Engagement Complications of Adolescents with Borderline Personality Disorder: Navigating Through a Zone of Turbulence

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Abstract

Background: Premature treatment discontinuation is a widespread phenomenon in child and adolescent mental health services that impacts treatment benefits and costs of care. Studies of specialized care for adolescents with BPD show that almost 40% of them do not complete treatment. Given that recurrence of suicidal behaviour is one of the main symptoms of BPD, and that the presence of past suicidal attempts is a strong predictor of subsequent attempts in young people, difficulties with treatment engagement in this population needs to be given special consideration. The aim of this study was to describe the process of treatment disengagement and identify warning signs that foreshadow dropouts of adolescents with BPD.

Methods: A constructivist grounded theory method was used. Thirty-three interviews with 3 groups of informants (adolescent, parent, clinician) were conducted to document 11 treatment trajectories.

Results: Disengagement is preceded by engagement complications, which may sometimes go unnoticed. These will unfold according to a three-step sequence starting with negative emotions associated with the appropriateness of treatment, the therapeutic relationship or the vicissitudes of treatment, followed by treatment interfering attitudes and openly disengaged behaviours. These engagement complications lead the way towards the development of a “zone of turbulence” which creates a vulnerable and unstable therapeutic process.

Conclusion: Engagement complications which arise during therapy illustrate how the initial engagement of adolescents with BPD and of their parents for treatment is neither static nor certain, but subject to fluctuating emotions and perceptions. This implies that engagement can never be taken for granted and must constantly be monitored during the therapeutic process. Maintaining the engagement of adolescents with BPD should be a therapeutic objective akin to reducing symptomatology or improving psychosocial functioning, and should therefore be given the same attention.

Introduction

Premature treatment discontinuation is a widespread phenomenon in child psychiatry that impacts treatment benefits and costs of services (Kazdin & Wassell, 2000). It is particularly prevalent amongst
adolescents with suicidal behaviour, as 40 to 70% fail to begin or complete recommended treatment (Burns, Cortell, & Wagner, 2008; Granboulan, Roudot-Thoraval, Lemerle, & Alvin, 2001). A growing body of evidence suggests that Borderline personality disorder (BPD) can be reliably diagnosed prior to 18 years of age (Kaess, Brunner, & Chanen, 2014) and that this disorder is common amongst among youths seeking help for suicidality (Chatagner, Olliac, Choquet, Botbol, & Raynaud, 2015; Greenfield et al., 2015; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Adolescents with BPD are heavy users of health care services and are notoriously difficult to engage in a treatment (Chanen, 2015; Loas et al., 2013). Indeed, studies of specialized care for adolescents with BPD show that almost 40% of them do not complete treatment (Chanen et al., 2008; Schuppert et al., 2009) compared to 11–20% of adolescents with depression or anxiety (Bailey, Hetrick, Rosenbaum, Purcell, & Parker, 2018; Puig & Encinas, 2012; Wergelanda et al., 2015). Given that recurrence of suicidal behaviour is one of the main symptoms of BPD (American Psychiatric Association, 2013), and that the presence of past suicidal attempts is a strong predictor of subsequent attempts in young people (Miranda, De Jaegere, Restifo, & Shaffer, 2014), difficulties with treatment engagement in this population needs to be given special consideration. Furthermore, amongst young people with mental illness, adolescents with BPD show the most severe psychosocial dysfunctions (Chanen, Jovev, & Jackson, 2007; Kaess et al., 2013). Consequently, those who end treatment prematurely do not receive the appropriate care they need despite being at high risk for both suicide and poor long-term psychosocial functioning.

Identifying the characteristics of young people at higher risk to dropout from treatment can be a useful way to prevent this phenomenon. However, although a large number of studies have examined potential predictors of dropouts in child and adolescent mental health services, no clear profile has emerged regarding the characteristics of non-completers (Abella & Manzano, 2000; de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013). A meta-analysis of 48 articles concludes that sociodemographic factors are poor predictors of treatment non-completion (de Haan et al., 2013). Additionally, no definite conclusions can be drawn on the impact of symptoms or diagnoses frequently associated with BPD, such as depression and anxiety (Baruch, Vrouva, & Fearon, 2009; Burns et al., 2008; Gonzalez,
Weersing, Warnick, Scahill, & Woolston, 2011; Granboulan et al., 2001; Johnson, Mellor, & Brann, 2008; Pellerin, Costa, Weems, & Dalton, 2010).

