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ScienceDirect

Comprehensive Psychiatry 80 (2018) 14–23

COMPREHENSIVE PSYCHIATRY

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Premature psychotherapy termination in an outpatient treatment program for personality disorders: a survival analysis

Dominick Gamache[a,b,*], Claudia Savard[b,c], Sophie Lemelin[d], Alexandre Côté[a], Evens Villeneuve[b,e]

[a]Université du Québec à Trois-Rivières, Département de psychologie, C.P. 500, Trois-Rivières, QC, Canada
[b]CERVO Research Center, 2601 Chemin de la Canardière, Quebec City, QC, Canada
[c]Université Laval, Faculté des Sciences de l'éducation, 2325 rue des Bibliothèques, Quebec City, QC, Canada
[d]Clinique Focus, 3679, rue de l'Hêtrière, Local 120, Saint-Augustin-de-Desmaures, QC, Canada
[e]Institut universitaire en santé mentale de Québec, Centre de traitement le Faubourg Saint-Jean, 2601 Chemin de la Canardière, Quebec City, QC, Canada

Abstract

Objective: Psychological treatment for patients with personality disorders (PD) is plagued with a high proportion of early dropouts, and attempts to identify risk factors for attrition have generated very few conclusive results. The purpose of the present study is to identify significant predictors of early treatment termination in a long-term psychotherapy program for PD.
Methods: Data was retrospectively retrieved from 174 files of patients who began long-term psychotherapy in an outpatient treatment program in Quebec City, Canada. Socio-demographic, initial disturbance, and diagnostic variables were considered for prediction, along with a measure specifically designed to identify PD patients at risk of dropping out early from psychotherapy, the Treatment Attrition-Retention Scale for Personality Disorders (TARS-PD). Survival analysis using Cox proportional hazard regression was performed to identify significant predictors.
Results: Results using univariate Cox proportional hazards regressions revealed that unemployment, Global Assessment of Functioning scores, and recent hetero-aggressive behavior were significant predictors of early dropout in the first six months of therapy. Adjusting for these three confounders, four of the factor scores from the TARS-PD (Narcissism, Secondary gains, Low distress, and Cluster A features) were significantly associated with dropout in univariate Cox proportional hazards regressions. Secondary gains and Narcissism remained significant predictors after entering all five TARS-PD factors in a multivariate Cox proportional hazards regression adjusting for confounders.
Conclusions: Taking into consideration specific treatment prognosis variables, such as those measured by the TARS-PD, might be more useful for dropout prediction in PD patients in comparison with more general demographic and diagnostic variables.

1. Introduction

Personality disorders (PD) affect about 10–13% of the general population [1]. These conditions impact various aspects of daily and psychological functioning. PD diagnoses are notably associated with impaired social functioning and interpersonal conflicts [2–3]. Further, PDs are associated with increased risk for hospitalization [4], criminality [5], and suicidal behavior [6], which may ensue from severe affect dysregulation, poor impulse control, and/or confusion over one's own sense of identity. Even though forms of treatment specifically tailored to this population have been developed and validated over the past 20 years [7–12], there is still an important heterogeneity in patients with regard to their capacity to fully benefit from biopsychosocial treatments. One out of four patients will discontinue psychological treatment prematurely according to recent meta-analytic results [13]. Early dropout or early treatment discontinuation has been linked to various damaging consequences for patients, including poorer treatment outcomes in patients with borderline [14–19], antisocial [20–22], and narcissistic PD [23]. Treatment non-completion may also lead to greater societal costs. Borderline PD patients who dropped out from treatment were found to stay three times longer in hospitals than treatment completers [24]. In forensic settings, PD patients who dropped out from an impatient treatment program were more likely to reoffend in a five-year follow-up period in

* Corresponding author at: Université du Québec à Trois-Rivières, Département de psychologie, C.P. 500, Trois-Rivières, QC G9A 5H7, Canada.
E-mail address: dominick.gamache@uqtr.ca (D. Gamache).

http://dx.doi.org/10.1016/j.comppsych.2017.08.001
0010-440X/

comparison with completers [25]. A study conducted in a forensic setting in the United Kingdom revealed that patients who did not complete treatment in a medium security hospital PD unit incurred £52,000 (approximately $80,000 USD) more in costs to the National Health Service over a period of 10 years following admission [26]. Other potential consequences of treatment dropout include compromised service cost-efficiency, waste of limited and valuable clinical resources, diminished staff morale, denial of services to others patients in need, and disruption of therapy groups [27].

