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The indication and agreement to initiate treatment during the initial evaluation of psychodynamic psychotherapy

Indicação e concordância em iniciar tratamento durante avaliação inicial para psicoterapia psicodinâmica

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Abstract. This naturalistic and longitudinal study, following 557 outpatients who sought psychodynamic psychotherapy, aimed to verify factors associated with non-indication for psychodynamic psychotherapy and to establish predictors of non-agreement to initiate treatment for patients indicated for this treatment. It found that patients consulting for somatic or attention problems and/or with a low educational level were less likely to be indicated for psychodynamic psychotherapy; patients perceiving their symptoms as intense were more likely to be indicated for this treatment. The following were the predictors of non-agreement to initiate psychodynamic psychotherapy: low educational level, low family income, diagnosis of schizophrenia, schizotypal or delusional disorders, depressive problems and/or never experiencing psychotherapy. Psychodynamic psychotherapy, as every other treatment, appears to be suitable for a specific group of patients. Unless the technique performed by psychotherapists during psychodynamic psychotherapy's initial stages is improved, the relevance of referring a non-concordant profile to this psychotherapeutic modality is herein discussed.

Keywords: treatment indication, treatment compliance, suitability, premature discontinuation, psychodynamic psychotherapy.

Resumo. Este estudo naturalístico e longitudinal, seguindo 557 pacientes ambulatoriais que buscaram psicoterapia psicodinâmica, teve por objetivo verificar fatores associados com não indicação para psicoterapia psicodinâmica, bem como estabelecer preditores de não concordância em iniciar tratamento entre pacientes que receberam indicação para esta modalidade terapêutica. A investigação encontrou que pacientes com queixas de problemas somáticos ou problemas de atenção e/ou com baixa escolaridade tiveram menor probabilidade de receberem indicação para psicoterapia psicodinâmica; pacientes que percebiam seus sintomas como intensos tiveram maior probabilidade de receberem indicação para este tratamento. Foram preditores de não concordância em iniciar psicoterapia psicodinâmica: baixa escolaridade, baixa renda familiar, diagnóstico de esquizofrenia, transtorno esquizotípico ou delirante, problemas depressivos e/ou estar buscando psicoterapia pela primeira vez. A psicoterapia psicodinâmica, como todas as formas de tratamento, parece ser adequada para um grupo específico de pacientes. A menos que as técnicas utilizadas pelos terapeutas durante as fases iniciais da psicoterapia psicodinâmica sejam aperfeiçoadas, a relevância de indicar o perfil de pacientes não concordantes para esta modalidade terapêutica é aqui discutida.

Palavras-chave: indicação para tratamento, aderência ao tratamento, contraindicação, abandono precoce, psicoterapia psicodinâmica.

Introduction

Before initiating treatment when receiving a potential patient for psychodynamic psychotherapy, the psychotherapist must perform an initial evaluation and decide the best specific course of action. This preliminary assessment aims to establish the best therapeutic approach for the case, based on indication or contraindication criteria (Rueve and Correll, 2006), and develops a therapeutic alliance. After the initial evaluation period, if the psychotherapist recommends psychodynamic psychotherapy for the patient, treatment goals are established and the contract is discussed between the psychotherapist and the patient. If both individuals agree to initiate treatment, psychodynamic psychotherapy commences. This assessment period typically requires several sessions/ interviews (Truant, 1998), generally, 2 to 4 (Etchegoyen, 2010).

Patient withdrawal during this initial period commonly occurs. The literature on this topic, although outdated, reveals this phenomenon: of 100 potential patients who contact a mental health service, only 50 will attend the initial interview (Garfield, 1994; Sparks *et al.*, 2003). Thirty-three individuals will attend the first session of psychotherapy (Philips, 1985), 20 will remain in psychotherapy at the third session (Pekarik, 1983) and fewer than 17 will remain in treatment at the end of the tenth session (Garfield, 1994). Thus, the initial phase of psychotherapy is fundamental for treatment continuation (Barrett *et al.*, 2008).

