2007; Wilson & Sperlinger, 2004). While discontinuation is a problem regardless of therapeutic approach, it may be particularly problematic in longer term psychotherapies, such as psychoanalytic therapies, because of the challenges associated with commitment to treatment over longer time periods. Swift and Greenberg (2012) used the weighted effect sizes of 125 studies to determine that patient discontinuation was less common if the psychotherapy was time-limited, rather than open-ended in duration.

A difficulty in commenting on the research literature relating to psychotherapy discontinuation is the definitional dilemma still apparent in the field: definitions and criteria for discontinuation have been inconsistent and there is a focus on different phases of treatment (Armbruster & Kazdin, 1994; Corning & Malofeeva, 2004; Hatchett & Park, 2003). Given the variance in operational definitions employed, the different psychotherapy modalities researched, and the heterogeneous patient samples studied, general conclusions regarding the phenomenon are difficult to reach.

Considering this field of research as a whole, the identified factors relevant to psychotherapy discontinuation relate to several domains.

Firstly, important patient variables have been identified, with unfulfilled patient treatment expectations found to be particularly relevant (Gold & Stricker, 2011; Philips, Wennberg, & Werbart, 2007; Werbart, von Below, Brun, & Gunnarsdottir, 2015).

Secondly, psychotherapist characteristics or skill levels, as experienced by psychotherapists or perceived by patients, have been noted as significant in discontinuation contexts (Anastasopoulos & Papanicolaou, 2004; Clarkin & Levy, 2004; Gold, 1995; Hill, 2010; Lambert, 2011; Levine, 1996; Ogrodniczuk et al., 2005; Piselli, Halgin, & Macewan, 2011; Simon, 1993; Watson, 2011).

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Thirdly, aspects of the therapeutic relationship have often emerged as crucial in discontinuation (Nuetzel & Larsen, 2012; Norcross & Wampold, 2011; Roos & Werbart, 2013). Many studies have found the therapeutic alliance aspect of the patient-psychotherapist relationship to be especially critical (Deakin, Gastaud and Nunes, 2012; Hill, 2010; Hilsenroth & Cromer, 2007; Ogrodniczuk et al., 2005; Piper, Ogrodniczuk, Joyce, McCallum, Rosie, O'Kelly, & Steinberg, 1999; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1993; Yeomans, Gutfreund, Selzer, Clarkin, Hill, & Smith, 1994).

Finally, contextual factors external to the psychotherapy process were reported by Westmacott, Hunsley, Best, Rumstein-McKean, and Schindler (2010) as playing a part in discontinuation, as perceived by both patients and psychotherapists.

While psychotherapist perspectives on discontinuation are easy to access, for example, in work by Piselli, Halgin, & Macewan (2011), there are obstacles to understanding patients' motives for leaving therapy. Difficulties arise in contacting former patients and these individuals may be reluctant to revisit their therapeutic experiences with interviewers or explore their motives for discontinuing treatment (Wilson & Sperlinger, 2004).

Nonetheless, it remains important to provide former psychotherapy patients with the opportunity to express their lived experience of psychotherapy and discontinuation contexts. This is especially warranted given the conclusion that, to date, quantitative research has not identified any reliably predictive variables responsible for early discontinuation (Krishnamurthy, Khare, Klenck, & Norton, 2015). This article reports the findings of a qualitative investigation of patient-reported reasons for discontinuing contact in a service offering psychoanalytic psychotherapy, a treatment orientation in which discontinuation has been less frequently and systematically explored.

Method

Context

The current study was part of the broader longitudinal and naturalistic Melbourne Outcome Study of Psychoanalytic Psychotherapy, conducted by a Monash University Research Team with patients and psychotherapists from the Glen Nevis Clinic for Psychoanalytic Psychotherapy (GNC) in Melbourne, Australia. The GNC was established by the Victorian Association of Psychoanalytic Psychotherapists (VAPP) to provide subsidised psychoanalytic psychotherapy to adult individuals of limited means, who were unable to afford the usual fees for such treatment. The GNC was funded by a private Foundation to provide this demonstration project service between 2008 and 2015. Patients passed a low annual income test to qualify for subsidised access to a maximum two years of twice-weekly psychoanalytic therapy, approximately 160 sessions.

Patients were allocated to 24 experienced psychoanalytic psychotherapists, 17 female and seven male, of whom 22 were members of the VAPP, while two were senior VAPP trainees. Twenty-two therapists were over 40 years of age, and original professional training included clinical psychology (12 psychotherapists), general psychology (2), social work (4), nursing (4), psychiatry (1), and school counselling (1). Patients participated in a four-session assessment over four weeks with the allocated psychotherapists. After the assessment period

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twice-weekly psychotherapy commenced if patients and psychotherapists agreed to this. In this way assessment-treatment continuity was ensured and patients knew that the service could extend to two years.

