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CHAPTER 8

Therapeutic relationship and dropout in youth mental health care with ethnic minority children and adolescents

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Abstract

Background Dropout in youth psychotherapy is high, especially for ethnic minority patients. An important determinant of dropout is the quality of the therapeutic relationship. This study evaluated the association between the therapeutic relationship and dropout in therapy with ethnic minority youth.

Method Our study was done in a community youth mental health care institution. 70 patients were included who were dropouts or completers of psychotherapy. The therapeutic relationship was measured with an instrument (C-SRS) that was completed each session by the patient. For each patient the treatment termination status (dropout or completer) was indicated. A General Estimation Equation (GEE) was conducted to indicate whether the course of total C-SRS scores during therapy differed for dropouts and completers.

Results The course of the scores differed significantly between dropouts and completers. Both groups started with similar scores, but on average the scores of dropouts decreased during therapy, while the scores of completers increased.

Conclusions Our results indicate that if there is a drop in the rated quality of the therapeutic relationship (i.e., monitor the difference between the present C-SRS score with the previous scores), the therapist should communicate this with the patient. This could lead to an improvement of the therapeutic relationship and a decrease in dropout.

Keywords: dropout; ethnic minorities; therapeutic relationship; youth mental health care.

Introduction

Premature termination or dropout of child and adolescent therapy is very common, with rates of 16% up to 69%, and is therefore generally recognized as a serious problem (Armbruster & Kazdin, 1994; Gopalan et al., 2010; Midgley & Navridi, 2006). In studies that compared dropout rates between ethnic groups, ethnic minority youth had even higher dropout rates than their ethnic majority peers (Kazdin, Holland, & Crowley, 1997; Kendall & Sugarman, 1997; Lamb, Anfield, & Sheeran, 2002; Miller, Southam-Gerow, & Allin Jr., 2008). More knowledge about determinants of dropout in child mental health care is relevant because it can result in more effective care (Dulmus & Wodarski, 1996; J. E. Wells et al., 2013). One of the more important determinants of dropout is the quality of the therapeutic relationship between the child or parent and the therapist (De Haan et al., 2013a; Garcia & Weisz, 2002; Hawley & Weisz, 2005; Kazdin & Wassell, 1998; J. Stevens et al., 2006). Indeed, developing effective therapeutic relationships with young patients and their family members may facilitate engagement and lessen resistance to treatment by providing a stable, accepting and supportive context within which therapy may take place (Karver et al., 2006), and there is evidence from a few studies that a negative or weak therapeutic relationship is predictive of therapy dropout (Zack et al., 2007).

There is much inconsistency in the definition of dropout being used across studies, and this might influence which dropout predictors were found per study (De Haan et al., 2013a; Warnick et al., 2012; Zack et al., 2007). It is therefore important for researchers to be aware of the impact of the chosen definition. For instance, when parents think that the child's treatment goals are reached and therapist disagrees, it is uncertain whether these patients should be counted as dropouts or completers. Therefore both the opinion of the therapist, as well as that of the parent and adolescent patient should be used to define dropout (De Haan et al., 2013a). A further problem in comparing studies on the therapeutic relationship and dropout, is that the time at which the therapeutic relationship was measured varies considerably. In some studies the quality of the relationship was measured retrospectively by the parents completing a questionnaire at the end of therapy (J. Stevens et al., 2006). In other studies, both the parent and the child were administered a questionnaire at the end of therapy (Hawley & Weisz, 2005). In most studies however, trained observers rated the therapeutic alliance at one or two therapy sessions during the course of therapy (Cordaro et al., 2012; Robbins et al., 2006; Robbins, Turner, Alexander, & Perez, 2003; Shelef et al., 2005). All these methods have shortcomings. Measuring the relationship by observers is a rather limited approach as it does not take the

patients' opinion about the relationship directly into account, and it depends on the observer how the relationship is rated. Measuring the relationship after therapy has ended, can give biased information as it might be influenced by the way patients and parents feel at that termination point. In addition, parents can hold a different view at the therapeutic relationship than the child. In their review on the therapeutic relationship within youth therapy, Zack et al. (2007) therefore stated that it is better to measure the therapeutic relationship during several sessions of the therapy process, instead of at the end of therapy or during only one or two sessions.

