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SYMPTOM PROFILE OF PATIENTS WHO DROPPED OUT OF COMPLEX
PSYCHOTHERAPY AT A DAY HOSPITAL FOR NEUROTIC DISORDERS.

A RETROSPECTIVE ANALYSIS

PROFIL OBJAWÓW PACJENTÓW, KTÓRZY PRZERWALI PSYCHOTERAPIĘ
KOMPLEKSOWĄ W DZIENNYM ODDZIALE LECZENIA NERWIC.

BADANIE RETROSPEKTYWNE

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Summary

Objectives: To identify from among the symptoms present before treatment risk factors for patients with neurotic disorders treated in a day hospital dropping out of intensive psychotherapy.

Methods: Material: Medical records containing sociodemographic data, life inventories and symptom checklists of 1,398 patients with neurotic disorders admitted to a day hospital. Methods: Comparison of the characteristics of the population dropping out of therapy before the 5th week and that remaining in treatment. The comparison between the proportions was performed using a two-tailed test for stratum weight, and the distribution of variables was compared using the Mann-Whitney U test.

Results: No correlation was found between age, marital status or type of employment and drop-out from or completion of therapy. More significant relations between the symptom picture, including presence and intensity of certain elements, and psychotherapy drop-out were found in the group of females abandoning treatment.

Conclusions: Higher global intensity of neurotic symptoms was associated with a great risk of therapy dropout, as was the presence of some particularly burdensome symptoms. Differences in the profiles of intense symptoms before treatment were identified in the group of both females and males who dropped out from therapy. Further studies are advised, taking into consideration the greater population of males failing to continue psychotherapy, as well as the picture of symptoms in the week preceding dropout.

Key words: psychotherapy dropouts, risk factors, day hospital, neurotic disorders

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Introduction

Although the phenomenon of dropout from psychotherapy by patients is common and its incidence ranges, according to various authors, up to 60% [1-3], (however in some studies it is not so frequent e.g. [4-13]) previous studies attempting to identify factors predicting it have not brought unequivocal results [e.g. 14-15]. Findings have included a relationship between dropout from treatment and poor quality of the therapeutic relationship, including patient's difficulties in sharing therapist with other group members, various incorrect beliefs regarding the treatment and its effects, patient's difficulty in adopting an open attitude, young age of patients, as well as some factors external to the therapeutic process, such as financial problems or relationship problems [e.g. 1, 16-17]. Attempts have also been made to determine the relationship between dropout from therapy and type of clinical diagnosis. Studies in this domain also remain ambiguous, some of them do not confirm the correlation between type of disorder and dropout [e.g. 18-19], while others indicate an increased frequency of dropout among patients with diagnoses of personality disorders, especially those in the A and B scope, i.e. mainly with borderline personality, paranoid personality, or dissociative, narcissistic and histrionic personality [1, 17, 20-26]. Patients suffering somatoform and hypochondriacal disorders [17, 27-28] as well as social phobias [14, 25] are also often considered to be at risk of drop out from therapy; furthermore, it has been indicated that the presence of comorbid depressive symptoms [29-31], abuse of psychoactive substances [32], and eating disorders may be significant [33-34]. However, the study results are not explicit for any of these cases [e.g. 35].

The authors point first of all to the significance for dropout of such factors as patient impulsiveness, hostility towards others, especially the therapist, difficulties in interpersonal relationships, and low self-esteem [20, 22, 33, 36-40]. Significant intensification of symptoms is considered by some authors to be a factor that contributes to the patient remaining in therapy [e.g. 29, 41], while others draw attention to the fact that it can be also connected with dropping out of treatment [31, 34, 42-44]. Yet other researchers claim that it has no predictive meaning [19].

The present study attempts to identify the relationship between dropout from intensive group psychotherapy in a day hospital, and intensity and type of symptoms in patients being treated for neurotic disorders and comorbid personality disorders.

Hypotheses

In patients who are burdened with a higher risk of dropping out of therapy, the following are more common:

1. Higher global intensity of symptoms (assessed with symptom checklist KO),
2. Greater number of responses indicating maximum intensity of symptoms,

3. Very burdensome symptoms, such as severe anxiety, impulsive actions (acting out, of lack of control over emotions), feelings of guilt, panic attacks, obsessions with threatening content, agoraphobia, severe somatoform or conversion symptoms, and sexual dysfunctions.

Aim

To identify risk factors in the sphere of symptoms in dropout from intensive psychotherapy among patients with neurotic disorders treatment in a day hospital.

Material

Medical records containing sociodemographic data, life inventories and symptom checklists of 1,398 patients admitted to a day hospital for neurotic disorders.

Intensive psychotherapy was provided in a day hospital for neurotic disorders with sixteen sessions per week (including one individual session, other sessions were held in heterogeneous (according to diagnosis and sociodemographic variables) open-ended group, lasting approximately 3 months.

Therapy was led according to integrative approach with predominating psychodynamic and elements of cognitive and behavioral approaches. Therapies were provided by teams of 2-3 therapists, mostly certified (by Polish Psychiatric Association) as psychotherapists or supervisors, working under regular group and individual supervision, as well as attending continuous professional education and trainings. Pharmacotherapy was rare, with assumption of further decrease of its importance, followed with its complete elimination.

Methods

Tools

The characteristics of the population dropping out of therapy before the 5th week (timeframe was selected because of scheduling of treatment progress evaluation session in the analysed institution i.e. a day hospital; there are other possible definitions of dropout - more see [11]) were compared with the characteristics of patients who remained in treatment – selected from a larger population of all patients treated between 1987 and 2002, due to the availability of the necessary data on continuing or abandoning the treatment, and diagnoses typical for a day hospital for neurotic disorders. Selection of data of patients whose dropout from treatment occurred during therapy at the day hospital before the 5th week (“*early dropouts*”) filtered out persons qualified for treatment who had not begun it (“*non-engagers*” - a term used by e.g. [45]). Material was used from the routine qualifying tests stored in the medical records and in a computerized database in the form of patients’ answers to the KO '0' symptom checklist [46-48], describing the occurrence and intensity of 135 symptoms over the seven days before the test, thus enabling calculation of the global

symptom level. The scales from the KO 'O' symptom checklist were also used [49]. Demographic data were taken from a structured computerized interview (Life Inventory) [50].

Statistical methods

The comparison between the proportions of the values of the nominal variable was performed using the two-tailed test for stratum weight, and the distribution of the results of interval variables with asymmetrical distributions was compared using the Mann-Whitney U test. Estimates of the risk coefficients of dropouts from treatment as odds ratios (OR) of the coexistence of the two nominal variables were made using logistic regression. A licensed statistical packet, STATISTICA PL, was used.