In addition to the low income hurdle, Clinic exclusion criteria were accident or work compensation claims, significant current substance abuse, active psychosis, and a history of violence.

An advantage of the GNC as a research setting was the clearly-defined treatment approach, psychoanalytic psychotherapy, thus reducing the confounding impact of therapists pursuing differing treatment orientations. The wide-ranging research aims of the overall GNC project agenda included quantitative evaluation of treatment outcomes and effectiveness (Dean, Tonge, Beaufoy, Godfrey, Taffe, Grady, Pullen, Smale, Hill, & Ivey, unpublished), and qualitative exploration of process factors underlying outcomes, including expectations of psychotherapy, the overall experience of psychotherapy and its benefits (Grady, Godfrey, Dean, Tonge, Beaufoy, Pullen, Hill, & Ivey, unpublished), as well as the factors facilitating change and impeding psychotherapy progress (Godfrey & Dean, 2013). The study reported here extended the research aimed at addressing obstacles and challenges in psychoanalytic psychotherapy. Phase One was quantitative in nature and sought to identify individual patient characteristics associated with discontinuation, by establishing differences between baseline measures of mental health symptomatology and personality dimensions at different stages of discontinuation.

The present study was completed while data collection in the overall research program was still in progress. At the time the present data analysis was conducted, 205 patients had both commenced and ceased contact with the GNC, 133 (64.9%) of these having been deemed to have discontinued before the full time-limit for treatment of two years.

Of the commencing 205 patients, 84 (41%) discontinued during assessment or soon thereafter (within the first few weeks of psychotherapy), constituting Group One of the present study, while 121 (59%) entered psychotherapy proper, constituting Group Two. Of these 121, 49 (40.5%) ceased psychotherapy before the two-year limit.

The overall discontinuation rate of 64.9% was only slightly higher than other long-term adult psychoanalytic psychotherapy studies (Ingenhoven et al., 2012), but considerably higher than the average 46.86% in Wierzbicki and Pekarik's (1993) meta-analytic study. Furthermore, the 40.5% discontinuation rate from the psychotherapy proper phase in our study was significantly higher than the weighted mean discontinuation rate of 19.7% reported in a more recent comprehensive meta-analysis (Swift and Greenberg, 2012). Noteworthy, too, was the latter study's findings that psychodynamic psychotherapy was not substantially elevated when compared to other treatment orientations, having a 20% discontinuation rate. Instructive in this regard is comparison with recently reported psychotherapy orientation-specific discontinuation rates: 20.6% in interpersonal psychotherapy (Linardon, Fitzsimmons-Craft, Brennan, Barillaro, & Wilfley, 2018), 26% in CBT (Fernandez, Salem, Swift, & Ramtahal, 2015), 16% in ACT (Ong, Lee, & Twohig, 2018), and 28% in DBT (Dixon & Linardon, 2019). The GNC discontinuation rate was thus more than three times higher than the 20% psychodynamic discontinuation reported in Swift and Greenberg's (2012) meta-analysis, and higher than any of the discontinuation rates in the other therapeutic approaches noted above.

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This paper, however, reports on Phase Two of the study, which aimed to understand why patients decided to leave when they did, before the two-year limit on treatment, and how this decision related to their overall experience at GNC. Reasons for discontinuing were explored among patients who ceased during the assessment period and among those who left in the course of the two-year treatment, during psychotherapy proper. The rationale for distinguishing these two discontinuation groups is that different predictor variables have been reported for discontinuation at different stages of therapy, particularly pre- and post- assessment (Corning & Malofeeva, 2004; Deakin, Gastaud, & Nunes, 2012; Gastaud & Nunes, 2010; Nuetzel & Larsen, 2012; Richmond, 1992).

Research questions

The main research question concerned the subjectively reported reasons for deciding to discontinue treatment at the GNC before the two-year treatment limit was reached. Interviews began with an exploration of patients' experience of the GNC, whether or not their expectations had been met, and how the decision to discontinue was made. The interviews concluded with an inquiry into participants' current mental health needs and support resources and whether or not they had commenced recent post-GNC mental health treatment elsewhere.

Participants

Patients all commenced contact with GNC between 2008 and 2013, before the funding horizon of the overall data collection in 2015. Over these five years 205 patients were tracked during their period of participation in the Clinic. Participants in this study ranged from 18 to 70 years of age at initial contact, with a mean age of 36 years. 68% of the sample was female. 40 of the 133 discontinuers provided telephonic interviews for the current project.