There is good evidence for analytically oriented psychotherapy for a range of disorders, in addition to studies indicating improvements in global functioning, interpersonal relationships, quality of life and patients' well-being (Leichsenring, 2005; Jung *et al.*, 2007). Nevertheless, psychotherapy, like any other effective treatment in medicine or psychology, may lead to negative effects in either the patient or those around him (Crown, 1983; Linden, 2013). It is necessary to study the factors associated with an indication and decision to initiate treatment, specifically for insight-oriented psychotherapies because they require different prerequisites for the participation in psychotherapeutic work.

The systematic selection of patients results in a better longer-term outcome for psychodynamic psychotherapy when compared to a control procedure of random treatment selection (Watzke *et al.*, 2010). Because systematic treatment selection appears to optimize the treatment outcome for psychodynamic psychotherapy, pursuing systematic treatment assignment strategies in mental healthcare settings is a worthwhile endeavor. However, clinical decision-making regarding the suitability of psychological therapies is hampered by limitations of psychotherapy research and

our failure to understand therapeutic mechanisms (Fonagy, 2010). The conflicting evidence regarding a patient's characteristics associated with indication and agreement to initiate psychodynamic psychotherapy results from the absence of general consensus on indication/contraindication criteria (Fonagy, 2010). Research is necessary to refine the criteria used to decide the allocation of individual and collective resources (Schestatsky, 1989).

Valbak (2004) reviewed the empirical studies published in the previous 20 years on outpatients' pre-therapy suitability for psychoanalytic psychotherapy and observed the following most promising variables with the highest correlations with a good outcome: a good quality of object relations, psychological mindedness and motivation for change. Nine years later, De Jonge *et al.* (2013) reviewed studies relating to patient characteristics, predictive factors and clinical judgments regarding the outcome of psychodynamic psychotherapy. Although observing similar results, the authors claim that object-related functioning, motivation and psychological mindedness appear to have low to moderate influence on the outcome of psychodynamic psychotherapy. However, in practice, the suitability of treatment was actually determined based on the clinical judgment of patient characteristics and an assessment of whether the psychotherapeutic process was likely to lead to a profitable patient-clinician relationship (De Jonge *et al.*, 2013).

Psychodynamic clinicians agree that the motivation for treatment (a spontaneous search for treatment or availability of financial resources) is crucial to indicate psychodynamic psychotherapy but also postulate other possible factors associated with indication: the patient's current moment in life (considerable psychological distress, intact reality testing, an absence of acute symptoms that places patients' lives at risk), the patient's diagnosis and defensive style (Dewald, 1964; Kernberg, 2004; Keidann and Dal Zot, 2005; Gabbard, 2005). Therefore, it is imperative to empirically verify which characteristics of patients are related to clinical judgments when indicating psychodynamic psychotherapy. Because it is not necessarily inadvisable that some patients disagree with the initiation of psychodynamic psychotherapy, it appears important to evaluate patients' decisions to initiate treatment, particularly because this decision is an important component of psychotherapy indication. Knowing the variables associated with an agreement to initiate treatment would also enable the planning of more appropriate interventions for this clinical population. Thus, this study aimed to assess associations between patient characteristics (gender, age, education, income, diagnosis, source of referral, reason for consultation, medical history, symptoms, defensive style and quality of life) and the training level of the psychotherapist for the (a) psychotherapist's decision to indicate/contraindicate psychodynamic psychotherapy and (b) patient's decision to initiate treatment, once indicated.

Methods

This longitudinal and naturalistic study was performed in an outpatient clinic in the city of Porto Alegre, Southern Brazil. The clinic is part of a three-year post-graduation training course for psychodynamic psychotherapy. The treatments performed in this institution are open-ended and count on the weekly attendance established by the patient and psychotherapist at the initiation of psychotherapy. Psychotherapies performed in this clinic are very heterogeneous regarding the weekly frequency and treatment duration. Most patients consult once a week and the frequency often varies along the same case; among patients who started treatment between 2009 and 2014 and have already left the clinic (considering discharges and dropouts), the mean duration of psychotherapy was 7.3 months (standard deviation = 8.7). The therapists who work at this outpatient clinic operate with several theoretical frameworks within the psychodynamic approach, but favor authors of contemporary reference – such as object relations theory (especially Bion, Winnicott, Kaës and Aulagnier), and self psychology (Kohut).