Systematic research on factors associated with dropout in PD patients has yielded up few conclusive and comprehensive results thus far [13,27]. Only a handful of variables, including younger age [28–31], complex PD presentations [15,24,32], high impulsivity [33–34], and poor therapeutic alliance [18,32,35–36], have been more consistently identified as predictors of attrition. Recently, however, a clinically-informed scale specifically tailored to assess a set of pre-treatment variables associated with early psychotherapy termination in PD patients, the Treatment Attrition-Retention Scale for Personality Disorders (TARS-PD) [37], has been developed and validated. An investigation of its psychometric properties has revealed promising results in terms of predictive validity for the global scale and its five factors (i.e., Narcissism, Antisociality, Secondary gains, Low distress, and Cluster A features). Despite these encouraging results, much work still needs to be done to understand early dropout from psychological treatment in PD patients; more studies to determine the best predictors, as well as the relationships between them, are in order.

Survival analysis has been shown to be a potent approach to prediction of early termination from day hospital [29] and long-term treatment [30,36] in PD patients. However, these studies have generally investigated large sets of disparate pre-treatment variables from multiple categories (e.g., socio-demographic, diagnostic, etc.), and have not focused on variables specifically chosen for treatment prognosis prediction. The purpose of the present study is to test the predictive power of different categories of pre-treatment variables, including variables from the TARS-PD which specifically target dropout prediction, to study early psychotherapy termination in a sample of PD patients after six months of a three-year outpatient treatment program. Cox proportional hazards regression models will be used. Four categories of predictive variables will be evaluated: socio-demographic, initial disturbance, diagnostic, and specific treatment prognosis variables (TARS-PD global score and factors). We hypothesize that very few variables from the first three categories will significantly predict treatment dropout, while specific treatment prognosis variables from the TARS-PD should be significant predictors.

2. Method

2.1. Participants

Files from 320 individuals (203 women, 117 men), who were consecutively assessed from September 2007 to December 2011 for admission at the Faubourg Saint-Jean Treatment Center, were reviewed. This outpatient clinic is linked to the Quebec Mental Health University Institute, a psychiatric hospital in Quebec City, Canada. All 320 patients were referred to the treatment center following a medical reference for an initial evaluation of suitability for inclusion in a three-year outpatient psychotherapy program. This treatment is integrative [38] and follows hierarchical treatment goals. The first six months focus on safety, containment, symptom reduction and management of impulsive behaviors; it includes psycho-educational group psychotherapy (e.g., on distress tolerance and interpersonal effectiveness skills) inspired by Linehan's Dialectical-Behavior Therapy (DBT) [39], and bimonthly individual therapy. After six months, treatment focus shifts to improving mentalizing skills and interpersonal functioning, and modifying core self- and other representations, with weekly individual 45- to 50-minute psychotherapy sessions, mostly inspired by evidence-based psychodynamic practice – i.e., Transference-focused psychotherapy [40] and Mentalization-based treatment [41] tactics and strategies. Inclusion criteria for the treatment program include age ≥18 years old, the presence of a moderate to severe personality disorder as main diagnosis, and the absence of severe antisocial personality features.

From these 320 patients, 174 (54.4%) began therapy at the treatment facility following assessment, while others (n = 146) who did not fit the treatment center's mandate (e.g., had no personality disorder, or had an Axis I disorder as primary diagnosis) were referred to a more appropriate treatment resource. Analyses in the present study will focus on the 174 patients who began psychotherapy. Institutional ethical guidelines for research using archival data were followed in the conduct of the present study.

2.2. Procedure and measures

As aforementioned, information was retrieved from assessment files included in a database of 320 patients consecutively referred to the Faubourg Saint-Jean Treatment Center for an initial intake evaluation of suitability for the psychotherapy treatment program. These evaluations were conducted by eight licensed clinical psychologists, with an experience with PD patients ranging from one to eleven years (M = 5.1, SD = 3.4), and by two supervised trainees who were graduate students in psychology. These intake evaluations generally last from 120 to 150 min, and are complemented by a thorough review of each patient's clinical files, which include notes and clinical reports from previous treatments and hospitalizations. Areas assessed during these interviews include:

(a) Socio-demographic information;
(b) Baseline evaluation of initial disturbance. Various areas of pre-treatment disturbance were assessed at intake, and were scored dichotomously (presence vs absence): recent self-injurious or suicidal behavior; recent suicidal ideation; recent hetero-aggressive or violent behavior; recent substance abuse problems;