Research procedure

Attempts were made to establish telephone contact with all patients who left the Clinic in the assessment period or during the treatment phase prior to the two-year limit. Many could not be contacted, but successful contacts were asked if they would participate in a telephone interview about their overall psychotherapy experience and decision to discontinue contact. It was surmised that telephone interviews would result in a higher participation rate than requests for face-to-face interviews, hence the choice this interview method. These interviews were conducted and recorded by an independent Clinical Psychologist who is also a qualitative researcher.

A total of 40 semi-structured interviews were conducted with consenting ex-patients who discontinued contact before the two-year point, to explore their experience of the service and reasons for not continuing. The 20 most detailed and informative interviews were selected for analysis from this pool.

Ethical issues

Prior to commencing, the research project was approved by the Human Research Ethics Committees of both participating universities. The research study was introduced to all patients in their initial phone contact with the Clinic, as well as in the patient application form, and all patients were briefed by the Clinic Psychologist about the research study at intake. Written informed consent to research participation, which was not a condition of

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treatment, was obtained prior to treatment commencing. Patients were routinely interviewed by the Clinic psychologist about their treatment progress at eight, 16 and 24 month time-points in the course of therapy. They were also interviewed at eight months follow-up. Those discontinuing prior to 24 months of treatment were contacted, where possible, and asked if they would consider participating in an 'exit' interview about their treatment experience and reasons for discontinuing. Those former patients who did not respond or declined were not contacted again.

The discontinuation interviews were conducted by an independent qualitative researcher who set out to investigate reasons for discontinuation at the GNC. The transcribed data was then coded by the first author, who had no association with the GNC and no vested interest in the results, and was thus able to provide an independent perspective.

Data Analysis

The aim of the qualitative analysis was to accurately capture the experiences of participants, their motivations, and the meanings they attributed to their discontinuation. To this end a data-derived thematic analysis method (Braun & Clarke, 2006) was considered adequate to the task. In the first stage of the analysis initial codes were generated by identifying salient features of the transcribed interviews pertaining to the research focus. In the next stage, themes and patterns important to the description and understanding of the phenomenon of discontinuation were identified. Codes were then collated into sub-themes and integrated into broader themes that captured salient aspects of the data.

A thematic analysis table (Table 1 below) was constructed to display themes and theme frequencies relevant to the research focus. It distinguishes the responses of patients discontinuing at or just after the end of the assessment period (Group One) from those of patients discontinuing before the two-year limit (Group Two).

The first author conducted the coding, after which two other members of the research team also read and coded interview notes. Coding and thematic discrepancies were noted and reconciled to ensure coding agreement and interpretive trustworthiness.

Findings and Discussion

Reasons for Discontinuation

The findings of the study are presented in tandem with discussion of their relevance in relation to extant psychotherapy discontinuation research. Rates of discontinuation from GNC are interpreted in light of the thematic analysis findings of the qualitative interviews with patients who discontinued, firstly in relation to factors experienced as leading to discontinuation, and then in relation to positive psychotherapy experiences reported by a number of participants. Presented below is an outline of salient themes concerning stated reasons for dissatisfaction with the service and patient discontinuation, illustrated by quotes from participant interviews.

11 of the interviews were with patients who discontinued during or just after the initial assessment phase (Sessions One to Four), and nine with patients who engaged in psychotherapy proper and discontinued prior to the two-year limit. The analysed transcripts revealed that these 20 discontinuers all indicated that they discontinued as a result of the discomfort or dissatisfaction they experienced with the service provided. However,

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a considerable proportion of Group Two, who had commenced psychotherapy post-assessment, also spoke of various positive aspects and outcomes of their psychotherapy. They reported that their treatment had helped them toward improved mental health and functioning, as indicated in the final section of Table 1.

Table 1

Participant themes from early (Group 1) and late (Group 2) discontinuers

Theme	**Sub-theme**	**Number of participants**	
		Group 1	**Group 2**
Total number of participants		*11*	*9*
CLINIC FACTORS			
TOTAL number of participants reporting this theme:		**9**	**8**
	Organisational Factors	5	3
	Physical setting	4	6
	Negative overall perception	2	
	Distance to clinic	1	
THERAPIST FACTORS			
TOTAL number of participants reporting this theme:		**8**	**7**
	Therapist style/technique	5	5
	Individual characteristics	5	4
	Therapist Follow-up	3	
	Therapist competence	2	
PATIENT FACTORS			
TOTAL number of participants reporting this theme:		**5**	**7**
	Lack of communication	1	
	Scepticism	2	
	Ambivalence	1	1
	Unmet expectations	3	5
	Practical barriers	2	4
	Unable to recall	1	
	Individual characteristics		2

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THERAPIST-PATIENT RELATIONSHIP FACTORS

TOTAL number of participants reporting this theme: 7 4

Salient themes concerning reasons for discontinuing were classified into five superordinate factors, namely clinic factors, therapist factors, patient factors, therapist-patient relationship factors, and therapy factors. The themes are discussed in relation to each factor in order of their frequency across the combined discontinuer groups.