Results:

Selection of the study group

At the initial stage of selection of patients for the study group from among all the patients treated between 1987 and 2002, 298 women and 117 men were excluded due to the lack of a clear diagnosis, or diagnosis of a psychotic or severe stress-related affective disorder or eating disorder. Next, the cases of records containing data gaps at the stage of qualification for treatment (due to changes in the electronic archiving system over the years) were excluded. The aim was to distinguish patients who had dropped out from treatment already begun (“*true dropouts*”), from those who had qualified but declined to start treatment (“*non-engagers*”), and from those whose records had random data gaps.

The profile of diagnoses in the selected study group and in the entire population of patients treated at the day hospital in the years 1987–2002 is presented in Table 1.

Table 1. Diagnoses in the study group and in the whole population of patients treated in the years 1987–2002

Diagnosis	Females		Males	
	Study group	Whole group	Study group	Whole group
Comorbid personality and neurotic disorders	**275 (28.1%)	**630 (33.8%)	*154 (36.8%)	*255 (29.9%)
Conversion/dissociative or somatoform disorders	*312 (31.9%)	*520 (27.9%)	108 (25.8%)	237 (27.8%)
Anxiety disorders	209 (21.4%)	367 (19.7%)	74 (17.7%)	183 (21.5%)
Neurasthenia	86 (8.8%)	181 (9.7%)	53 (12.6%)	92 (10.8%)
Dysthymia	77 (7.9%)	124 (6.7%)	*19 (4.5%)	*67 (7.9%)
Obsessive-compulsive disorder	19 (1.9%)	42 (2.3%)	12 (2.9%)	18 (2.1%)
Total	978 (100.0%)	1864 (100.0)	420 (100%)	852 (100.0)

*p<0.05, p<0.005

As shown in Table 1, those excluded from the study group (which numbered 1,398 persons) were primarily patients with diagnoses that were deliberately excluded from the study (for instance

psychoses). The group included significantly more individuals with diagnoses of neurotic disorders, and fewer with diagnosed neurotic disorders with comorbid personality disorders.

The average age of the patients in the study group proved highly similar to the age of the whole population of patients (Table 2), in both female and male subgroups.

Table 2. Age of the patients in the study group and in the whole population of patients treated in the years 1987–2002

Age	Females		Males	
	Study group	Whole population	Study group	Whole population
18-20	51 (5.2%)	139 (6.4%)	22 (5.2%)	56 (5.8%)
21-25	*152 (15.5%)	*404 (18.7%)	117 (27.9%)	241 (24.9%)
26-30	180 (18.4%)	351 (16.2%)	91 (21.7%)	193 (19.9%)
31-35	189 (19.3%)	373 (17.3%)	64 (15.2%)	156 (16.1%)
36-40	172 (17.6%)	381 (17.6%)	49 (11.7%)	117 (12.1%)
41-45	124 (12.7%)	273 (12.6%)	**33 (7.9%)	**106 (10.9%)
46-50	74 (7.6%)	159 (7.4%)	29 (6.9%)	67 (6.9%)
Over 50	36 (3.7%)	82 (3.8%)	15 (3.6%)	33 (3.4%)
Total	978 (100.0%)	2162 (100.0%)	420 (100.0%)	969 (100.0%)

* $p < 0.05$, ** $p < 0.01$

According to the demographic characteristics in the female group – described by all the items in the Life Inventory, with a total of over 700 tested items (in groups of 978 and 2,169 persons), only 7 statistically significant differences were found (between the study group and the entire population of female patients of the day hospital): a smaller number of women aged 21–25 years (15.5% vs 18.7%, $p < 0.05$), fewer maidens single women (33.5% vs 36.6%, $p < 0.05$), more women who were not in formal education at the time of the study (78.3% vs 74.5%, $p < 0.05$), fewer female students (11.0% vs 14.0%, $p < 0.05$), more women who had their first intercourse at the age of 17–18 (23.6% vs 20.4%, $p < 0.05$), more women with no partner or husband (29.0% vs 32.8%, $p < 0.05$), and more women who had had at least one normal pregnancy and had given birth (50.0% vs 46.1%, $p < 0.05$). It is noteworthy that most of the other – statistically insignificant – differences ranged from 1% to 3% (the authors decided against presenting a comparison of the results indicating degree of insignificance of differences).

In the male group only one statistically significant, though relatively small, difference was indicated, in the percentage of diseases or head injuries reported by the patients (in groups of 420 and 969 persons) – 25.0% vs 19.6% ($p < 0.05$). The above results, as well as the results listed in Tables 1 and 2, confirmed the appropriateness of the choice of the 1,398 persons for the study group from the 3,131 patients treated in the years 1987–2002.

Results of comparisons of individuals dropping out of treatment and completing treatment – selected demographic variables:

The selected group of patients who dropped out of treatment before the 5th week of therapy consisted of 125 people, 42 (34%) males and 83 (66%) females, while the group of patients who completed treatment numbered 1,273: 378 (30%) males and 895 (70%) females. Despite the slightly higher percentage of males in the study group, no significant differences (also in age) were found.

Two statistically significant differences were found in both groups in terms of diagnoses. As might have been expected, the presence of personality disorders comorbid with neurotic disorders was a risk factor of dropout from treatment (Table 3). The dominance in the picture of anxiety disorders (codes F40.x and F41.x in ICD-10) correlated significantly with a lower incidence of dropout from therapy. No significant differences were found in relation to other diagnoses of neurotic disorders (i.e. conversion disorders and somatoform disorders, dysthymia, neurasthenia, and obsessive-compulsive disorder).

Table 3. Diagnoses in the group of patients dropping out of treatment vs completing treatment.

Diagnosis	Dropping out of treatment (n=125)	Completing treatment (n=1,273)
Conversion/dissociative or somatoform disorders	36 (29%)	384 (30%)
Comorbid personality and neurotic disorders	**55 (43%)	**374 (29%)
Anxiety disorders	*15 (12%)	*268 (21%)
Dysthymia	6 (5%)	90 (7%)
Obsessive–compulsive disorder	1 (1%)	30 (2%)
Neurasthenia	12 (10%)	127 (10%)

*p<0.05, **p<0.005

The results were correlated for gender (Table 4) and remained significant in the female group, whereas in the considerably less numerous group of males only a similar, statistically unimportant tendency was found.