Substance abuse, and externalizing symptoms, also associated with BPD were, however, often associated with treatment dropout (Baruch et al., 2009; Burns et al., 2008; de Haan et al., 2013; Gonzalez et al., 2011; Johnson et al., 2008; Pagnin, de Queiroz, & Saggese, 2005; Pelkonen, Marttunen, Laippala, & Lonnqvist, 2000). Halaby (2004) specifically addressed predictors of treatment dropout amongst adolescents with three or more BPD features by exploring the treatment attendance of 133 adolescents enrolled in a Dialectical Behaviour Therapy (DBT) program. No specific BPD symptoms were significantly associated with noncompliance. However, adolescents with a greater amount of BPD diagnostic criteria attended significantly fewer sessions. In addition, parents' positive perception of treatment was found to be the strongest predictor of attendance.

Treatment dropout predictors have mainly been explored through the use of objective variables even though the subjective experience of care might be fundamental for patients with BPD (Martino, Menchetti, Pozzi, & Berardi, 2012). It has been demonstrated that perceived irrelevance of treatment, as well as poor relations between parents and therapists, are associated with premature termination amongst families of preteens referred for oppositional, aggressive, and antisocial behaviours (Kazdin, Holland, & Crowley, 1997). Adolescent and parents' alliances with therapists were also found to discriminate between dropouts and completers (Cordaro, Tubman, Wagner, & Morris, 2012; Garcia & Weisz, 2002; Robbins et al., 2006; Stevens, Kelleher, Ward-Estes, & Hayes, 2006).

Premature discontinuation of treatment has received greater attention in adults with BPD, highlighting both objective and subjective factors. Psychological characteristics such as hostility, anger, impulsivity, a disorganized attachment style, experiential avoidance and drug use have all been associated with a higher risk of treatment non-completion (Löffler-Stastka et al., 2003; Martino et al., 2012; Rusch, Schiel, et al., 2008; Wnuk et al., 2013). Difficulty tolerating painful affects as well as negative perceptions of therapists were also reported by patients with BPD as motives for prematurely ending group psychotherapy (Hummelen, Wilberg, & Karterud, 2007). Finally, a meta-analysis found that a lack of commitment to change, poor therapeutic alliance, and the presence of
impulsivity predicted treatment dropout, although evidence was minimal (Barnicot, Katsakou, Marougka, & Priebe, 2011). The authors concluded that research on the psychological processes involved in treatment non-completion could further inform dropout rates.

Indeed, most studies have investigated adolescents’ treatment dropout as a dichotomous outcome variable (in treatment or dropped out), and have focused solely on stable pre-treatment variables that cannot be changed during treatment (Armbruster & Kazdin, 1994; de Haan et al., 2013). This approach fails to consider factors that may emerge throughout the course of treatment, which limits our knowledge of potential solutions to prevent dropout. Like Barnicot et al. (2011), Armbruster & Kazdin (1994) suggest that the identification of underlying processes behind premature termination remains necessary in order to fully understand the phenomenon. Thus, conceptualizing treatment dropout as a process evolving from engagement to progressive disengagement, and ultimately to dropout, could highlight the mechanisms involved. A few studies have addressed disengagement behaviours in a context of adult psychotherapy and have shown that resistance and silences can allow the patient to avoid painful emotions and safeguard therapeutic alliance (Frankel & Levitt, 2009; Stringer, Levitt, Berman, & Mathews, 2010). However, disengagement behaviours were not examined as precursors of treatment termination. This perspective could be relevant considering that BPD is associated with intense and chaotic therapeutic processes (Gabbard & Horowitz, 2009).

In the light of current knowledge, a paradigm shift from prediction to understanding processes in the study of treatment dropout could help bring new insights to improve treatment engagement in adolescents with BPD (X, 2013). Consequently, we conducted a study based on the conceptualization of treatment dropout as a process, which led to the elaboration of the Model of Engagement and Dropout of Adolescent with BPD shown in Fig. 1(X et al. 2016). This paper presents the component of the model that specifically relates to the process of treatment disengagement in adolescents with BPD, and highlights the warning signs of premature termination (Fig. 1 here).

Method
A constructivist grounded theory (CGT) method was used (Charmaz, 2006) to capture how participants’ intersubjective experience of treatment lead to their disengagement (Suddaby, 2006).
Grounded theory provides methods to study actions and processes, in addition to meaning (Charmaz, 2016). The constructivist perspective was favoured because it seeks multiple perspectives (Charmaz, 2016) and asserts that individuals construct their own understanding of reality through their perceptions and social interactions (Mills, Bonner, & Francis, 2006).