Most available therapeutic relationship measures for child therapy are parent-report measures. An exception is the Therapeutic Alliance Scale for Children and Adolescents (TASC/A), which was specifically designed for use with children and adolescents (DeVet, Kim, Charlot-Swilley, & Ireys, 2003; Kazdin, Marciano, & Whitley, 2005; Shirk & Saiz, 1992). This scale however, was designed to be administered at only one or two sessions during therapy. The only available child-report instrument that can measure the therapeutic relationship during all sessions, is the Child version of the Session Rating Scale (B.L.; Duncan et al., 2003; S. D. Miller & Duncan, 2004). This instrument is a specific clinical tool for day-to-day use. In addition, the child version of this tool makes it possible to assess the child's self-reported relationship with the therapist.

Most of the described studies in the review of Zack et al. (2007) were conducted in randomized control trials (RCT's). The information obtained in these studies is very relevant, but some groups of patients (especially minority patients) were hardly included or even excluded from this research because of the strict inclusion criteria that are used for selecting patients in RCT's (Flicker et al., 2008; Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006; Pereira et al., 2006). Because many authors have described the importance of ethnic and cultural background in psychotherapy with ethnic minorities (Leach & Aten, 2010; Pedersen, Draguns, Lonner, & Trimble, 2008), and several studies showed higher dropout rates among ethnic minority groups, it is important to study the association between the therapeutic relationship and dropout for ethnic minority patients.

Due to the above mentioned reasons, the aim of our study was to extend and specify insights on the association between the therapeutic relationship and dropout in psychotherapy with ethnic minority children and adolescents. In accordance with Zack et al. (2007), we measured the therapeutic alliance during several sessions of psychotherapy with the Child

version of the Session Rating Scale (C-SRS) (B.L.; Duncan, Sparks, Miller, Bohanske, & Claud, 2006). The few studies evaluating the (C-)SRS have confirmed the psychometric quality and usability of the instrument, or showed that there was an association between the therapeutic relationship and therapeutic chance or outcome (i.e., whether the problems and complaints of a patient would decrease or incline) (Campbell & Hemsley, 2009; B.L.; Duncan et al., 2003; Sundet, 2012). Until now, the association between the (C-)SRS and dropout has not been studied though. 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). The practical goal of our study was to analyse whether the development in the therapeutic relationship, as measured by the C-SRS, is different for dropouts and completers. Our study was done in a community based youth mental health care institution in a big city in the Netherlands.

Method

Participants

I-psy - de jutters is the intercultural specific department of Stichting De Jutters, a YMHC centre in The Hague (one of the three main cities of The Netherlands). Our study included 70 patients that were treated at this YMHC centre in 2008 and 2009. 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.

The age of the patients was 6-20 years ($M = 13$, $Sd = 3.5$). 27 patients (38.6%) were boys, and 43 patients (61.4%) were girls. 12 patients were diagnosed with a mood disorder (17.1%), 12 patients with parent-child relational problems (17.1%), 11 patients with an adjustment disorder (15.7%), 5 patients with an anxiety disorder 7.1%, 4 patients with a conduct disorder (5.7%), 3 patients with a hyperactivity disorder (4.3%), and 23 patients with other disorders (32.9%). The diagnoses were further grouped into four diagnostic groups, i.e. internalizing problems (mood disorders, anxiety disorders) (24.3%), externalizing problems (conduct disorders, hyperactivity disorders, adjustment disorders) (25.7%), parent-child relational problems (17.1%), and other disorders (32.9%).

The ethnic background of the patients and the therapists was specified as follows: if the country of birth of both parents was the Netherlands (regardless of the country of birth of the child), the

child was seen as native Dutch. If one or both parents born abroad, the child was seen as an ethnic minority. All the 70 included patients in our study were of an ethnic minority background: 22 were Turkish, 15 were Surinamese, 16 were African, and 17 were from other countries (i.e., India, Pakistan, Iraq, Iran, Afghanistan, China, Bulgaria, Aruba).

The three therapists (all female, aged 27-32) had an Iraqi, a Turkish and a Surinamese background. 20 patients were treated by the Iraqi therapist, 28 patients were treated by the Turkish therapist, and 22 patients were treated by the Surinamese therapist. The three therapists had similar years of experience, i.e., the Iraqi and the Turkish therapist had been working for five years as a psychologist, while the Surinamese therapist had been working for three years as a psychologist.

Measures

The Child Session Rating Scale (C-SRS) (B.L.; Duncan et al., 2006; S. D. Miller & Duncan, 2004) is a four-item visual analogue instrument with emoticons (smiley and frowny faces) and child friendly language to aid the child's understanding. The version for adolescents uses a plus (+) and a minus (–) sign (in concurrence with the adult version of the SRS) in stead of the emoticons. The C-SRS has been translated in Dutch by Hafkenscheid et al. (2006). The scale is suitable for youth of various ethnic origins, because of the universality of the emoticons. The Dutch C-SRS has already been used in research in the Netherlands (Boon, De Boer, & Ravestijn, 2012). The reliability (internal consistency) of the Dutch version of the C-SRS was satisfactory (Cronbach's $\alpha = .86$).

