Personality disorders and insecure attachment among adolescents

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Chapter 4: **Therapeutic relationship and dropout in high risk adolescents intensive group psychotherapeutic programme**

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Abstract

Background: Dropout rates in youth psychotherapy are high. An important determinant of dropout is the quality of the therapeutic relationship. This study evaluated the association between the therapeutic relationship and dropout in an intensive MBT treatment for adolescents with personality disorders.

Method: Patients (N=105) included were dropouts or completers of intensive MBT treatment. The therapeutic relationship was measured with the Child version of the Session Rating Scale (C-SRS) that was completed after each group therapy session by the patient. For each patient, the treatment termination status (dropout or completer) was indicated by the treatment staff. The reliable change index (RCI) was calculated for the C-SRS to determine significant changes in the therapeutic relationship.

Results: Both groups started with similar scores on the C-SRS, while at the end of the treatment period the scores differed significantly between dropouts and completers. On average, the scores of completers increased from the start to the end of therapy while the scores of dropouts decreased during therapy, although dropout could not be predicted based on the C-SRS scores. During the last two sessions however a significant decrease (RCI) in C-SRS scores occurred more often for dropouts.

Conclusions: Our findings show that the patient's judgement of the quality of the therapeutic relationship should be monitored continuously, and decreases discussed with the patient and the group with the aim to prevent dropout.

Introduction

Dropout of child and adolescent therapy is a common phenomenon (De Haan, Boon, De Jong, Hoeve, & Vermeiren, 2013; Hauber, Boon, & Vermeiren, 2017; Owen, Miller, Seidel, & Chow, 2016a). When youngsters drop out of psychiatric treatment, their disorders might persist or even worsen later in life. For instance, children with untreated disorders are likely to grow up as adults who rely on mental health services, which has negative consequences for themselves, their surroundings and society (Dulmus & Wodarski, 1996; Kessler, Chiu, Demler, & Walters, 2005; Reis & Brown, 1999). Therefore premature termination of therapy is considered a serious problem (Armbruster & Kazdin, 1994; Gopalan et al., 2010; Midgley & Navridi, 2006). In adolescent mental health care dropout percentages of 38.4% for outpatients (De Haan, Boon, De Jong, Hoeve, & Vermeiren, 2015) and 34.4% for inpatients (De Boer, Boon, De Haan, & Vermeiren, 2016) were found. A determinant for dropout is the quality of the therapeutic (patient-therapist) relationship (De Haan et al., 2013; Garcia & Weisz, 2002; Hawley & Weisz, 2005; Kazdin & Wassell, 1998; Owen et al., 2016a; Stevens, Kelleher, Ward-Estes, & Hayes, 2006). Therapeutic relationship or therapeutic alliance has commonly been defined as the agreement between the therapist and client on the goals for treatment as well as the ways to reach those goals and the emotional or relational bond between the client and therapist (Bordin, 1979). Although several studies have been conducted on the relation between the therapeutic relationship and dropout, it is hard to compare these studies because the time at which the therapeutic relationship was measured varies considerably (Cordaro, Tubman, Wagner, & Morris, 2012; Robbins et al., 2006; Robbins, Turner, Alexander, & Perez, 2003; Shelef, Diamond, Diamond, & Liddle, 2005). In several studies trained observers rated the therapeutic alliance at one or two therapy sessions during the course of therapy, but this approach does not take the patients' opinion about the relationship into account. Other studies measured the relationship after therapy has ended, although this will be strongly influenced by the way patients feel at that termination point. In a review on the therapeutic relationship within youth therapy, it is advised to measure the therapeutic relationship during several sessions of the therapy process (Zack, Castonguay, & Boswell, 2007). If adolescents perceive the therapeutic relationship as supportive and agree with the topics and goals of the sessions this will facilitate their engagement (Karver, Handelsman, Fields, & Bickman, 2006). Until now however adolescent patients are hardly used as an informants about the therapeutic alliance (De Haan et al., 2013). In adult therapy a moderately strong relationship between psychotherapy dropout and therapeutic alliance is found (Sharf, Primavera, & Diener, 2010).