The initial evaluation procedure occurs at two time frames: (i) an intake interview is conducted to initially screen patients who seek psychodynamic psychotherapy and (ii) if psychodynamic psychotherapy is indicated by the interviewer, the patient participates in a second evaluation with a psychotherapist. The 12 interviewers that performed the intake interviews were psychologists, specialists in psychodynamic psychotherapy, and had at least four years of clinical interview experience. The 58 psychotherapists were psychologists; 58.6% had previously completed the specialization course at the time of the study.

The study sample comprised all patients over 18 who sought treatment between May 2009 and December 2010 and agreed to participate in the study (signing an informed consent after the research goals and methods had been fully explained). The project was approved by the Research Ethics Committee of the Municipal Health Department of Porto Alegre.

Instruments

A clinical and socio-demographic questionnaire – Self-provided patient data were obtained from the initial registration form completed by patients during the intake interview and records of the psychologists who performed these interviews.

The World Health Organization Quality of Life – brief version (WHOQOL-Brief) – This instrument assesses patients' quality of life in four domains: Physical, Psychological, Social Relationships and Environment. The Brazilian version of the WHOQOL instruments was developed by the WHOQOL Centre for Brazil (Fleck *et al.*, 2000).

The Symptom Check-List-90-Revised (SCL-90-R) – This instrument assesses nine dimensions of patients' symptomatology: Somatization, Obsessiveness/Compulsivity, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism. This instrument also provides a measurement of the patient's global severity (GSI – Global Severity Index), the number of symptoms indicated by the patient within 90 possibilities (PST – Positive Symptom Total) and the intensity of the presented symptoms scored by the patient (PSDI – Positive Symptom Distress Index) (Derogatis and Savitz, 2000; Laloni, 2001).

The Defense Style Questionnaire (DSQ-40) – This instrument assesses patients' defensive style and enables the classification of the defenses used by a patient in three categories: mature, neurotic and immature factors. The instrument was originally developed by Bond *et al.* (1983), reorganized in the current format by Andrews *et al.* (1993) and translated and validated for the Brazilian population by Blaya *et al*. (2004, 2007).

Definitions of Terms

Previous psychiatric and psychotherapeutic treatment: treatment approaches conducted by a psychiatrist and only based on medication were considered psychiatric treatments; psychotherapeutic treatments included all psychotherapeutic approaches conducted by either psychiatrists or psychologists.

The reason for seeking treatment was defined according to the description given by the patient to the professional who conducted the initial interview. The interviewers rated the patients' complaints based on the definitions proposed in the internalizing, externalizing, neutral, and social behaviors scales of the ABCL - Adult Behavior Checklist (Achenbach and Rescorla, 2003). The categories included depressive problems, anxiety problems, somatic problems, avoidant personality problems, attention deficit/hyperactivity problems, antisocial personality problems.

Diagnosis: the patient's initial diagnosis provided by the interviewer through the International Classification of Diseases - 10th Edition (ICD-10) was considered. All interviewers were previously trained for this diagnostic classification system and received systematic supervision and guidance regarding the patients' diagnoses. For analytical purposes, the broad categories that comprise the chapter on mental and behavioral disorders were used (World Health Organization, 1992):

- F00-F09: Organic, including symptomatic, mental disorders
- F10-F19: Mental and behavioral disorders because of psychoactive substance use
- F20-F29: Schizophrenia, schizotypal and delusional disorders
- F30-F39: Mood [affective] disorders
- F40-F48: Neurotic, stress-related and somatoform disorders
- F50-F59: Behavioral syndromes associated with physiological disturbances and physical factors
- F60-F69: Disorders of adult personality and behavior
- F70-F79: Mental retardation
- F80-F89: Disorders of psychological development
- F90-F98: Behavioral and emotional disorders with an onset typically occurring in childhood and adolescence
- F99: Unspecified mental disorder.

Non-agreement to initiate treatment: it is important to distinguish a patient's withdrawal from psychotherapy dropout during this initial period. Garfield (1989) proposes that dropout is when the patient undergone psychotherapy and the evaluation period (initial interviews)

precedes the psychotherapeutic process. The evaluation stage (the entire evaluation period preceding the contract) is a time when both patient and psychotherapist are evaluating whether this is a treatment to significantly invest in (Clarkin *et al.*, 2006). Thus, the term "dropout" would be used to describe patients who agree to initiate psychotherapy but interrupt treatment before it is complete.