In the C-SRS, the therapeutic relationship is defined with three interacting elements: (a) a relational bond between the therapist and patient; (b) agreement on the goals of therapy; and (c) agreement on the tasks of therapy. The C-SRS translates these theoretical ideas into four 10-cm visual analogue scales, with instructions to place a hash mark on a line with negative responses depicted on the left (frowny face or - sign) and positive responses indicated on the right (smiley face or + sign). First, a relationship scale rates the session on a continuum from "The therapist did not listen to me" to "The therapist listened to me". Second 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 do or talk about" to "We did do or talk about what I wanted to do or talk about". Third is an approach or method scale requiring the patient to rate the session on a continuum from "I did not like what we did today" to "I liked what we did today". Finally, and reiterating,

the fourth scale looks at how the patient perceives the session in total along the continuum: “Overall, today’s session was not right for me” to “Overall, today’s session was right for me”.

For each session, the total score can be somewhere between 0 and 40: the individual scores on each of the four items (the 10 cm line represents scores between 0 and 10) are added up. High average total scores or an increasing line in the total scores, is an indication for a high quality or an improving quality of the therapeutic relationship.

Procedure

The C-SRS was presented to the patient at the end of each therapy session, with the remark that the child could fill in the questionnaire and drop it in a closed box so the therapist would not be able to see what the child answered. With this method, the likelihood of the child giving socially desirable answers was decreased. 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 and the forms were not always returned, in general the C-SRS was completed during most of the therapy sessions.

The first C-SRS was completed during the first therapy session. The C-SRS that was completed during the session that appeared to be the last one (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

After therapy had ended, both the therapist and the patient (or in the case of children under the age of 12, the parents) were asked why the therapy had ended. Only when both the therapist and the patient 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 Statistical Package for the Social Sciences, version 20.0 (SPSS, 2012). Our study consisted of longitudinal repeated measurements (the scores on the C-SRS forms) within the same subjects, therefore a General Estimation Equation (GEE) was conducted to indicate whether the course of total C-SRS scores during therapy differed for dropouts and completers.

First, a t-test was conducted to analyse whether the first C-SRS score differed significantly between dropouts and completers. The purpose was to indicate whether dropouts and completers were, at the start of therapy, similar groups with respect to their rated quality of the therapeutic relationship. Then, separate univariate GEE analyses were carried out to analyse the relationship between several child and therapy variables and the total C-SRS scores. This way it was analysed which of these variables were possible covariates in the association between the C-SRS scores and the treatment termination status. The child and therapy variables were age, gender, child ethnicity (i.e., four dummy variables were created for the four main ethnic groups: Turkish, Surinamese, African, and other), therapist (i.e., three dummy variables were created for the three different therapists), therapy length (both total number of sessions as total number of weeks in therapy were taken into account), and the diagnosis (i.e., four dummy variables were created for the four main groups of diagnoses: Internalizing problems, Externalizing problems, Relational problems between parent and child, and other problems).

Last, a multivariate GEE analysis was conducted to analyse the association between the course of total C-SRS scores and the treatment termination status. Dependent on the length of therapy and the total number of sessions, the patients differed in how many C-SRS forms they completed. They also differed in the time that passed between completing two subsequent C-SRS forms, i.e., some patients came to therapy every week and thus completed a form every week, while other patients came once a month or on an irregular basis. Therefore a variable 'Time' was created. For each patient, the value of this time variable was zero at the first session. Next, the value of the time variable represented the number of weeks between this first session and every subsequent session until the last session. The variable 'Time' was thus an indication for the duration of therapy in weeks. In the multivariate GEE, the variable 'Treatment

Termination' (dropout = 1 and completion = 0), the variable 'Time', and an interaction variable 'Time x Treatment Termination' were taken as independent variables, with the 'total C-SRS score per session' as the dependent variable. The variables that had a significant association with the C-SRS scores according to the univariate GEE analyses, were taken as covariates in the multivariate GEE analysis.