Table 4. Diagnoses in the group of patients dropping out of treatment vs completing treatment

Diagnosis	Females		Males	
	Dropping out of treatment	Completing treatment	Dropping out of treatment	Completing treatment
Conversion/dissociative or somatoform disorders	27 (32.5%)	285 (31.8%)	9 (21.4%)	99 (26.2%)
Comorbid personality and neurotic disorders	*35 (42.2%)	*240 (26.8%)	20 (47.6%)	134 (35.4%)
Anxiety disorders	*9 (10.8%)	*200 (22.3%)	6 (14.3%)	68 (18.0%)
Neurasthenia	7 (8.4%)	79 (8.8%)	5 (11.9%)	48 (12.7%)
Dysthymia	5 (6.0%)	72 (8.0%)	1 (2.4%)	18 (4.8%)
Obsessive-compulsive disorders	0	19 (2.1%)	1 (2.4%)	11 (2.9%)
Total	83 (100.0%)	895 (100.0%)	42 (100.0%)	378 (100.0%)

*p<0.05,

The groups under comparison were not statistically different in terms of age (Table 5).

Table 5. Age in the group of patients dropping out of treatment vs completing treatment

Age (Years)	Females		Males	
	Dropping out of treatment	Completing treatment	Dropping out of treatment	Completing treatment
18-20	5 (6.0%)	46 (5.1%)	1 (2.4%)	21 (5.6%)
21-25	13 (15.7%)	139 (15.5%)	10 (23.8%)	107 (28.3%)
26-30	11 (13.3%)	169 (18.9%)	6 (14.3%)	85 (22.5%)
31-35	18 (21.7%)	171 (19.1%)	9 (21.4%)	55 (14.6%)
36-40	17 (20.5%)	155 (17.3%)	7 (16.7%)	42 (11.1%)
41-45	9 (10.8%)	115 (12.8%)	3 (7.1%)	30 (7.9%)
46-50	6 (7.2%)	68 (7.6%)	3 (7.1%)	26 (6.9%)
Over 50	4 (4.8%)	32 (3.6%)	3 (7.1%)	12 (3.2%)
Total	83 (100.0%)	895 (100.0%)	42 (100.0%)	378 (100.0%)

All differences statistically insignificant (p>0.05)

No relationships between the patients' age, their marital status, or type of employment, and dropout from psychotherapy or completion of the treatment were found.

Results of comparisons of individuals dropping out of treatment and completing treatment – picture of symptoms.

In the next stage of the research, the global symptom level (the GSL coefficient) and the values in particular scales of the symptom checklist KO '0' [46-49] were analyzed. The results are shown in Table 6.

Table 6. Global symptom level and values of symptom checklist scales in groups of patients dropping out of treatment vs. those completing treatment

GSL symptom level and KO'O' scales	Females		Males	
	Dropping out of treatment n=83	Completing treatment n=895	Dropping out of treatment n=42	Completing treatment n=378
Initial GSL level (the outpatients' clinic)	*454.7±148.3 428.0 (338.0; 602.0)	*418.5±129.0 403.0 (317.0; 508.0)	384.8±134.7 350.5 (307.0; 475.0)	388.9±130.2 370.5 (289.0; 476.0)
1. Phobic disorders	5.9±1.8 6.0 (4.0; 7.0)	5.7±1.8 6.0 (4.0; 7.0)	5.7±1.6 6.0 (4.0; 6.0)	5.8±1.8 6.0 (5.0; 7.0)
2. Other anxiety disorders	5.8±1.6 6.0 (5.0; 7.0)	5.6±1.8 6.0 (4.0; 7.0)	6.0±1.7 6.0 (5.0; 7.0)	6.0±1.7 6.0 (5.0; 7.0)
3. Obsessive-compulsive disorders	**6.1±1.7 6.0 (5.0; 7.0)	**5.5±1.9 5.0 (4.0; 7.0)	5.8±1.5 6.0 (5.0; 7.0)	5.9±1.7 6.0 (5.0; 7.0)
4. Conversions and dissociations	5.7±1.8 6.0 (4.0; 7.0)	5.5±2.0 6.0 (4.0; 7.0)	5.5±1.8 5.5 (4.0; 7.0)	5.8±1.8 6.0 (5.0; 7.0)
5. Autonomic disorders (cardiovascular system)	5.5±1.5 6.0 (5.0; 7.0)	5.3±1.9 5.0 (4.0; 7.0)	5.7±1.9 6.0 (4.0; 7.0)	5.7±1.8 6.0 (4.0; 7.0)
6. Somatization disorders	5.8±2.0 6.0 (4.0; 7.0)	5.5±1.9 6.0 (4.0; 7.0)	5.6±1.8 6.0 (4.0; 7.0)	5.9±1.8 6.0 (5.0; 7.0)
7. Hypochondriacal disorders	5.7±1.8 6.0 (4.0; 7.0)	5.6±1.8 6.0 (4.0; 7.0)	5.6±1.5 5.0 (5.0; 7.0)	5.8±1.8 6.0 (4.0; 7.0)
8. Neurasthenia	**6.2±2.0 6.0 (5.0; 8.0)	**5.4±1.9 5.0 (4.0; 7.0)	5.8±2.0 5.5 (4.0; 7.0)	6.0±1.9 6.0 (5.0; 7.0)
9. Depersonalization and derealization	*6.2±1.9 6.0 (5.0; 8.0)	*5.6±1.8 6.0 (4.0; 7.0)	5.7±2.1 5.5 (4.0; 7.0)	5.9±1.9 6.0 (5.0; 7.0)
10. Avoidance and dependence	*6.2±2.1 6.0 (5.0; 8.0)	*5.7±1.8 6.0 (4.0; 7.0)	6.0±2.2 6.0 (4.0; 7.0)	6.1±1.8 6.0 (5.0; 7.0)
11. Impulsiveness and histrionism	*6.0±2.0 6.0 (5.0; 8.0)	*5.6±1.9 6.0 (4.0; 7.0)	5.8±1.9 6.0 (4.0; 7.0)	5.6±1.9 6.0 (4.0; 7.0)
12. Non-organic sleep disorders	x 5.7±1.8 6.0 (4.0; 7.0)	x 5.3±1.9 5.0 (4.0; 7.0)	*6.5±2.2 7.0 (5.0; 8.0)	*5.6±1.7 5.0 (4.0; 7.0)
13. Sexual dysfunctions	5.8±2.1 6.0 (4.0; 7.0)	5.5±1.9 6.0 (4.0; 7.0)	5.9±2.2 6.0 (4.0; 8.0)	5.7±2.0 6.0 (4.0; 7.0)
14. Dysthymia	*6.2±1.8 6.0 (5.0; 8.0)	*5.8±1.6 6.0 (5.0; 7.0)	6.3±1.8 6.0 (5.0; 7.0)	6.2±1.8 6.0 (5.0; 7.0)

*p<0.05. **p<0.005. x p<0.1 (Man-Whitney U test)

As shown in Table 6, a higher global symptom level (GSL) was associated with a risk of dropping out of treatment for female patients, but not for male patients. It seems that this phenomenon was determined mainly by a significantly ($p < 0.05$) higher value of several scales: including symptoms of obsessions/compulsions, neurasthenia, depersonalization/derealization, avoidance/dependence, impulsiveness/histrionism and dysthymia in the subgroup of women dropping out of treatment. In the male group, dropout from treatment was associated only with the scale of non-organic sleep disorders (while in the female group only a trend was observed in this scale – a difference at the limit of statistical significance ($p < 0.1$)).