Clinic factors. Most frequently, and almost equally in both groups, patients described problematic organisational issues and negative impressions of the physical setting. The organisational issues ranged from time spent on the Clinic waiting list, patients' lack of freedom to choose their own therapist, and perceived inadequacy of Clinic communication. These issues relate to what Kehoe, Hassen and Sandage (2016) broadly term "*administrative hospitality*… a constellation of interpersonal behaviours that negotiate the liminal space of administrative areas through professionalism, attentiveness, and awareness to foster a constructive therapeutic alliance" (p.12).

Although apparently not a deciding factor in the decision to discontinue, the physical setting certainly did affect overall experience of the Clinic. The GNC building, a restored two-storey Victorian villa, was described as "*cold*", "*austere*", "*mysterious*", and even "*unwelcoming*". Likewise, ex-patients used words such as "*cold*", "*dark*" and "*impersonal*" to describe the décor and clinic ambience. In particular, 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 considerable negative impact.

In their wide-ranging review of withdrawal from psychotherapy, Barrett, Chua, Crits-Christoph, Gibbons and Thomson (2008) commented on the subtle effects of environmental factors on patient attrition. These included physical clinic features and the interpersonal quality of reception services. Our interpretation of participants' heightened sensitivity to the clinic environment is guided by the related notions of holding (Winnicott, 1960) and containing (Bion, 1962). Adult psychotherapy patients who have not experienced adequate provision of a maternal holding environment or containing mind in infancy tend to be particularly sensitive to the physical space in which their treatment occurs, which is implicitly associated with the quality of maternal provision received as infants (Kehoe, Hassen, & Sandage, 2016; Kieffer, 2011). Consequently, the absence of a physical 'holding' space in the form of a waiting room and reception area may not be a minor inconvenience, but instead be experienced as failure of the 'clinic-mother' to provide an essential level of emotional attunement and care.

The only four interviewees to make positive remarks about the Clinic setting were from Group Two, patients who had commenced psychotherapy. One "*liked*" the building, while the others enjoyed the convenience of the Clinic's accessibility, thanks to on-site parking and proximity to public transport.

Psychotherapist factors. The second important group of themes concerned negatively perceived psychotherapist qualities and therapeutic style, believed to be a major impediment to their forming a therapeutic relationship, thereby negatively impacting motivation to continue contact. The personal characteristics and interpersonal style of therapists was more important for patients than psychotherapists' perceived competence,

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which was mentioned by only one participant. The perceived empathic failure of psychotherapists was a consistent theme across both groups, with some patients reporting that their psychotherapists did not listen attentively and thus failed to hear or adequately understand them on an emotional level. Patients used a variety of words to describe the negative characteristics of their therapists, such as "*odd*", "*strange*", "*rude*", "*hostile*", and "*mysterious*", or spoke of feeling criticised when interacting with their therapists.

Negative patient attitudes towards psychotherapists is known to be associated with early discontinuation (Clarkin & Levy, 2004), impacting on patient trust and motivation for personal disclosure. These factors had more of an impact on the assessment phase discontinuers of Group One in the present study, although psychotherapist characteristics were reported as a problematic in both groups.

Given the established importance of psychotherapist qualities for therapeutic engagement and persistence (Anastasopoulos & Papanicolaou, 2004; Hill, 2010; Simon, 1993), negatively perceived characteristics are obviously not conducive to creating a supportive and trustworthy environment or a collaborative working relationship. As all GNC psychotherapists were psychoanalytic in orientation, it is possible that the manner in which certain therapists interpreted and expressed their analytic stance had a role to play in these negative patient perceptions. One of the criticisms levelled at psychoanalytic practitioners is that efforts to maintain the receptive and neutral listening stance, which characterise the analytic attitude, may be experienced by certain patients as coldness, indifference, or rudeness (Ivey, 1999; Levine, 1996). While it is not known what actual psychotherapist behaviours prompted these experiences, or to what extent these experiences are a function of unavoidable transference reactions stemming from patients' interpersonal histories, it is certainly possible that psychotherapists may overlook, minimise, or misinterpret signs of patient dissatisfaction (Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010) and fail to address this or modify their stance toward disaffected patients.