Data analysis

The variables were initially characterized in terms of frequencies and percentages. To detect associations between the outcomes and categorical variables (gender, education, income, diagnosis, source of referral, reason for consultation, medical history and training level of the psychotherapist), a Chi-Square test was performed. For less prevalent diagnoses, an association with the outcomes was determined using a Fisher's exact test. Because nearly all continuous variables had a normal distribution, a Student's *t*-test was performed to verify the association between outcomes and age, symptoms, severity of symptomatology, defensive style and quality of life. The variable without a normal distribution (Phobic Anxiety scores) was analyzed using a Mann-Whitney test. A Poisson regression was performed to verify the predictors of indication/non-indication and agreement/non-agreement to initiate psychotherapy (Barros and Hirakata, 2003; McNutt *et al.*, 2003). All factors that were associated with the outcomes of a p value equal or less than 0.20 entered the stepwise regression. After including all these factors, those with a p value higher than 0.10 were excluded until the final model was achieved (a backward selection of variables) (Hosmer and Lemeshow, 2000). The results with a p value equal or inferior to 0.05 were considered significant.

Seventeen patients did not appropriately answer the WHOQOL-Brief, 41 did not appropriately answer the SCL-90-R and 51 did not appropriately answer the DSQ-40; the results of these cases were estimated by multiple imputation (Schafer, 1997), accounting for the answer standards from variables associated with the lost results.

Results

Between May 2009 and December 2010, 638 patients sought treatment in the clinic. Of these patients, 557 agreed to participate in this research, thus generating the final sample. Tables 1 and 2 describe the sample. The mean age of the patients was 35.2 years old (standard deviation = 13.1).

The highest percentage of patients was referred to specialist professionals after the intake interview (n = 161; 28.9% of the total sample). Thirty-six patients (6.5%) were referred to trainees (undergraduate students), 81 (14.5%) to psychotherapists in their first year of specialization training practice, 69 (12.4%) to psychotherapists in their second year and 82 (14.7%) to psychotherapists in their third year of training practice.

Indication for Psychotherapy

Psychodynamic psychotherapy was not indicated for 54 (9.7%) patients after the intake interview. A further 199 (35.7%) patients did not agree to initiate psychotherapy, and 304 (54.6%) agreed to initiate treatment. The inter-

Table 1. The Socio-Demographic Characteristics of the sample.

	n	**%**
Sex		
Male	184	33.0
Female	373	67.0
Age		
18 - 39	389	69.8
40 - 59	132	23.7
60 - 79	33	5.9
80 +	3	0.5
Education		
Primary Education (Basic)	34	6.1
Secondary Education (High School)	168	30.2
Higher Education (College)	355	63.7
Income[a]		
Up to 1 MW	56	10.1
From 1 to 3 MW	183	32.9
From 4 to 6 MW	178	32.0
7 or more MW	140	25.1

Notes: The patient's records did not provide continuous information regarding Education and Income, only as categorical variables. ([a]) Income was measured in minimum wages (MW). The minimum wage in Brazil is R$ 724.00, which approximately corresponds to US$ 280.00 per month.

Table 2. The Clinical Characteristics of the Sample.

	n	%
Diagnosis		
F00-F09	2	0.4
F10-F19	24	4.3
F20-F29	16	2.9
F30-F39	244	43.8
F40-F48	169	30.3
F50-F59	25	4.5
F60-F69	69	12.4
F70-F79	1	0.2
F90-F98	5	0.9
Environmental stressors without diagnosis	2	0.4
Source of referral		
Patient's own initiative	159	28.5
Medical specialties	132	23.7
Friend/Colleague	89	16.0
Family	84	15.1
Psychologist	49	8.8
School/University	15	2.7
Others[a]	29	5.2
Reason for consultation		
Depressive problems	247	44.3
Anxiety problems	162	29.1
Avoidant personality problems	53	9.5
Antisocial personality problems	53	9.5
Somatic problems	25	4.5
Attention deficit/ hyperactivity problems	17	3.1
Previous treatments		
Psychotherapy	199	35.7
Psychiatric treatment	229	41.1
Psychiatric hospitalization	54	9.7
Use of psychotropic medication	275	49.4

Note: ([a]) In the "Others" category we gathered sources of referral with fewer than five patients, such as a nutritionist, lawyer, speech and language therapist, etc.

viewers contraindicated psychodynamic psychotherapy for 9.7% of the cases, but no psychotherapist contraindicated psychodynamic psychotherapy during the initial evaluation stages.