The results of comparisons conducted for particular symptoms, including their presence at the highest intensity at the qualification stage, are presented in Tables 7-9.

Table 7. Differences in the ranges of symptoms of persons dropping out of treatment and remaining in treatment.

Item	Females			Males			Whole group
	Dropping out of treatment n=83	Completing treatment n=895	OR and CI for females	Dropping out of treatment n=42	Completing treatment n=378	OR and CI for males	OR and CI for the whole group
constant feeling of anxiety	76 (91.57%)	799 (89.27%)	ns	34 (80.95%)	314 (83.07%)	ns	ns
including in extreme intensity (answer 'c'):	**49 (59.04%)	**372 (41.56%)	**2.03 (1.28; 3.20)	12 (28.57%)	100 (26.46%)	ns	*1.62 (1.12; 2.34)
panic attacks	**59 (71.08%)	**502 (56.09%)	**1.92 (1.18; 3.15)	22 (52.38%)	184 (48.68%)	ns	*1.58 (1.07; 2.31)
including in extreme intensity (answer 'c'):	*28 (33.73%)	*185 (20.67%)	*1.95 (1.20; 3.17)	8 (19.05%)	46 (12.17%)	ns	**1.82 (1.21; 2.76)
fear in open spaces	*33 (39.76%)	*255 (28.49%)	*1.83 (1.16; 2.90)	6 (14.29%)	88 (23.28%)	ns	ns
including in extreme intensity (answer 'c'):	6 (7.23%)	76 (8.49%)	ns	1 (2.38%)	20 (5.29%)	ns	ns
intrusive thoughts of aggressive content	32 (38.55%)	309 (34.53%)	ns	17 (40.48%)	145 (38.36%)	ns	ns
including in extreme intensity (answer 'c'):	*15 (18.07%)	*91 (10.17%)	*1.95 (1.07; 3.55)	4 (9.52%)	30 (7.94%)	ns	*1.71 (1.01; 2.88)
blasphemous or obscene thoughts or fantasies	*32 (38.55%)	*242 (27.04%)	*1.68 (1.06; 2.68)	15 (35.71%)	182 (48.15%)	ns	ns
including in extreme intensity (answer 'c'):	*12 (14.46%)	*62 (6.93%)	*2.27 (1.17; 4.41)	2 (4.76%)	27 (7.14%)	ns	ns
desire to take one's own life	34 (40.96%)	332 (37.09%)	ns	22 (52.38%)	151 (39.95%)	ns	ns
including in extreme intensity (answer 'c'):	*14 (16.87%)	*78 (8.72%)	*2.13 (1.14; 3.95)	4 (9.52%)	24 (6.35%)	ns	*1.93 (1.13; 3.31)
lack of control over expression of emotions	*61 (73.49%)	*559 (62.46%)	ns	25 (59.52%)	210 (55.56%)	ns	ns
including in extreme intensity (answer 'c'):	24 (28.92%)	186 (20.78%)	ns	4 (9.52%)	40 (10.58%)	ns	ns
breaking objects in a state of nervousness	*29 (34.94%)	*207 (23.13%)	1.77 (1.10; 2.86)	13 (30.95%)	94 (24.87%)	ns	*1.61 (1.09; 2.39)
including in extreme intensity (answer 'c'):	7 (8.43%)	43 (4.80%)	ns	2 (4.76%)	13 (3.44%)	ns	ns
"nervousness", nervous movements	64 (77.11%)	751 (83.91%)	ns	35 (83.33%)	320 (84.66%)	ns	ns
including in extreme intensity (answer 'c'):	*32 (38.55%)	*241 (26.93%)	*1.70 (1.07; 2.72)	6 (14.29%)	71 (18.78%)	ns	ns
uncontrollable mass of thoughts	65 (78.31%)	731 (81.68%)	ns	36 (85.71%)	302 (79.89%)	ns	ns
including in extreme intensity (answer 'c'):	*41 (49.40%)	*336 (37.54%)	*1.62 (1.03; 2.55)	18 (42.86%)	113 (29.89%)	ns	*1.64 (1.13; 2.37)

*p<0.05, **p<0.005. OR – odds ratios, CI – confidence intervals for odds ratios

Table 8. Symptom profile of patients dropping out of treatment and remaining in treatment, and value of the odds ratios in the males and females subgroups as well as in the whole of the studied population.