This finding also highlights the importance of psychotherapist style and technique in either engaging patients or contributing to their withdrawal. Across both groups, patients expressed frustration at psychotherapists perceived as being too confronting or not confronting enough, failing to provide sufficient feedback, being inactive or non-responsive, dealing poorly with sensitive disclosures, or over-using silence as an intervention. For some patients, psychotherapist failure to be sufficiently challenging was experienced as discouraging; for others it was the perception that the psychotherapist was not adequately supportive, making patients feel defensive or disengaged. Some patients reported feeling anxious, even "*traumatised*" (P6), by the lack of psychotherapist responsiveness or feedback. This was particularly troubling for two patients who disclosed abuse experiences in treatment but felt they did not receive the validation they needed from their therapists.

The current findings are in line with earlier research linking patient discontinuation with psychotherapist style, including the perceived level of detachment, confrontation, or forcefulness (Gold, 1995; Hilsenroth & Cromer, 2007; Norcross & Wampold, 2011; Piselli et al., 2011; Roos & Werbart, 2013).

Psychotherapists' perceived rigid adherence to the psychoanalytic frame at the expense of the therapeutic relationship also appeared to be a problem encountered by some patients who discontinued from the

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GNC. When the purpose of their strict observance of the frame was not understood by patients, it resulted in patient irritation and a perception of being unduly deprived or provoked. These findings stress the relevance of flexibility as a key therapeutic skill, which is consistent with previous claims that technical flexibility can minimise patient discontinuation (Watson, 2011). Clearly, setting the frame and outlining the patient's treatment role, what is expected of them and what they can expect from the psychotherapist, cannot be underestimated (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008). Attention to this may minimise patient confusion, frustration and disappointment, in what is inherently a very challenging and uncomfortable process.

Psychotherapy factors. The third most prevalent theme, equal in frequency to patient factors, concerned psychotherapy factors, either related to psychotherapy in general, or to psychoanalytic psychotherapy specifically.

In terms of general psychotherapy factors, two Group One participants who discontinued before psychotherapy proper were unhappy with the termination process; one participant wanted more time to discuss why the sessions were unsuccessful, but felt there was "*no space for this.*" (P6) Two other Group One patients stated that attending therapy was challenging because it felt unsettling and "*stirred up too many things*" (P7). Another reported feeling confused about the "*complexity of the mental health industry*" (P8), with its myriad therapeutic approaches, and felt unsure how to navigate it. One Group One participant reported experiencing negative outcomes from his assessment sessions: *"I only attended a few times. It wasn't helpful for me, made me worse. Felt like the person was making problems out of nothing… not sure if it would ever have helped me."* (P5)

With reference to the psychoanalytic approach, two Group One patients disliked the focus on past relationships and events, and one participant described bringing up issues from her past as "*traumatising.*" (P6) Patients in both groups commented upon a struggle with the analytic frame, a hallmark of psychoanalytic therapy, because they experienced it as too inflexible. For example, one observed that the psychotherapist's "*rigid*" adherence to session duration and scheduling created a "*combative dynamic*" between them (P11).

One third of Group Two, the later discontinuers, was unhappy with the lack of therapeutic benefits from attending the GNC. For example, one patient said: *"Therapy helped me get insight into where problems were coming from, but this didn't help me cope better."* (P15) Another did not experience any change resulting from her psychotherapy and could not identify any benefits of attending. A third patient did notice some changes but attributed this to antidepressant medication, rather than psychotherapy.

Patient factors. Patient factor themes were as frequently noted as psychotherapy factor themes in relation to discontinuation. These included reference to expectations of psychotherapy, scepticism about the process, reluctance to communicate, inadequate motivation, ambivalent feelings about psychotherapy, and practical barriers to attendance.

Experiencing unmet expectations was a dominant theme here, contributing markedly to patient dissatisfaction. In some instances, patients' expectations, especially in Group One, discontinuing during or following assessment, seemed to be shaped by previous exposure to therapeutic approaches where therapists were more active and directive, such as cognitive-behavioural therapy. Despite receiving psychotherapy

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education during the intake process, some patients had a fixed expectation that they would receive strategies to manage their symptoms and were disconcerted when these were not provided. For example, one participant commented: *"I need a therapist to give me feedback. How 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."* (P2) In a similar vein, another patient who explicitly said they would have preferred cognitive-behavioural therapy, made the following remark: *"I knew why I did things and where they came from. I needed to know how to deal with issues such as anger. Needed more strategies and learn to move forward in my life."* (P4) In expecting to have a more practical therapy focus, this patient felt misled by the psychotherapist. Yet another patient entered therapy with the specific goal of returning to work as soon as possible, and was then unhappy that the psychotherapist did not immediately address this goal. He eventually discontinued, claiming that his needs were too urgent for long-term psychotherapy.