The final regression model was composed of the variables described in Table 3. Therefore, this study observed that patients consulting for somatic or attention problems and/or with a low educational level were less likely to be indicated for psychodynamic psychotherapy; patients perceiving their symptoms as intense were more likely to be indicated for this treatment.

Agreement to initiate Treatment

Among patients who had an indication for psychodynamic psychotherapy, 60.4% agreed to initiate treatment. Patients who did not agree to initiate treatment interrupted the evaluation process after the intake interview (*n*=74; 37.2%), 1 interview (33; 16.6%), 2 interviews (30; 15.1%), 3 interviews (23; 11.6%), 4 interviews (26; 13.1%), 5 interviews (4; 2.0%), 6 interviews (4; 2.0%), 7 interviews (3; 1.5%) or 8 interviews (2; 1.0%). Therefore, in 93.5% of cases in which the patient did not agree to initiate treatment, the initial evaluation phase involved the initial four interviews with a limit that could be extended to eight appointments (an average of 1.74 interviews, in addition to the intake interview – *SD*=1.87).

Table 4 shows the reasons provided by non-concordant patients for not initiating treatment. Altogether, 36.2% of cases did not justify the reason for discontinuing the appointments, simply not attending the following scheduled session. Financial problems were the most prevalent reason for non-concordance (17.1%). One patient claimed to be already satisfied with the results and only attended the screening interview. When informed how psychotherapy works, fifteen patients did not agree with the indication for psychodynamic psychotherapy and stated that this form of assistance would not be necessary.

The variables described in Table 5 comprised the final model. Therefore, the following were predictors of non-agreement to initiate psychodynamic psychotherapy during the initial evaluation stages: a low educational level, low family income, diagnosis of schizophrenia, schizotypal or delusional disorders, depressive problems and/or never participating in psychotherapy.

Table 3. The Results of the Poisson Regression in Non-Indications for Psychodynamic Psychotherapy.

Variable	Relative risk[a]	Confidence interval (95%)	Significance
Only Primary Education[b]	2.31	1.19 - 4.49	*p*=0.014
Somatic problems[b]	3.04	1.62 - 5.71	*p*=0.001
Attention problems[b]	2.46	1.14 - 5.25	*p*=0.021
PSDI[b]	0.64	0.44 - 0.94	*p*=0.021
Previous Psychiatric Treatment	1.97	0.98 - 3.98	*p*=0.058
Use of psychotropic medication	2.04	0.91 - 4.61	*p*=0.086

Notes: ([a]) When RR<1, the factor is protective for non-indication; when RR>1, the factor is at risk for non-indication. ([b]) Variables associated with an outcome of $p \leq 0.05$.

Table 4. The Reasons Stated by Patients for not Initiating Treatment after Receiving an Indication for Psychodynamic Psychotherapy.

	n	%
Did not attend the scheduled session and did not give any reason	72	36.2
Financial problems	34	17.1
Demotivation about treatment	21	10.6
Timetable incompatibility	17	8.5
Patient believes that the prescribed treatment is not necessary	15	7.5
Dissatisfaction with the service or rules of the institution	13	6.5
Change of city	8	4.0
Health problems	7	3.5
Family problems	7	3.5
Problems concerning the clinic's location	4	2.0
Patient believes that they have previously achieved the treatment goals	1	0.5
Total	**199**	**100**

Table 5. The Results of the Poisson Regression for Non-Agreement to Initiate Psychodynamic Psychotherapy.