Item	Females			Males			Whole group
	Dropping out from treatment n=83	Completing treatment n=895	OR and CI for females	Dropping out from treatment n=42	Completing treatment n=378	OR and CI for males	OR and CI for the whole group
compulsive counting of streetlights, cars, etc.	**34 (40.96%)	**222 (24.80%)	**2.10 (1.32; 3.34)	9 (21.43%)	106 (28.04%)	ns	*1.50 (1.02; 2.22)
including in extreme intensity (answer 'c'):	**13 (15.66%)	**58 (6.48%)	**2.68 (1.40; 5.13)	2 (4.76%)	20 (5.29%)	ns	*2.09 (1.16; 3.76)
unexpected, intense experience of delight	42 (50.60%)	365 (40.78%)	ns	14 (33.33%)	137 (36.24%)	ns	ns
including in extreme intensity (answer 'c'):	*14 (16.87%)	*77 (8.60%)	*2.16 (1.16; 4.01)	3 (7.14%)	17 (4.50%)	ns	*1.97 (1.14; 3.43)
difficulties falling asleep	*67 (80.72%)	*611 (68.27%)	*1.94 (1.10; 3.40)	33 (78.57%)	259 (68.52%)	ns	*1.85 (1.17; 2.91)
including in extreme intensity (answer 'c'):	29 (34.94%)	226 (25.25%)	ns	**18 (42.86%)	**81 (21.43%)	**2.75 (1.42; 5.32)	**1.90 (1.29; 2.78)
frequent waking	56 (67.47%)	590 (65.92%)	ns	30 (71.43%)	229 (60.58%)	ns	ns
including in extreme intensity (answer 'c'):	16 (19.28%)	192 (21.45%)	ns	**13 (30.95%)	**53 (14.02%)	*2.75 (1.34; 5.63)	ns
sleeplessness	58 (69.88%)	553 (61.79%)	ns	32 (76.19%)	230 (60.85%)	ns	*1.61 (1.07; 2.42)
including in extreme intensity (answer 'c'):	24 (28.92%)	197 (22.01%)	ns	**14 (33.33%)	**50 (13.23%)	**3.28 (1.61; 6.67)	**1.81 (1.21; 2.72)
hypersomnia	*65 (78.31%)	*579 (64.69%)	*1.95 (1.14; 3.35)	24 (57.14%)	258 (68.25%)	ns	ns
including in extreme intensity (answer 'c'):	22 (26.51%)	204 (22.79%)	ns	6 (14.29%)	65 (17.20%)	ns	ns
a feeling of benevolence toward others	59 (71.08%)	573 (64.02%)	ns	25 (59.52%)	242 (64.02%)	ns	ns
including in extreme intensity (answer 'c'):	*23 (27.71%)	*160 (17.88%)	*1.76 (1.06; 2.93)	4 (9.52%)	62 (16.40%)	ns	ns
a feeling of lack of interest from others	55 (66.27%)	588 (65.70%)	ns	25 (59.52%)	253 (66.93%)	ns	ns
including in extreme intensity (answer 'c'):	*21 (25.30%)	*143 (15.98%)	*1.78 (1.05; 3.02)	7 (16.67%)	53 (14.02%)	ns	*1.59 (1.01; 2.48)
vaginismus or premature ejaculation or lack of erection	26 (31.33%)	243 (27.15%)	ns	19 (45.24%)	146 (38.62%)	ns	ns
including in extreme intensity (answer 'c'):	7 (8.43%)	78 (8.72%)	ns	*10 (23.81%)	*44 (11.64%)	*2.37 (1.09; 5.17)	ns
discomfort connected with masturbation	***18 (21.69%)	***83 (9.27%)	**2.67 (1.51; 4.72)	*5 (11.90%)	*111 (29.37%)	*0.40 (0.16; 0.97)	ns
including in extreme intensity (answer 'c'):	*6 (7.23%)	*20 (2.23%)	*3.41 (1.33; 8.75)	1 (2.38%)	28 (7.41%)	ns	ns
reduction of sexual potency	37 (44.58%)	420 (46.93%)	ns	20 (47.62%)	175 (46.30%)	ns	ns
including in extreme intensity (answer 'c'):	17 (20.48%)	139 (15.53%)	ns	*8 (19.05%)	30 (7.94%)	*2.73 (1.16; 6.44)	*1.63 (1.02; 2.61)

*p<0.05. **p<0.005. ***p<0.0005, OR – odds ratios, CI – confidence intervals for odds ratios

Table 9. Profiles of patients dropping out of treatment and remaining in treatment

Item	Females			Males			Whole group
	Dropping out of treatment n=83	Completing treatment n=895	OR and CI for females	Dropping out of treatment n=42	Completing treatment n=378	OR and CI for males	OR and CI for the whole group
muscle spasms while performing activities (e.g. writing)	*50 (60.24%)	*415 (46.37%)	*1.70 (1.07; 2.69)	19 (45.24%)	174 (46.03%)	ns	ns
including in extreme intensity (answer 'c'):	11 (13.25%)	91 (10.17%)	ns	3 (7.14%)	34 (8.99%)	ns	ns
periodical loss of sensation of pain or touch	29 (34.94%)	254 (28.38%)	ns	8 (19.05%)	92 (24.34%)	ns	ns
including in extreme intensity (answer 'c'):	*11 (13.25%)	*52 (5.81%)	*2.48 (1.24; 4.96)	0 (0.00%)	13 (3.44%)	ns	ns
pains in the heart area	*64 (77.11%)	*593 (66.26%)	*1.71 (1.01; 2.90)	25 (59.52%)	235 (62.17%)	ns	ns
including in extreme intensity (answer 'c'):	***26 (31.33%)	***138 (15.42%)	**2.50 (1.52; 4.12)	7 (16.67%)	43 (11.38%)	ns	**2.16 (1.41; 3.32)
fainting	*35 (42.17%)	*276 (30.84%)	*1.61 (1.02; 2.55)	6 (14.29%)	92 (24.34%)	ns	ns
including in extreme intensity (answer 'c'):	**13 (15.66%)	**60 (6.70%)	**2.58 (1.35; 4.94)	1 (2.38%)	19 (5.03%)	ns	*1.91 (1.04; 3.48)
accumulation of excess of saliva in the mouth	**36 (43.37%)	**255 (28.49%)	*1.92 (1.22; 3.04)	16 (38.10%)	121 (32.01%)	ns	*1.69 (1.16; 2.47)
including in extreme intensity (answer 'c'):	8 (9.64%)	52 (5.81%)	ns	2 (4.76%)	17 (4.50%)	ns	ns
involuntary urination, for instance while sleeping	***12 (14.46%)	***43 (4.80%)	**3.27 (1.65; 6.48)	2 (4.76%)	17 (4.50%)	ns	**2.51 (1.36; 4.63)
including in extreme intensity (answer 'c'):	*1 (1.20%)	*8 (0.89%)	ns	1 (2.38%)	3 (0.79%)	ns	ns
menstruation disorders in females	**37 (44.58%)	**265 (29.61%)	*1.88 (1.19; 2.97)	---	---	---	---
including in extreme intensity (answer 'c'):	**16 (19.28%)	**82 (9.16%)	**2.37 (1.31; 4.28)	---	---	---	---
burning sensation in the esophagus, heartburn	41 (49.40%)	371 (41.45%)	ns	15 (35.71%)	184 (48.68%)	ns	ns
including in extreme intensity (answer 'c'):	*15 (18.07%)	*93 (10.39%)	*1.90 (1.04; 3.46)	4 (9.52%)	33 (8.73%)	ns	ns
muscle spasms forcing constant twisting of the head	***24 (28.92%)	***128 (14.30%)	**2.42 (1.45; 4.02)	12 (28.57%)	69 (18.25%)	ns	**2.20 (1.45; 3.33)
including in extreme intensity (answer 'c'):	6 (7.23%)	32 (3.58%)	ns	2 (4.76%)	10 (2.65%)	ns	ns
nausea	49 (59.04%)	457 (51.06%)	ns	16 (38.10%)	175 (46.30%)	ns	ns
including in extreme intensity (answer 'c'):	*16 (19.28%)	*100 (11.17%)	*1.90 (1.06; 3.41)	4 (9.52%)	32 (8.47%)	ns	ns