Failed patient expectations have been associated with premature discontinuation in previous research (Hansen et al., 1992; Nock & Kazdin, 2001; Reis & Brown, 1999; Swift & Callahan, 2008). Expectations refer to the anticipatory beliefs that patients have about the process, content, structure or length of therapy, which can influence both attendance and outcomes (Nock & Kazdin, 2001). Importantly, patients in the present study mainly expressed unmet or partially met role expectations, rather than simply outcome expectations. Role expectations are related to patients' preconceived ideas about the structure of therapy sessions and the respective therapist and patient behaviours required in them (Dew & Bickman, 2005). When patients are not given a thorough enough role induction and informed about what to expect from the psychotherapy process, and how this differs from other therapeutic approaches, they may feel confused, frustrated or dissatisfied and eventually choose to discontinue. People in distress frequently anticipate being offered practical strategies that they can use to cope in their daily lives, an expectation fuelled by the dominant cognitive-behavioural mental health discourse. Patients' assumptions about what is curative in psychotherapy, when these are not fulfilled, are known to be related to early discontinuation (Philips, Wennberg, & Werbart, 2007). Consequently, given the relatively unstructured nature of psychoanalytic treatment, outlining the patient's role and clarifying their expectations of therapy is even more imperative for therapists conducting psychoanalytic psychotherapy (Gold & Stricker, 2011; Werbart, von Below, Brun, & Gunnarsdottir, 2015).

In the present study, patient scepticism about psychotherapy also had a negative impact on their treatment experience. For example, one participant said, *"I didn't go in thinking it was going to work*." (P2) This fatalistic view of the psychotherapy negatively affected the patient's level of commitment. One patient expressed ambivalent feelings, saying she felt unable to continue psychotherapy but ultimately regretted her decision to leave.

Suggested here is a connection between inadequate patient communication and discontinuation. For example, one patient openly spoke of her decision not to share negative feelings about psychotherapy with the psychotherapist, thus denying the therapist an opportunity to engage with those negative feelings. Unwillingness to communicate negative feelings with the psychotherapist was a clear pattern in the group of patients who discontinued before psychotherapy proper commenced. These inhibitions possibly made this group more

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inclined to act out their frustrations by simply leaving. This finding supports previous research linking early discontinuation to difficulty expressing negative emotions (Oei & Kazmierczak, 1997), and linking patient assertiveness to more successful outcomes (Hill, 2010). It also supports the view of Ogrodniczuk, Joyce, and Piper (2005) that psychotherapists should actively encourage patients to voice their doubts, fears and questions, and facilitate exploration of the negative transference to help patients integrate and tolerate negative affect, instead of acting on their frustrations by leaving.

As noted by Barrett et al. (2008), practical barriers may also contribute to patients discontinuing, which proved to be the case in our study. These barriers included changed work commitments, travel plans, physical health problems, distance to the Clinic, or difficulty sustaining the twice-weekly commitment. Usually these practical barriers led directly to discontinuation, and were slightly more prevalent in the late discontinuation group, becoming more evident as psychotherapy progressed. It is possible that such factors are less immediately associated with therapeutic dissatisfaction than with the pressing realities of everyday life.

Psychotherapist-patient relationship factors. The fifth most frequently reported category of themes concerned the therapist-patient relationship, involving either therapeutic alliance or transference issues. Regarding the former, patients reported feeling disappointed with or unsafe in the relationship, noting a lack of rapport or emotional connection with the psychotherapist. One described having "*no positive feeling back*" (P7) and complained of the therapist's perceived lack of reciprocity and failure to repair alliance ruptures, which led to feeling ignored. Another participant was disappointed by the psychotherapist's failure to engage with their expressed dissatisfaction about therapy: *"A couple of times I tried to raise the issue of whether the therapy was helping or not but I was just told to 'give it time' by the therapist."* (P1)

Three participants in Group One spoke of a lack of safety they felt in the therapeutic relationship, citing a variety of reasons. One did not believe that their emotional distress was managed effectively by the psychotherapist, another felt *"generally uncomfortable"* (P1) with the psychotherapist, while a third experienced the psychotherapist as dismissive. Two spoke of a lack of clarity around what was expected of them during sessions, or regarding the therapeutic tasks and processes more broadly, resulting in either confusion or anxiety.

One participant experienced distressing transference feelings towards her psychotherapist, who reminded her of an abuse perpetrator from her past. This patient was upset by the perceived lack of emotional responsiveness from the psychotherapist following the patient's disclosure of this history, prompting the patient's discontinuation.

Approximately half the participants in both groups were discomforted by the intervention style or technique of their therapists. Two patients found their psychotherapists were not sufficiently active or interactive during sessions, which made one person feel anxious: *"I was hoping for a therapist that would ask me more questions, but the 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."* (P8) One patient expected more feedback from the therapist and was disappointed because they were insufficiently challenged in the therapy. This patient wanted a "*stronger person*" as a therapist, "*someone who tells it like it is*". (P2)

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Silence, which is a technical invitation to free association and fantasy used in the psychoanalytic approach, was negatively experienced by some patients. One participant stated she "*dreaded coming to sessions*" (P1) because of the psychotherapist's use of silence, while another said that "*sessions were anxiety-provoking*" (P7) due to the psychotherapist waiting and silently staring at her during sessions.