Studies on the relationship between the therapeutic alliance and dropout in youth therapy have been hindered by two topics: first, the method in which the therapeutic relationship was measured and second, the definition of dropout. First, most available measures for the therapeutic relationship in child and adolescent therapy are parent report measures. The therapeutic Alliance Scale for Children

and Adolescents (TASC/A) is an exception and was designed to be administered to children and adolescents themselves (DeVet, Kim, Charlot-Swilley, & Ireys, 2003; Kazdin, Marciano, & Whitley, 2005; Shirk & Saiz, 1992). The TASC/A was however designed to be administered at only one or two sessions during therapy. The only available child-report instrument that measures the therapeutic relationship during all sessions, is the Child version of the Session Rating Scale (C-SRS) (B. Duncan, Sparks, Miller, Bohanske, & Claud, 2006; B. L. Duncan et al., 2003; Miller & Duncan, 2004). This instrument is designed to be used at the end of every therapy session and the child version of this tool makes it possible to assess the child's or adolescent's self-reported relationship with the therapist. Although designed for individual therapy, the instrument can also be used for group therapy. Second, there is also no agreement in the way dropout is defined. The definition varies across studies, and influences which dropout predictors were found per study (De Haan, Boon, De Jong, Geluk, & Vermeiren, 2014; De Haan et al., 2013; Warnick, Gonzalez, Weersing, Scahill, & Woolston, 2012; Zack et al., 2007). In our study therapy dropout had been defined as occurring when a participant discontinued the treatment program before completing the treatment protocol. So only participants completing the treatment program as planned, were considered completers.

The aim of our study was to extend and specify insights on the association between the therapeutic relationship and dropout during adolescent group psychotherapy. In accordance with Zack et al. (2007), we measured the therapeutic alliance of each psychotherapy session with the authorized Dutch version of Child-Session Rating Scale (C-SRS) (B. Duncan et al., 2006; Hafkenscheid et al., 2006). Studies evaluating the (C-)SRS have confirmed the psychometric quality and usability of the instrument, and showed an association between the therapeutic relationship and therapeutic change or outcome (Boon, De Boer, & Ravestijn, 2012; Campbell & Hemsley, 2009; B. L. Duncan et al., 2003; Owen, Miller, Seidel, & Chow, 2016b; Sundet, 2012). The association between the C-SRS and dropout has been studied in a sample of ethnic minority youth (De Haan, Boon, De Jong, et al., 2014). It was also shown that the scores on the C-SRS were not influenced by whether the patient knew that the scores would or would not be observed by the therapist, or whether the questionnaires were completed in presence of the therapist, nor were the (C-)SRS scores significantly correlated with a measure of social desirability (Reese et al., 2013).

Method

Setting

The studied facility, a department of De Jutters-Youz, a YMHC centre in The Hague (one of the three main cities of the Netherlands), offers a five days a week structured and integrative

psychodynamic group psychotherapy programme. This treatment commonly starts as residential treatment and transitions into a day treatment halfway through. It is a mentalization based treatment (MBT) programme, manualized and adapted for adolescents (Bateman & Fonagy, 2006, 2012; Hauber, 2010) facilitated by a multidisciplinary team trained in MBT. The programme differs from the MBT programme for adolescents in England (Rossouw & Fonagy, 2012) in the psychodynamic group psychotherapy approach with an optimal group therapy size of 6 members instead of 8. The different therapies main focus is on the adolescents' subjective experience of himself or herself and others, and on the relationships with the group members and the treatment staff. Next to weekly group psychotherapy, other (non-verbal) group therapies as well as individual- and family psychotherapy are offered. In case medication is needed in addition to the treatment, this is prescribed by a psychiatrist of the treatment according to protocol.