*p<0.05, **p<0.005, ***p<0.0005, OR – odds ratios, CI – confidence intervals for odds ratios

As shown in tables 7-9, the symptoms that occurred significantly more frequently before treatment (and present irrespective of intensity) in females who dropped out of psychotherapy were as follows: panic attacks (similarly for maximum intensity), agoraphobic fears, blasphemous or obscene thoughts (similarly for maximum intensity), discomfort surrounding masturbation (also for maximum intensity), a sense of lack of control in expressing emotions, a tendency to break things out of nervousness, obsessive counting (also for maximum intensity), difficulties in falling asleep as well as sleepiness, muscle spasms while performing various activities, heart pains (also for

maximum intensity), fainting (also for maximum intensity), accumulation of excess saliva in the mouth, involuntary urination (also for maximum intensity), and menstrual disorders (also for maximum intensity) as well as torticollis.

The extreme intensity of some symptoms (constant presence of anxiety, aggressive content of intrusive thoughts, suicidal thoughts, “nervousness”, uncontrollable mass of thoughts, unexpected feelings of excitement, a feeling of benevolence toward others, a feeling of lack of interest from others, conversive loss of sensation, “heartburn”, nausea) were significantly more frequent in females dropping out of treatment, although this relationship was not confirmed for the occurrence of a given symptom.

In the male group, the symptoms associated with dropout from treatment were identified in much smaller number, and there was no such connection with their occurrence, but only with maximum intensification. These symptoms were: difficulties falling asleep, frequent waking, and sleeplessness.

Logistic univariate regression analyses conducted for the whole group and separately for males and females confirmed the conclusions resulting from the significance of differences in percentages (listed in Tables 7-9), and their results are also included in these tables in the form of risk factors (odds ratios, OR) for therapy dropout depending on the occurrence of a particular symptom or its presence at maximum intensity. The coefficients calculated for the whole group - because of the much larger number of female patients - obviously indicate links similar to the ones found in the female group.

An interesting exception is a different relationship between the presence of discomfort associated with masturbation and lower risk of dropping out of therapy in among males.

Discussion of results

The results of the study presented here are partly consistent with the literature. It is interesting that although global symptom level was widely considered to be a factor increasing the risk of dropout from treatment [e.g. 31, 34, 42-44], such an association was confirmed only in the female group, which at the same time demonstrated a significantly larger number of pre-treatment symptoms (with extreme intensity) connected with dropout from therapy. Obviously this regularity is also related to the method of assessing the GSL coefficient [47].

It is not clear, however, why most of these relationships were present among females, while in males almost exclusively sleep disorders were meaningful; these are clinically associated with mood disorders, most cases of which (except for patients suffering from dysthymia) we attempted to exclude from the study. The process of “autoselection” of patients for psychotherapy treatment – including what seem to be particularly intense forms in day hospital [51] – might be of some

importance in contributing to what is around the three times higher number of women in therapy, and is probably responsible for the different characteristics of the sub-population of males (also those dropping out of treatment). However, this observation is in accordance with the subject literature, which indicates a greater risk of dropout in case of symptoms of depression comorbid with anxiety disorders [e.g. 30-31].

The correlation outlined in the literature between hypochondriacal symptoms and the risk of dropout from treatment was not confirmed in the study, and only a few somatoform (and conversion) symptoms turned out to be risk factors, exclusively in the female group. Similarly, only in the group of female patients was a relationship between agoraphobia (making it difficult to reach psychotherapy and systematically attend sessions) and dropout from treatment confirmed. Neither was any greater risk of dropping out of psychotherapy confirmed in patients with social phobia or reporting symptoms of this nature, which may be especially surprising given the intensive group psychotherapy form of treatment in a day hospital.

The importance of the symptoms of discomfort connected with masturbation and reduction of sexual potency as predictors of dropout may be understood to be connected with real or expected (e.g. by projection) aversion from the group, the patient's own difficulties in addressing the issue, or the conviction that group therapy is not a suitable place for addressing such a issue [52-55]. This would be especially true in the analyzed period, (1987–2002), when there was a lesser degree of openness in society regarding sexual issues. A similar mechanism might come into play in the context of blasphemous, aggressive or obscene content of intensified compulsions, which are often perceived by patients as “weird” or “shameful”.

The results obtained confirmed a higher risk of dropout from day hospital treatment by female patients with a diagnosis of neurotic disorders comorbid with personality disorders, as well as a relationship between symptoms associated with personality traits such as impulsivity, dependency, or histrionic tendencies.

The results partially confirmed –with regard to the female subgroup – the research hypothesis concerning the significance for dropout of a higher intensity of symptoms (usually connected with their greater number), as well as of assessment of a greater number of symptoms as intense ('c' answer in Likert type scale) – which, as clinical practice indicates, often require more work in a therapeutic group, which in turn may be associated with tension between patients, as well as being slower to produce symptomatic improvement, and hence demotivating. On the other hand, it is these patients, with initial symptom intensification, that experience symptomatic relief at the very beginning of treatment, due to what are often nonspecific treatment factors [e.g. 17, 25, 56].

Limitation of a current study is lack of information regarding influence of culture transformations on results obtained, after so many years (1987-2002) of data collecting as well as

lack of information regarding persons who did not started therapy (non-engagers). Results obtained may be also dependent on diagnostic tool applied (symptom checklist KO'0').

Perhaps a profile analysis of symptoms of patients (both females and males) in the week preceding the decision to end treatment prematurely could provide additional information. This would also be a separate source of data indicating an increasing risk of dropout. Such research is planned in the future as well as prospective studies.

Conclusions

1. In the female group it was indicated that a higher risk of dropping out of psychotherapy was connected with a higher global symptom level, which was not proved for males.
2. The presence of some especially burdensome symptoms, such as panic attacks, fears in open spaces, obsessive thoughts with threatening content, compulsive counting, and fainting, was associated with dropout from treatment by females, however no such connections were confirmed for males.
3. Differences in the profile of intense symptoms before treatment were indicated in both the female and male groups. These symptoms for females were as follows: constant feelings of anxiety, a compulsion to count, pains in the heart area, fainting, and menstruation disorders. For males they were: three symptoms from the sleeping disorder spectrum (difficulties falling asleep, frequent waking, and “sleeplessness”), as well as two symptoms from the sexual disorder spectrum (erectile disorders, premature ejaculation, and potency disruptions).
4. Consideration of the results obtained here should help to extend especial care [more e.g. 10-11] to patients manifesting symptoms that constitute risk factors – especially greater attention in situations of their maximum intensity.
5. The burden of comorbid personality disorders and affective disorders is probably one of the clearest risk factors, especially when associated with avoidance-dependency and impulsivity-histrionism.
6. Further studies with a larger male population, both dropping out and continuing treatment, and also involving a profile of symptoms in the week preceding dropout, may disclose a larger number of correlations.