Results

Descriptives

All seventy patients completed the C-SRS at least three times ($M = 8$, $Sd = 4.9$). The maximum of completed C-SRS forms was 26 times: 97% of the patients completed the C-SRS 3 to 17 times, two patients completed it 21 or 26 times. Dropouts ($N = 25$) completed the C-SRS on average 7,16 times and completers ($N = 45$) completed it on average 8,49 times ($t(67.59) = 1.253$, $p = .214$). Dropouts had on average 7,32 therapy sessions and completers had on average 8,71 therapy sessions ($t(67.49) = 1.258$, $p = .213$). Dropouts stayed in therapy for on average 23,24 weeks, and completers for 28,69 weeks ($t(67.39) = 1.534$, $p = .130$). No significant difference was found ($t(68) = -0.39$, $p = .37$) between the first C-SRS scores for dropouts ($M = 33.4$, $Sd = 5.9$) and completers ($M = 33.9$, $Sd = 5.6$). Both groups thus started with similar scores on the quality of the therapeutic relationship.

Univariate General Estimation Equation analyses

Only total number of weeks (Wald $\chi^2(1) = 4.735$, $p = .030$), being treated by the Surinamese therapist (Wald $\chi^2(1) = 4.695$, $p = .030$), and being diagnosed with 'parent-child relational problems' (Wald $\chi^2(1) = 11.318$, $p = .001$) had a significant association with the C-SRS scores. These three variables were thus taken as covariates in the multivariate GEE analysis.

Multivariate General Estimation Equation analysis

The Wald χ^2 test indicated that, when corrected for the covariates, the interaction variable 'Time x Treatment termination status' was significant (Wald $\chi^2(1) = 4.009$, $p = .045$). The association between time and the course of the total C-SRS scores per session thus differed significantly between dropouts and completers. Total C-SRS scores decreased by .06 points per week on average for dropouts, but increased by the same amount per week for the completers.

Table 1: Multivariate GEE analysis

	Wald chi ²	df	β	SE
(Intercept)	360.980**	1	33.825	1.7803
Time x Treatment termination status	4.009*	1	.115	.0574
Time	-1.123	1	-.055	.0521
Treatment termination status	.004	1	-.109	1.6726
Surinamese therapist	1.004	1	1.611	1.6076
Diagnosed with parent-child relational problems	7.719**	1	-2.664	.9556
Total number of weeks	.767	1	.030	.0342

** $p < .01$; * $p < .05$

The Wald χ^2 of the variable 'parent-child relational problems' was also significant, which indicated that the diagnosis of the patient had a significant association with the total C-SRS scores, even when several other variables were taken into account. Indeed, patients diagnosed with parent-child relational problems had on average significant higher C-SRS scores than the ones with other diagnoses ($t(68) = 2.589$, $p = .012$). There was no significant difference in treatment termination status between patients with and without this specific diagnosis though ($\chi^2(1) = .090$, $p = .764$).

Discussion

The aim of our study was to extend the knowledge on the association between the quality of the therapeutic relationship and treatment termination status with ethnic minority children and adolescents in community institutions. We measured the therapeutic relationship during psychotherapy with the child version of the Session Rating Scale (C-SRS), enabling the child to rate the therapeutic relationship with its therapist. To our knowledge this is the first study using the C-SRS to analyse the association between the quality of the therapeutic relationship and dropout with youth.

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 relationship 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 results indicate that an improving therapeutic relationship during the course of therapy is associated with patients completing therapy, while a decreasing quality of the therapeutic relationship during the course of therapy is associated with the patient dropping out. As stated in the introduction, most former studies on the quality of the therapeutic relationship focused on the association between this relationship and the outcome of therapy (i.e., whether there is an increase or decrease in psychiatric problems). The few studies that focused on the association between the quality of the therapeutic relationship and the completion or dropout of therapy indeed also found that this association was present. These former studies were mostly studies on substance abusing adolescents though, and the quality of the therapeutic relationship was often measured in retrospect at the end of therapy, or by trained observers that rated the therapeutic alliance at one or two therapy sessions during the course of therapy. For the second approach, a research setting is needed, it is therefore not useful in clinical practice. Our study showed that a rather short instrument, which can be easily applied in clinical practice and which is completed by the child or adolescent patient, can be a very valuable tool to measure the quality of the therapeutic relationship.