Variable	Relative risk[a]	Confidence interval (95%)	Significance
Without Higher Education[b]	1.29	1.03- 1.62	*p*=0.024
Family income lower than 4 MW[b]	1.26	0.99- 1.58	*p*=0.051
Diagnosis of F20-F29[b]	1.52	1.05 - 2.19	*p*=0.027
Depressive problems[b]	1.25	1.01 - 1.55	*p*=0.042
Not having undergone previous psychotherapy[b]	1.53	1.19- 1.96	*p*=0.001
Obsessiveness/Compulsivity	1.11	0.99- 1.23	*p*=0.065

Notes: ([a]) When RR<1, the factor is protective for non-agreement; when RR>1, the factor is at risk for non-agreement. ([b]) Variables associated with an outcome of $p \leq 0.05$.

Discussion

In this study, the interviewers had a pattern of not indicating psychodynamic psychotherapy in the initial interview. The variables that were independently associated with treatment indication included education level, reason for consultation (somatic or attention problems) and symptom intensity.

Somatic and attention problems are complaints that are frequently associated with conditions that necessitate pharmacological treatment and are more frequently referred to physicians, psychiatrists or neurologists than psychotherapists. This referral process is a possible explanation for these problems being associated with a non-indication for psychotherapy. Furthermore, in order to treat patients with somatic complaints in psychodynamic psychotherapy it is necessary to consider the technical and theoretical precepts of Psychoanalytic Psychosomatics, taking into account that some somatic complaints may have psychological origins and repercussions.

The motivation to initiate psychotherapy depends on the patient's psychological distress level. It appears reasonable that interviewers indicate psychodynamic psychotherapy for patients who perceive their symptoms as intense and, therefore, show great motivation.

Patients provided various reasons for not initiating treatment, some of which (such as family problems, health problems or moving to another city) did not necessarily involve a non-agreement with the treatment modality. Nevertheless, most patients did not initiate treatment because of the characteristics of the interviewers, psychotherapists, clinic or treatment modality. As previously noted, psychodynamic psychotherapy is not suitable for every type of patient. Since the time when psychoanalysis was the predominant form of psychotherapy, modified psychoanalytic techniques and other methods and approaches have dominated the psychiatric treatment scene. Psychotherapists have selected patients for psychotherapy in a variety of manners, from quick clinical presumptions to extensive long-lasting examinations and testing, and based on all types of grounds, from idiosyncratic beliefs to formal theories or research data (Valbak, 2004). The selection of patients for different forms of psychotherapy remains a challenge, and the assessment of patient suitability is a difficult task in clinical practice. Therefore, the decision to forego treatment is not necessarily harmful to the patient, considering that the initial assessment of his/her suitability for this specific treatment was not always well performed. Furthermore, because psychotherapies can produce side effects (Berk and Parker, 2009), it is not necessarily inadvisable that some patients disagree with the initiation of such treatment.

The following comments will focus on raising possible methods to improve the initial evaluation of patients considered for psychodynamic psychotherapy and launching possible technical changes to increase treatment compliance in cases of correct indication. Education level, income, diagnosis (schizophrenia, schizotypal or delusional disorders), depressive problems and the absence of previous psychotherapy were factors independently associated with patients' non-agreement to initiate psychotherapy.

The inverse relationship between education level and patient withdrawal during the early stages of psychotherapy, as shown in this study, corroborates the results obtained by Wierzbicki and Pekarik (1993) in their meta-analysis 20 years ago. Higher levels of education appear to be related to more benefits in psychotherapy (Olfson *et al.*, 2010), most likely because patients with higher education levels identify themselves more with their psychotherapists, professionals with high education levels (Garfield, 1986; Weirzbicki and Pekarik, 1993). Furthermore, a low education level is related to expectations of fast and immediate psychotherapeutic effectiveness (Westmacott and Hunsley, 2010), thus leading to lower compliance. Specifically for psychodynamic psychotherapies, higher levels of education may also predict the suitability for treatment because they are related to a greater capacity for mentalization, introspection and a capacity to grasp metaphoric concepts.

Regarding the patient's income, reviews performed in the 1970s and 1980s (Baekeland and Lundwall, 1975; Garfield, 1986) noted that the economic position of the patient was inversely related to treatment compliance. In these cases, the absence of resources to invest in long-term psychotherapy may be responsible for the lower compliance (Hauck *et al.*, 2007; Wang, 2007). Difficulties in accessing the clinic (dependency on unsatisfactory or insufficient transportation), incomplete information regarding their health conditions (dependency on public services with long waiting lines) and

the limited knowledge regarding the functioning of psychotherapy are common problems faced by patients with financial difficulties.