Participants

The participants were a sample of 105 patients with clinically diagnosed personality disorders admitted between 2013 and 2018. Upon arrival, patients and their parents were asked to sign a consent form to indicate that their data could be used anonymously for scientific research. Adolescents mean age at the start of treatment was 17.7 (*SD* = 1.7 range = 15-22), (females 81.0%). Average duration of treatment during this study was 215.2 days (*SD* = 100.8, range 21-640). Most of the patients (90.4%) were clinically diagnosed with a personality disorder often with comorbid axis- I disorders (mood disorder 48.5%, anxiety disorder including PTSS 57.3%, eating disorder 8.7%, ADHD 7.6 %, substance dependence 3.9 %, dissociative disorder 1.9% and ASD 4.8%). Of the 94 patients diagnosed with a personality disorder, 49 (52.1%) were diagnosed as Personality disorder NAO, 16 (17%) Borderline, 16 (17%) Avoidant, 2 (2.1) Dependent and 1 (1.1%) Antisocial. Intelligence estimated based on level of education was average to above average. Most patients 94.4% had a native Dutch background and the Dutch language was fluently spoken by all participants.

Measures

The Child-Session Rating Scale or C-SRS (Duncan et al., 2006; Miller & Duncan, 2004) is a four item visual analogue instrument. The version for adolescents differs from the adult version of the SRS because it uses emoticons: a smiley (positive) and a frowny face (negative). The C-SRS has been translated in Dutch by (Hafkenscheid et al., 2006). The Dutch C-SRS has already been used in Dutch research (Boon et al., 2012; De Haan, Boon, Vermeiren, & De Jong, 2014). The reliability (internal

consistency) of the Dutch version of the C-SRS was satisfactory (Cronbach's $\alpha = 0.86$) (Hafkenscheid, Duncan, & Miller, 2010). The therapeutic relationship is defined with three interacting elements: (1) a relational bond between the therapists, the group members and patient; (2) agreement on the goals of therapy; and (3) agreement on the tasks of therapy. In the C-SRS these theoretical ideas are represented by four 10-cm visual analogue scales with emoticons. Respondents are instructed to place a hash mark on a line. Negative responses are placed on the left (frowny faces) and positive responses indicated on the right (smileys). The first item is a relationship scale to rate the session on a continuum from "The therapists and group members did not listen to me" to "The therapists and group members listened to me." The second item is a goals and topics scale that rates the session on a continuum from "We did not do or talk about the things I wanted to work on or talk about" to "We did do or talk about what I wanted to work on or talk about." The third item is an approach or method scale asking the patient to rate the session on a continuum from "I did not like the way the therapists and group members approached my problems today" to "I liked the way the therapists and the group members approached my problems today." The fourth item asks how the patient perceived the session in total and the group alliance along the line from: "Overall, today's session was not right for me - I did not feel part of the group." to "Overall, today's session was right for me – I did feel part of the group." Because the scores on the four items (the 10 cm line represents scores between 0 and 10) are added, the session total score will vary between 0 and 40: High average total scores are an indication for a high quality of the therapeutic relationship.

Procedure

The C-SRS was presented to the patients at the end of each weekly group therapy session, after which it was collected and viewed by the therapist. Our purpose was to let the patients fill in the form during every therapy session. Although therapists sometimes forgot to hand out the C-SRS, in general the C-SRS was completed during most of the group therapy sessions. The first C-SRS was completed after the first therapy session. The C-SRS that was completed during the last session (planned in the case of completers and unplanned in the case of dropouts), was marked as the last C-SRS. It largely depended on the length of therapy how many C-SRS forms the patient finally completed.