Four of the nine Group Two patients reported that their relationship with the psychotherapists was difficult to negotiate. Patients could feel misunderstood and one reported a "*wall"* between psychotherapist and patient, impeding communication and halting progress. In contrast to Group One patients, however, those in Group Two described similar experiences but were clearly more capable of working through them.

These findings confirm what has been reported in other studies, that an unsatisfactory therapeutic alliance may considerably impact 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 research conclusions by Nuetzel and Larsen (2012) that relationship factors, such as the emotional bond between therapist and patient, rather than patient personality factors alone, are critical in discontinuation. In addition, it supports the contention of Deakin et al. (2012) that poor capacity to form a robust alliance is associated with an increased likelihood of early termination.

Slightly fewer patients in the late discontinuation group reported obstacles in the therapist-patient relationship, compared with the early discontinuation group. This suggests that those in the late discontinuation group were somewhat more capable of forming workable relationships with their psychotherapists and, as would be expected, this may have facilitated their perseverance beyond the assessment period. A number of patients who reported feeling anxious, disturbed, frustrated or annoyed with the process and the psychotherapist, persisted with their treatment, sometimes for close to a year. One patient who stayed for some months of treatment was better able to cope with a psychotherapist perceived as critical and was better equipped to openly resolve these issues. This may reflect on individual patient qualities; for example, patients who have more adaptive defences may better manage distressing affect and weather ruptures in the alliance that might result in discontinuation for less adaptive patients (Perry et al., 2007).

Negative aspects of the overall psychotherapy experience were frequently noted by both groups of patients who discontinued from the GNC. In terms of their experience of psychotherapy in general, patients talked about their disappointment with treatment outcomes, confusion about the mental health field and what to expect from it, and dissatisfaction with the termination process. For example, one patient who attended therapy for a year said he had *"gained insight"* (P17) but that his emotional coping capacity had not improved. Another patient sought further therapy after leaving the GNC to process a *"very negative clinic experience" (P16)*, while another felt that the psychotherapy created more problems than it alleviated. These experiences, which psychotherapists may be unaware of at the time, are important to heed and anticipate, especially as patients' voices often go unheard in research on discontinuation. Therapists may misread or fail to detect patients' quiet dissatisfaction until it culminates in surprising (to the therapist) patient disengagement or departure (Lambert, 2011).

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Positive aspects of patient experience. For the majority of the Group Two patients (seven of the nine), who undertook psychotherapy proper for a period of time, alongside their reflections on dissatisfaction with aspects of their psychotherapy sat the appreciation of some positive aspects. These themes are displayed in the last section of Table 1. Most of these comments concerned the overall experience of therapy being "*positive*" and "*helpful*". For example, one patient who was very depressed and anxious upon commencing, noted that *"talking helped initially."* (P10) Another asserted that his encounter with the Clinic was "*valuable*" and that he would consider returning in future. There was also one person who described her treatment as "*multi-faceted*" (P12), alluding to its richness and complexity.

Indeed, despite their decision to leave when they did, over half of the Group Two participants reported positive psychotherapy outcomes, including increased insight into patterns of relating to self and others, and a change in outlook on life. For example, one patient reported a significant perspective shift and cited improvements in her interpersonal awareness, self-awareness and assertiveness: *"I know myself, how I see the world, I'm accepting of life and the wrongs in the world, more realistic. Relationship improvements, too, I'm more assertive and aware of my own mental processes."* (P13) Similarly, other patients claimed that psychotherapy 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 suicidal thoughts because he felt psychotherapy helped him understand and cope with them. He said he was able to make a "*link with the past*" and understand "*where they originated from and developed*", so was less affected by them and consequently felt "*a lot more positive*". (P19) This patient asserted that psychotherapy had improved multiple domains of his life, including finances and career, and allowed him to make healthier relationship choices.

Three participants in Group Two, all of whom remained at the Clinic for some time, spoke positively about their therapists' qualities. For example, one patient who attended the Clinic for a year spoke appreciatively of a "*calming*" and "*containing"* psychotherapist who was *"patient*" and able to hold her level of distress and personal disorganisation (P15). Another patient experienced her therapist as "*dependable and committed*" (P14), which likely contributed to staying in treatment for 16 months. One patient who stayed for six months said the psychotherapist provided him with understanding, support and validation. Two of these patients also referred to a positive working alliance with the psychotherapist.