In this study, patients who had previously participated in psychotherapy agreed more often to initiate treatment than patients initiating psychotherapy for the first time. This result is in accordance with previous studies (Werner-Wilson and Winter, 2010). Previous experiences with psychotherapy most likely led to more realistic expectations regarding its functioning, thus decreasing frustration concerning the frequency of sessions, duration of treatments and expectations regarding the psychotherapist.

There is a possibility that psychodynamic psychotherapy should not be the primary choice of treatment for patients presenting a diagnosis of schizophrenia, schizotypal or delusional disorders, even when combined with psychotropic medication. This study showed that patients with these diagnoses tended to disagree with the initiation of psychotherapy. According to Krarup (2008), there is evidence for the effect of cognitive behavioral psychotherapy on reducing persistent positive symptoms, improving social functioning, improving insight and reducing the time to remission. There is no evidence of any effect of psychodynamic psychotherapy on relapse rates, but the model is helpful for psychotherapists to obtain an empathic understanding of patients (Krarup, 2008). However, this perspective is not unanimous among clinicians (Valbak *et al*., 2003; Brenner and Volkan, 2004; Margison, 2005; Gibbs, 2007). The treatment for patients with psychotic spectrum disorders could combine individual psychodynamic psychotherapy, psychopharmacology, family approaches, intensive psychosocial engagement, and educational treatment (Rosenbaum *et al*., 2006; Tillman, 2008). Nevertheless, according to psychodynamic theory, psychotic patients resist initiating and sustaining any type of treatment because of their narcissistic relationships, primitive defense mechanisms, particularly splitting, and omnipotent denial (Murawiec and Zechowski, 2007).

In this study, depressive problems included constant crying, an absence of appetite, difficulty in decision-making, sleeping problems, low energy and sadness. These problems are difficult to tolerate, and some patients require immediate relief, whereas the nature of the psychodynamic approach tends to be exploratory, less directive and its visible results typically require many sessions. There is also the characteristic pessimism of patients presenting depressive problems in relation to initiating any task. Depressed patients may also only partially respond to treatment or prematurely withdraw (Taylor *et al*., 2012). Of those showing these sub-optimal therapeutic responses, Stimpson *et al.* (2002) estimated that a minimum of 30% of patients experience recurrent treatment failures. Some patients, perhaps following many failed attempts at treatment, may withdraw from all treatment endeavors. These patients feel they have exhausted all treatment possibilities and become seriously neglected and deprived (Taylor *et al*., 2012). Accumulating evidence suggests that to be effective, treatments for these depressions must be more complex and longer than required for simpler disorders (Hollon and Ponniah, 2010). Because patients' outcome expectations play an important role in initial appointment attendance (Swift *et al*., 2012), the desire for immediate relief should be explored in the early stages of psychodynamic psychotherapy.

One of the limitations of this study was that it focused nearly entirely on patient variables and failed to cover the characteristics of psychotherapists. The analytical field and therapeutic alliance established during the initial stages of psychotherapy play an important role in the concordance to remain in treatment (Piper *et al*., 1999; Barrett *et al*., 2008), but these roles were not focused on in the present research because they have been previously well-established in the literature.

Nevertheless, the only variable related to the psychotherapist tested in the present study, training level, did not show any association with the patients' decision to initiate treatment. The literature is contradictory on the relationship between the experience of the psychotherapist and patients' compliance with treatment (Krauskopf *et al*., 1981; Jenkins *et al*., 1986). In principle, it should be expected that the higher the training level, period of study and clinical experience of the psychotherapist, the higher the chance he/she will be qualified to perform a good evaluation and enable a good therapeutic alliance. However, other factors may compensate for the absence of experience, such as the possibility to supervise all cases and dedication to each specific case (because they have fewer patients). The enthusiasm of new psychotherapists, which Malan (1976) called "therapeutic *eros*", may play its role in this compensation.

We need to consider that, in psychodynamic psychotherapies, unconscious dimensions of the therapist and the patient (such as transference, countertransference, resistance to improvement, etc.) play an important role in adherence to treatment and its outcome. Quantitative research with large samples can hardly include the analysis of this unconscious dimension; this is a limitation of this research. We suggest the realization of single case studies, with process assessments – not only results – to try to understand the role that unconscious factors can play in understanding the indication and agreement to initiate treatment.