Termination Status: Dropout and Completion of Therapy

In case premature termination was suggested by a patient, the patients family or the treatment staff, a supportive reassessment of treatment was organized. Only when both the therapist and the patient (and family) agreed that therapy goals had been reached, or when both agreed to terminate while therapy goals had only partly been reached, was the patient classified as a "completer." When both stated that therapy was not completed yet, or only the patient or only the therapist stated that therapy was not completed, the exact reasons for termination were examined. In these cases, the patient was classified as a "dropout" when the patient prematurely terminated therapy but the therapist did not agree on this termination (i.e., according to the therapist the therapy should have been continued). The intention was to classify the patients as "unilaterally terminated by the therapist" when the therapist wished to terminate therapy while the patient wished to continue. Among the included 70 patients, there were no cases of "unilaterally terminated by the therapist." Finally, 25 patients were classified as dropouts, and 45 patients were classified as completers.

Statistical analyses

All analyses were performed using the SPSS, version 25.0 (IBM, 2017). First, using a t-test dropouts and completers were compared on the C-SRS score of the first session and the last session. A mixed model analysis was performed with the C-SRS score as dependent variable and time and dropout as independent variables to see if dropout was related to C-SRS scores over time.

Second, the reliable change index (RCI) for the C-SRS was calculated using Jacobson and Truax formula (Jacobson & Truax, 1991), based on all questionnaires (N=2378) with a reliability (Cronbach's Alpha) = .921 and *SD* = 8.15, the standard error was 3.24. The reliable change criterion was (1.96 * 3.24) 6.35.

Third, a Generalized Estimating Equations analysis (GEE) with an exchangeable working correlation matrix was performed to see if a descent in C-SRS score could predict dropout with the dichotomous variable significant decrease (RCI) in the C-SRS score between two consecutive sessions as independent and dropout within three sessions as dependent variable.

In a fourth step percentages of significant decreases (using RCI) during the last five sessions of therapy were compared between dropouts and completers.

Results

Descriptives

The 105 subjects attended group psychotherapy between march 2013 and October 2018, with an average number of group members of 5.0. The number of C-SRSs completed per participant ranged from 2 to 43 times (M = 22.07, SD = 10.45). The number of missed sessions (M = 3.53, SD = 4.97) was calculated by subtracting the attended sessions (M = 25.6, SD = 12.7) from number of planned sessions (M = 26.3, SD = 12.7), based on which the percentage of missed sessions per respondent was calculated. This percentage did not differ (p =.72) between completers 2.78% (SD= 0.58) and dropouts 3.27 (SD = 1.51). Of the 2832 attended sessions, 2367 C-SRS were completed (response 83.6%).

Dropouts versus completers

The treatment duration of the dropouts (M = 125.56 days, SD = 99.1) was significantly (t = 7.497, p < 0.001) lower than that of the completers (M = 261.91 days, SD = 63.3). Dropouts (N = 36) completed the C-SRS on average 13.42 times (SD = 11.38), and completers (N = 69) completed it on average 26.58 (SD = 6.33) times. These numbers differed significantly (t = 7.629, p < 0.001).

Table 1. *Comparison first- and last session scores C-SRS completers and dropouts*

	N	SRS 1st session		SRS last session			
		M	*SD*	*M*	*SD*	*t*	*p*
Completers	69	27.30	6.67	32.34	6.41	4.84	.001
Dropout	36	26.47	7.45	23.83	9.69	1.44	.159
Total	105	27.01	6.92	29.42	8.66		

For completers the C-SRS scores of the first and the last session increased significantly, while the scores of the dropouts did not differ (Table 1). No significant difference was found (t = 0.583, p = 0.577) on the first C-SRS scores for dropouts versus completers. The scores of the last session however differed significantly (t = 4.756; p < .001, Cohen's d = 1.035) between both groups. Total C-SRS scores decreased by 0.86 points per session on average for the dropouts, while increasing by 0.18 points per session for the completers.