Several other findings are worth discussing here. For instance, the total number of therapy sessions and the total number of weeks in therapy did not differ significantly between dropouts and completers. This finding might indicate an alternative explanation for the association between the course of C-SRS scores and treatment termination status. Indeed, after an average of seven to nine sessions had been completed, the therapist judged that for some patients the therapy had been fulfilled. Apparently, according to the therapists, the patients that became completers needed less therapy than the patients that became dropouts. This might indicate that the problems of the dropout group are more serious and more difficult to treat than the problems of the completer group. It might be easier to increase the quality of the therapeutic relationship with the patients that become completers, because for these patients improvement of psychiatric problems is reached earlier than for the dropout patients. The completer patients might therefore be more satisfied with the treatment and the therapist, which leads to increasing scores on the C-SRS forms. This indicates that not the quality of the therapeutic relationship itself leads to completion or dropping out of therapy, but that this association is influenced by the seriousness of the problem of the patient. Indeed, we also found that the diagnosis had a significant association with total C-SRS scores, i.e., patients that were diagnosed with child-parent relational problems had a higher average C-SRS score than the other patients.

According to the Diagnostic and Statistical Manual of Mental Disorders IV-TR (American Psychiatric Association, 2000), parent-child relational problems are less serious than the other categories of diagnoses in our study. We did not find an association between being or not being diagnosed with this specific diagnosis and treatment termination status. We therefore conclude that the course of total C-SRS scores during therapy, and thus the course of the quality of the therapeutic relationship, is an important indicator to monitor which patients might drop out of therapy.

There are thus some important implications for practical use. Our results indicate that if there is a drop in the rated quality of the therapeutic relationship (i.e., monitor the difference between the present C-SRS score with the previous scores), the therapist should communicate this with the patient (i.e., give feedback) and it might even be considered to arrange switching therapists. This method is called the Client Directed Outcome Informed (CDOI) method (B.L.; Duncan, Miller, & Sparks, 2004; S. D. Miller et al., 2006). In our study, the instrument was used for research purposes and no feedback to the patient was given during therapy. Based on our results, the next step is to use the instrument in combination with the CDOI method. It is probable that giving feedback to the patient about the course of the therapeutic relationship will lead to an improvement in this relationship, and will then lead to a decrease in dropout and an increase in completion of therapy. The therapist might present the graphics of the declining or improving scores during therapy and discuss possible hurdles and ways to improve the quality of the relationship with the patient. It is likely that this can help to prevent dropout, thus increasing the effectiveness of therapy. Possibly, a phone call by the therapist after a 'bad session' can make the difference between a successful therapy and one that is terminated prematurely.

Our study has several limitations. Our sample was rather small and we did not use the C-SRS consistently in each session. We therefore invite other researchers to study the C-SRS in clinical practice in the hope that our results will be replicated and the value of the instrument can be affirmed. The fact that our sample was rather small also inhibited us to study the association between the four separate items of the C-SRS and treatment termination status. We suggest that this should be done in future research, as it could be that different aspects of the quality of the therapeutic relationship relate differently with treatment termination status. Another shortcoming is that we did not analyse the parent-therapist relationship. Some former studies found that only parent-therapist relationship was predictive for dropout and not child-

therapist relationship (Hawley & Weisz, 2005). It might therefore be best to have both the parent and the youth patient as the respondents (Zack et al., 2007) in order to get both the child's or adolescent's and the parent's perspective on the quality of the therapeutic relationship. Similarly, it would have been informative to include therapist reports of the quality of the therapeutic relationship as well. We recommend that this should be done in future studies. Unfortunately, as far as we know there is no instrument available that can measure the therapist's perspective on the quality of the therapeutic relationship during all sessions. The best available alternatives are the therapist version of the Therapeutic Alliance Scale for Children and Adolescents (TASC/A) (Shirk & Saiz, 1992), or the therapist version of the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989). A third limitation is that it is unclear whether these results found in a sample consisting of immigrant patients can be generalized to therapy with majority patients. While most studies in the field are performed with ethnic majority populations and it is assumed that the results are valid for ethnic minority populations too, the limitation of our study is the other way around. Indeed, in the study of Reese et al. (2013), mostly ethnic majority patients were included and it was thus stated that the SRS should be studied with racial/ethnic minority patients. This study focused on adult patients though. We therefore recommend research on the association between dropout and the quality of the therapeutic relationship in samples consisting of both ethnic majority and minority children and adolescents, so the results between the various ethnic groups can be compared.

Nevertheless, we hope that the C-SRS can help therapists to timely intervene when the therapeutic relationship may go astray, which is all the more important in the challenging context of therapy with ethnic minority youth. Similar to Reese et al. (2013), we conclude that the (C-)SRS can be a very useful measure for evaluating the therapeutic relationship, and that the course of total C-SRS scores during therapy (and thus the course of the quality of the therapeutic relationship) is an important indicator to monitor which patients might drop out of therapy.