References:

1. Thormählen B, Weinryb RM, Norén K i in., Vinnars B, Bågedahl-Strindlund M. Patient factors predicting dropout from supportive-expressive psychotherapy for patients with personality disorders. *Psychother. Res.* 2003; 13, 4: 493-509.
2. Schaeffer JA, Kaiser EM. A structured approach to processing clients' unilateral termination decisions. *Am J Psychother.* 2013; 67(2): 165-83.

3. Sly R, Morgan JF, Mountford VA, Lacey JH. Predicting premature termination of hospitalised treatment for anorexia nervosa: the roles of therapeutic alliance, motivation, and behaviour change. *Eat Behav.* 2013; 14(2): 119-23. doi: 10.1016/j.eatbeh.2013.01.007.
4. Melville KM, Casey LM, Kavanagh DJ. Dropout from Internet-based treatment for psychological disorders. *Br J Clin Psychol.* 2010; 49(Pt 4): 455-71. doi: 10.1348/014466509X472138.
5. Issakidis C, Andrews G. Pretreatment attrition and dropout in an outpatient clinic for anxiety disorders. *Acta Psychiatr Scand.* 2004; 109(6): 426-33.
6. Arnow BA, Blasey C, Manber R, Constantino MJ, Markowitz JC, Klein DN. i wsp. Dropouts versus completers among chronically depressed outpatients. *J Affect Disord.* 2007; 97(1-3): 197-202.
7. Kroger C, Harbeck S, Armbrust M, Kliem S. Effectiveness, response, and dropout of dialectical behavior therapy for borderline personality disorder in an inpatient setting. *Behaviour Research And Ther.* 2013; 51(8): 411-416. DOI:10.1016/j.brat.2013.04.008.
8. Harte CB, Hamilton LD, Meston CM. Predictors of Attrition from an Expressive Writing Intervention for Sexual Abuse Survivors. *J Child Sex Abuse.* 2013; 22(7): 842-857 DOI:10.1080/10538712.2013.830670.
9. Imel ZE, Laska K, Jakupcak M, Simpson TL. Meta-Analysis of Dropout in Treatments for Posttraumatic Stress Disorder. *J Cons Clin Psychol.* 2013; 81(3): 394-404. DOI:10.1037/a0031474.
10. Gajowy M, Mikułowicz D, Sala P, Simon W. Przedwczesne przerywanie psychoterapii grupowej - specyfika zjawiska i sugestie jego ograniczania. *Psychoterapia.* 2010; 2(153): 33-48.
11. Gajowy M, Marchewka D, Sala P, Simon W. Analiza przyczyn przerywania psychoterapii grupowej (drop-out) w aspekcie czynników dotyczących pacjenta. *Psychoterapia.* 2004; 2(129): 47-55.
12. Sala P, Marchewka D, Simon W. Porzucanie leczenia (drop-out) w trakcie psychoterapii zaburzeń odżywiania. *Psychoterapia.* 1(120) 33-40.,
13. de Barbaro B, Zielińska E, Grabowski G, Budzyna-Dawidowski P. Drop-out w terapii rodzin. *Badania własne. Psychoterapia.* 2003; 4(127): 21-33.
14. Eskildsen A, Hougaard E, Rosenberg NK. Pre-treatment patient variables as predictors of drop-out and treatment outcome in cognitive behavioural therapy for social phobia: A systematic review. *Nordic Journal of Psychiatry.* 2010; 64, 2: 94-105.
15. Piper WE, Ogrodniczuk JS, Joyce AS, McCallum M, Rosie JS. et als. Prediction of dropping out in time-limited, interpretive: Individual psychotherapy. *Psychotherapy.* 1999; 36, 2: 114-122.
16. Pekarik G. Posttreatment adjustment of clients who drop out early vs. late in treatment. *J Clin Psychol.* 1992; 48, 3: 379-387.
17. Yalom ID, Leszcz M. *The theory and practice of group psychotherapy.* New York: Basic Books; 2005.
18. Arehart-Treichel J. A Study Seeks Answers To Treatment Dropout. *Psychiatric News.* 2002; 37, 12: 28. The study, "Dropping out of mental health treatment: patterns and predictors among epidemiological survey respondents in the United States and Ontario," <http://ajp.psychiatryonline.org/cgi/content/full/159/5/845>. *Am J Psychiatry* 2002; 159, 5: 845,
19. Keijsers GPJ, Kampman M, Hoogduin CAL. Dropout prediction in cognitive behavior therapy for panic disorder. *Behavior Therapy.* 2001; 32, 4: 739-749.
20. Smith TE, Koenigsberg HW, Yeomans FE i in. Predictors of dropout in psychodynamic psychotherapy. *Journal of psychotherapy practice and research,* 1995; 4: 205-213.
21. Hummelen B, Wilberg T, Karterud S. Interviews of female patients with borderline personality disorder who dropped out of group psychotherapy. *Int. J. Group Psychother.* 2007; 57, 1: 67-91.