Table 2: *RCI between first- and last session scores C-SRS for completers and dropouts*

	Completers		Dropouts		Total	
	N	%	N	%	N	%
Significantly increased	28	40.6	9	25.0	37	35.2
No significant change	36	52.2	12	33.3	48	45.7
Significantly decreased	5	7.2	15	41.7	20	19.0

Mixed model analyses showed no differences (p =.665) in C-SRS scores over time between dropouts and completers, implicating that dropout cannot be predicted from the progression of C-SRS scores. A GEE-analysis did not reveal dropout to be a significant predictor of significant (RCI) decreases in C-SRS scores (p = .730). Therefore the next step was to identify the last five sessions of therapy and compare the differences in C-SRS scores between these sessions. No differences were found between completers and dropout in comparison of the fifth- and fourth-last session. Comparison of the third-last and the second-last session showed that 7.1% (n = 3) of the completers (N = 42) had a significant (RCI) decrease in C-SRS score between these sessions, while for drop-out (N = 17) this was 35.3% (n = 6) (df = 1, $\chi 2$ = 7.419, p = .006). Subsequently, a comparison of the C-SRS score of the second-last and the last session showed that 4.0% (n = 2) of the completers (N = 50) had a significant (RCI) decrease in C-SRS score between these sessions, while for drop-out (N = 30) this was 26.7% (n = 8) (df = 1, $\chi 2$ = 8.808, p = .003) (table 2). During the last three sessions 7.2% (n = 5) of the completers showed a significant decrease in C-SRS scores, compared to 38.9% (n =14) of the dropouts (df = 1, $\chi 2$ = 15.98, p < .001). The differences between sessions for all respondents for all sessions (N = 1906) showed that 324 times (14.3%) a significant decrease (RCI) in C-SRS scores occurred.

Discussion

The aim of our study was to gain deeper insights on the association between the quality of the therapeutic relationship and treatment termination status among high risk adolescents receiving intensive MBT. We measured the therapeutic relationship during group therapy with the C-SRS, with which the adolescent rated the therapeutic group alliance. No differences were found in the initial scores of the C-SRS, indicating that dropouts and completers did not differ in the way they experience the therapeutic alliance at the start of therapy. The development of C-SRS scores during the course of therapy however, was different for the two groups: completers showed improving scores of the therapeutic relationship during the course of therapy, while dropouts showed declining scores during the course of therapy. These differences however occurred mainly at the end of the treatment course.

These results indicate that an improving therapeutic relationship during the course of therapy is associated with adherence to therapy, while a decreasing quality of the therapeutic relationship during the course of therapy is associated with the patient ending therapy prematurely. Our study showed that the rather short instrument (C-SRS), which can be easily applied in clinical practice and which is completed by adolescent patients themselves, is a valuable instrument for measuring the quality of the therapeutic relationship.

A significant decrease in the therapeutic alliance in the last three sessions was a predictor of dropout. For dropouts such a decrease occurred in 38.9% of the cases, for completers the was 7.2%. Because such a significant decrease in therapeutic group alliance occurred during the treatment process in 14.3% of all cases, only with hindsight it was clear that such decrease has led to dropout. To prevent dropout out of therapy this means that every substantial decrease in C-SRS score is worthwhile discussing. In this study, some participants spoke of being satisfied with the session, while on the C-SRS they rated the therapeutic alliance of that same session as low. By using the C-SRS, such unspoken inconsistency can be recognized, understood and worked through in the next session and thereby outcomes can be improved (Norcross & Lambert, 2018). In case the drop has to do with something that occurred in the working alliance with the therapists and/ or the group members, differences in perspective and thoughts, beliefs, wishes and feelings can be explored and validated (Bateman & Fonagy, 2012). In this way group psychotherapy is a shared attentional process which strengthens mentalizing capacities and interpersonal functioning.

Limitations of this study must be mentioned. First limitation is that it is not clear if these results found in a sample of high risk adolescents can be generalized to group psychotherapy with other patients with personality pathology and patients with other pathology. Second limitations is that Axis-I disorders were left out due to the practical consideration of not overloading patients with assessment instruments. Nevertheless, the C-SRS can help psychotherapists to timely intervene when breaks occur in the therapeutic alliance with adolescents with personality pathology that may lead to dropout.

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