This finding suggests that, while patient discontinuation is often linked to perceived negative psychotherapist qualities, relationship dissatisfaction, and insufficient faith in the psychotherapy process, some patients can retrospectively appreciate positive experiences and treatment gains notwithstanding their decision to discontinue psychotherapy. It also strongly suggests that patients may make important gains in psychoanalytic psychotherapy despite ambivalence about the clinic setting, the treatment itself, and their relationship with their therapists. Such ambivalence may be interpreted as expressions of inevitable resistance, which may be the growing edge of workable transference relationships as long as patients are willing to stay and explore them. However, as discussed earlier, therapists need to be constantly vigilant about how patients experience their interventions and show willingness to take some responsibility for the possible contribution their actions or inactions may have in fuelling patient ambivalence.

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Conclusion

In summary, this study found an overall discontinuation rate of nearly 65%, significantly higher than the rates reported in recent published research. Of those commencing assessment, 41% discontinued before entering psychotherapy proper (Early discontinuers). In the case of those commencing psychotherapy, 40.5% discontinued before the two-year limit (Late discontinuers).

Reasons for dissatisfaction or discomfort experienced by patients, flagged as relevant to discontinuing contact with the GNC, were also equally balanced between the two groups. Those discontinuing after a period of psychotherapy tended to report domains of discomfort similar to participants discontinuing before psychotherapy properly commenced. Psychotherapist factors, factors in the psychotherapy itself, patient factors (including practical barriers), and psychotherapist-patient relationship factors have all been identified in previous research, and they were reported by each group in roughly the same frequency.

The only significant discrepancy between the groups was that late discontinuers were less likely to mention psychotherapist-patient relationship factors as a source of dissatisfaction. It is very possible that in some instances, especially among the early discontinuers who expressed discomfort in the assessment sessions, unaddressed negative transference dynamics were at play. Because these could not be identified and explored, given the early discontinuation, they may have remained implicit and their meaning unconscious but nonetheless impactful.

A factor less frequently reported in the literature was the experience of the clinic itself, particularly organisational matters and the building's physical setting, for example the absence of a waiting room. These factors were equally problematic for early and late discontinuers. This finding indicates the importance of the symbolic invitation and holding-containing function served by the reception space and reception procedures, which may play a contributing role in inclining some ambivalent patients to continue or discontinue treatment they are uncertain about.

Themes relating to positive aspects of psychotherapy emerged for the majority of interviewees who experienced a period of psychotherapy. This finding suggests that defining patients' leaving in terms of stipulated time frames as premature discontinuation may be problematic, as the therapist or researcher verdict of prematurity may not be shared by the patients concerned. A proportion of late discontinuers may feel that they have sufficiently attained their therapeutic goals, even if this perception is contested by their therapists.

Questions remain as to why the overall discontinuation rate (64.9%) is so high relative to the discontinuation rates reported in recent published literature; the closest recent comparison is the integrative CBT discontinuation rate of 57% reported by Kegel and Fluckiger (2015). Patient characteristics may play a role here. GNC patients were selected on the basis of their lower income status and referred to the Clinic because the severity and chronicity of their mental health difficulties warranted longer-term and more intensive treatment. Lower socioeconomic status is consistently linked to psychotherapy discontinuation (Barrett, et al, 2008), and Thormahlen et al (2003) report higher attrition rates for patients with more complex and severe diagnostic

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profiles. The combination of these factors in our sample could have contributed to the significantly higher discontinuation rate.

Of course, the nature of the treatment itself may also have played a contributing role. The intensity of twice weekly sessions together with the unstructured, expressive treatment, focused on the exploration of discomforting unconscious interpersonal dynamics, may also have influenced patients' decision to terminate treatment. Further research on the experience of intensive psychodynamic therapy discontinuation is necessary to examine the relative impact of session frequency and the distinguishing features of psychodynamic treatment on the choice to end therapy.

Study limitations

This study could have been strengthened by interviews with more discontinuers. Secondly, a finer grained interview protocol exploring the actual process of discontinuation may have clarified the relative significance of the various contributing factors. Thirdly, complementary psychotherapist interviews regarding therapists' perceptions of their patients' discontinuation may have aided interpretation of the findings, especially concerning therapeutic relationship difficulties.

Notwithstanding these criticisms, this qualitative study confirms the value of exploring, with patients seeking and receiving long-term psychoanalytic psychotherapy, their experiences of terminating treatment. Taken together with findings relating to patients who received a full two-year service (Grady, J., Godfrey, C., Dean, S., Tonge, B., Beaufoy, J., Pullen, J., Hill, C., & Ivey, G., unpublished), the present findings contribute to knowledge of how to further evaluate the impact of psychotherapy, particularly psychoanalytic psychotherapy.

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