22. Yeomans FE, Gutfreund J, Selzer MA, Clarkin JF, Hull JW. et als. Factors Related to Drop-outs by Borderline Patients. Treatment Contract and Therapeutic Alliance. *J. Psychother. Pract. Res.* 1994; 3: 16-24.
23. Chiesa M, Drahorad C, Longo S. Early termination of treatment in personality disorder treated in a psychotherapy hospital. Quantitative and qualitative study. *Br. J. Psychiatry.* 2000; 177: 107-111.
24. Hilsenroth MJ, Holdwick DJ, Castlebury FD, Blais MA. The effects of DSM-IV cluster B personality disorder symptoms on the termination and continuation of psychotherapy. *Psychotherapy.* 1998; 35, 2: 163-176.
25. Kratochvil S. Zagadnienia grupowej psychoterapii nerwic. PWN, 1986.
26. Junkert-Tress B, Tress W, Hildenbrand G, Hildenbrand B, Windgassen F. et als. Premature termination - A multifactorial phenomenon. *Psychotherapie Psychosomatik Medizinische Psychologie.* 2000; 50, 9-10: 351-365.
27. Aleksandrowicz JW, Bierzyński K, Romeyko A. Porzucenie leczenia (drop-out) – próba analizy. *Psychoterapia* 1981; 38: 49-58.
28. Macnair RR, Corazzini JG. Client factors influencing group-therapy dropout. *Psychotherapy.* 1994; 31, 2: 352-362
29. Issakidis C, Andrews G. Pretreatment attrition and dropout in an outpatient clinic for anxiety disorders. *Acta Psychiatrica Scandinavica.* 2004; 109, 6: 426-433.
30. Brown C, Schulberg HC, Madonia MJ, Shear MK, Houck PR. Treatment outcomes for primary care patients with major depression and lifetime anxiety disorders. *Am. J. Psychiatry.* 1996; 153: 1293-1300.
31. Ong JC, Kuo TF, Manber R. Who is at risk for dropout from group cognitive-behavior therapy for insomnia? *Journal of Psychosomatic Research.* 2008; 64, 4: 419-425.
32. Kofoed L, Kania J, Walsh T, Atkinson RM. Outpatient treatment of patients with substance abuse and coexisting psychiatric disorders. *Am. J. Psychiatry.* 1986; 143: 867-872.
33. Bados A, Balaguer G, Saldana C. The efficacy of cognitive-behavioral therapy and the problem of drop-out. *Journal of Clinical Psychology.* 2007; 63, 6: 585-592.,
34. Sala P, Gajowy M, Marchewka D i in. Czynniki motywacyjne w psychoterapii zaburzeń odżywiania się. *Psychiatria Polska* 2005; 39, 4: 731-740.
35. Meresman JF, Horowitz LM, Bein E. Treatment assignment, dropout, and outcome of depressed patients who somaticize. *Psychther Res* 1995; 5, 3: 245-257.
36. Lothstein LM. The group psychotherapy dropout phenomenon revisited. *Am. J. Psychiatry.* 1978; 135: 1492-1495.
37. Hillis G, Alexander DA, Eagles JM. Premature termination of psychiatric contact. *Int J Soc Psychiatry.* 1993; 39, 2: 100-107.
38. Berghofer G, Schmidl F, Rudas S, Steiner E, Schmitz M. Predictors of treatment discontinuity in outpatient mental health care. *Social Psychiatry and Psychiatric Epidemiology.* 2002; 37, 6: 276-282.
39. MacNair-Semands RR. Predicting attendance and expectations for group therapy. *Group Dynamics-Theory Research and Practice.* 2002; 6, 3: 219-228.
40. Davis S, Hooke GR, Page AC. Identifying and targeting predictors of drop-out from group cognitive behaviour therapy. *Australian J Psychology.* 2006; 58, 1: 48-56.
41. Ogrodniczuk JS, Piper WE, Joyce AS. Treatment compliance among patients with personality disorders receiving group psychotherapy: What are the roles of interpersonal distress and cohesion? *Psychiatry-Interpersonal and Biological Processes.* 2006, 69, 3: 249-261.
42. Derisley J, Reynolds S. The transtheoretical stages of change as a predictor of premature termination, attendance and alliance in psychotherapy. *Br. J. Clin. Psychol.* 2000; 39, Pt 4: 371-382.
43. Bowden CL, Schoenfeld LS, Adams RL. A correlation between dropout status and improvement in a psychiatric clinic. *Hosp. Comm. Psychiatry.* 1980; 31: 192-195.

44. Minnix JA, Reitzel LR, Repper KA, Burns AB, Williams F. et als. Total number of MMPI-2 clinical scale elevations predicts premature termination after controlling for intake symptom severity and personality disorder diagnosis. *Personality and Individual Differences*. 2005; 38, 8: 1745-1755.
45. Huang T, Hill C, Gelso C. Psychotherapy engagers versus non-engagers: Differences in alliance, therapist verbal response modes, and client attachment. *Psychotherapy Research*. 2013; 23(5): 568-577.
DOI:10.1080/10503307.2013.807378.
46. Aleksandrowicz JW, Bierzyński K, Filipiak J, Kowalczyk E, Martyniak J. et als. Kwestionariusze objawowe „S” i „O” – narzędzia służące do diagnozy i opisu zaburzeń nerwicowych. *Psychoter*. 1981; 37: 11–27.
47. Aleksandrowicz JW, Hamuda G. Kwestionariusze objawowe w diagnozie i w badaniach epidemiologicznych zaburzeń nerwicowych. *Psychiatr. Pol.* 1994; 28, 6: 667–676.
48. Zawadzki B. Kwestionariusze osobowości. Strategie i procedura konstruowania. Warszawa: Wydawnictwo Naukowe Scholar; 2006
49. Rewer A. Skale kwestionariusza objawowego „O”. *Psychiatr. Pol.* 2000; 34, 6: 931–943.
50. Aleksandrowicz JW, Bierzyński K, Kołbik I, Kowalczyk E, Martyniak J, et als. Minimum informacji o pacjentach nerwicowych i ich leczeniu. *Psychoter*. 1981; 37: 3–10.
51. Sobański JA, Klasa K, Rutkowski K, Dembińska E, Müldner-Nieckowski Ł. Kwalifikacja do intensywnej psychoterapii w dziennym oddziale leczenia nerwic. *Psychiatria i Psychoterapia* 2011, Tom 7, Nr 4: s.20-34
http://www.psychiatriapsychoterapia.pl/?a=articles_show&id=1224
52. Jodko A, Głowacz J, Kokoszka A. Zgłaszanie zaburzeń funkcji seksualnych jako objawu podczas terapii zaburzeń lękowych. *Seksuol. Pol.* 2008; 6, 1: 26–32.
53. Lew-Starowicz Z, Krajka K, Darewicz B, Ciesielska B, Robacha A. et als. Zdrowie seksualne – trudny problem dla lekarzy. *Seksuol. Pol.* 2004; 2, 2: 33–38.
54. Sobański JA, Müldner-Nieckowski Ł, Klasa K, Rutkowski K, Dembińska E. Objawy i problemy związane z seksualnością pacjentów dziennego oddziału leczenia zaburzeń nerwicowych. *Psych. Pol.* 2012, 46, 1: 21–34
55. Feldhaus-Dahir M. Female sexual dysfunction: barriers to treatment. *Urol. Nurs.* 2009; 29, 2: 81–8.
56. Sobański JA. Zmiany objawów zaburzeń nerwicowych podczas intensywnej psychoterapii na oddziale dziennym i ich związek z wynikami leczenia. *Przegląd piśmiennictwa. Psychoter*. 2004; 3, 130: 81-90.