Despite this study being based on a large sample of patients, the data were collected in only one clinic with particular features that limited the generalization of the results. Moreover, we decided to perform a naturalistic study based on the natural environment of psychotherapies and not one deliberately established for research. This methodological approach has the advantage of providing a less artificial portrait of the reality of psychodynamic psychotherapies, but has the methodological disadvantage of a loose control of the studied variables.

Notwithstanding these limitations, this study emphasizes the possible characteristics of patients who do not adhere to psychodynamic psychotherapy. These results must be tested in further studies, in other clinics and cultural contexts, to draw definitive conclusions regarding the complex phenomenon of indication and decisions to initiate psychotherapy.

Conclusions

In this study, the following factors were associated with a non-indication for psychodynamic psychotherapy: consulting for somatic or attention problems, having an education level limited to primary education and the patient's perception that his/her symptoms have little intensity. The following factors were associated with not initiating psychodynamic psychotherapy: the absence of higher education, a family income lower than 4 Brazilian minimum wages, diagnosis of schizophrenia, schizotypal or delusional disorders, consulting for depressive problems and/or having no previous experience in psychotherapy.

Even if this study has analyzed patients during their evaluation period for psychotherapy, no patient referred for psychotherapy after the intake interview received a contraindication for psychotherapy by his/her psychotherapist. Psychodynamic psychotherapists must consider the profile of patients who disagree with treatment initiation when indicating this psychotherapeutic modality and avoid treatment attempts that tend to fail. The psychodynamic technique adopted during the initial interviews must be improved to encompass the profile of probable non-concordant patients, or the criteria of indication and contraindication for psychodynamic psychotherapy must be reviewed and employed more rigorously by clinicians.

Some of the predictors of patients' early treatment interruptions observed in this study show inconsistency in the literature and must be better studied. However, other predictors have been associated with treatment dropout and non-adherence to psychotherapy in several studies, such as low income and low education (Baekeland and Lundwall, 1975; Wierzbicki and Pekarik, 1993; Garfield, 1994; Barrett *et al*., 2008; Swift and Greenberg, 2012). Psychotherapists that provide assistance to these cases must be aware that changes in standard psychodynamic techniques might be necessary for the success of these treatments, such as providing educational information about the patients' diagnosis, the employed technique of treatment and operationalization of psychotherapy (Walitzer *et al*., 1999; Wang *et al*., 2000; Edlund *et al*., 2002; Beutler *et al*., 2002; Reis and Brown, 2006; Barrett *et al*., 2008), and the use of aspects of the motivational interview to help patients explore and resolve their ambivalent feelings regarding treatment (Miller and Rollnick, 1991; Swart *et al*., 2007; Edlis-Matityahou, 2010).

To provide assistance to the low income and education population groups, it may not be sufficient to offer reduced fees; clinics must facilitate these patients' access to assistance by providing transportation and information regarding the disease and treatment. For those patients who do not fulfill the indication criteria for classic or standard psychodynamic psychotherapy, it may be useful to include a period of pre-therapy in the initial interviews that develops the capability to achieve insight. Despite the inconsistency of the techniques used in this pre-therapy period and classical psychodynamic principles, the literature has shown the potential benefit, for some patients, of using mixed techniques (Serralta *et al*., 2010).

Swift and Greenberg (2012) remind us that a number of strategies for reducing premature

discontinuation in psychotherapy have been identified, including discussing expectations regarding psychotherapy roles and behaviors, providing education regarding adequate treatment duration, addressing motivation, repairing alliance ruptures, using psychotherapist feedback, addressing client preferences, providing time-limited interventions, and increasing perspective convergence in the psychotherapy dyad.

Despite the complexity and difficulty of empirically assessing this topic, more research must be performed to understand the indication and contraindication criteria for psychodynamic psychotherapy used by clinicians. Only in this manner will we be able to understand the high dropout rates and non-adherence described in the literature, to increase the effectiveness of the services provided, and to establish more efficient techniques to be used in the assessment period for psychodynamic psychotherapy.

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