Cases under study consisted of adolescent mental health treatment trajectories, which included all treatment-related events from help seeking to treatment dropout or treatment completion. Treatment dropout was conceptualized as a dynamic process that progresses from engagement to disengagement, and ultimately to a termination. As proposed by Wierzbicki & Pekarik (1993), the operational definition of dropout was based on therapist judgment. Dropout was established when all clinicians involved in the case considered the following conditions to be present regardless of treatment duration: 1) adolescent had unilaterally decided to terminate treatment against the clinical opinion of clinicians, and 2) treatment was still necessary given the severity of BPD symptoms.

**Recruitment and Procedures**

Cases were collected from a severe mood disorders outpatient clinic, located in a Canadian child psychiatric facility where assessment and treatment are provided by a multidisciplinary team (child psychiatrists, nurses, occupational therapists, psychologists and social workers). All adolescents treated at this clinic were evaluated following a standardized multidisciplinary assessment protocol (psychiatric evaluation, Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS), Beck Depression Inventory (BDI), Diagnostic Interview for Borderline-revised (DIB-R), occupational therapy’s and social work’s assessment). BPD was diagnosed by the child psychiatrist based on all collected data and in accordance with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition recommendations regarding personality disorders prior to 18 years of age (American Psychiatric Association, 2000). All mental health treatment trajectories concerned adolescents with BPD (DIB-R score ≥ 7, suggestive of borderline personality disorder, demonstrated emotional as well as relational instability, intense anger, self-harm, and attempted suicide at least once). In all cases, treatment included psychotherapy for the adolescents and their parental guidance. Adolescents with intellectual impairments, autism spectrum disorders, manic symptoms, or psychotic
symptoms were excluded.

In accordance with grounded theory, a theoretical sampling strategy was adopted (Gentles & Vilches, 2017). Adolescents with BPD who did not drop out were also included to test rival understandings of the disengagement processes. Data collection ceased when theoretical saturation was reached.

**Data Collection**

For each case, a semi-structured interview was conducted with the adolescent, one parent, and at least one clinician involved in the treatment, when possible. Based on the literature and the clinical experience of the first 2 authors, a different interview guide was elaborated for each type of informants. Each informant’s perception on factors related to the adolescent, the parent, and the care setting (structures, processes of care, staff, protocols, crisis management, etc.) were explored. Adolescents and parents described their experiences with both help seeking and treatment. They were also asked to describe how their disengagement unfolded when they first considered leaving treatment. In order to obtain thorough information of the processes involved in disengagement, a behavioural chain analysis type of questioning was used to identify vulnerabilities to dropout, their precipitating events, and links between precipitating events and dropout including thoughts, emotions, and behaviours (Koerner & Linehan, 2012). Adolescents and parents were also asked what might have improved their engagement and prevented treatment dropout. Clinicians described their understanding of their patient's disengagement, and provided suggestions on how to improve engagement. Each of these three groups of informants provided data on factors involved in treatment disengagement such as adolescent and parental characteristics, as well as factors relating to the care setting. Interviews were recorded, transcribed and imported into Atlas.ti 8 software.

**Data Analysis**

To grasp the systemic dimensions of disengagement from treatment, three units of analysis were used (Brewer & Hunter, 2006; Yin, 2007): the adolescent, the parent, and the care setting (Figure 2). The first author performed open coding with the first 3 cases. Three independent experts with extensive clinical experience with adolescents and adults with personality disorders then proceeded to code 50 phenomenological units randomly selected from these cases, reaching 75% agreement.
The definition of ambiguous conceptual categories were then clarified, and a final consensus was reached. Axial coding led to the development of new conceptual categories, which were hierarchically organized to reflect the views of the 3 groups of informants and to specify their dimensions. After the sixth case, a second review performed by the same 3 experts was conducted to revise the hierarchy of categories. Theoretical coding followed in order to formulate plausible hypotheses to integrate in the emergent model (Hernandez, 2009). Through coding, memoing, and the development of a conceptual map, theoretical codes capturing disengagement processes were generated. These analyses led to the development of the first hypotheses regarding processes involved in engagement complications. Five cases were selected thereafter to challenge the emerging model. All previous interviews were subjected to a new analysis each time a new hypothesis emerged. This constant comparative analysis was continued up until the third expert review (performed by the second author) verified that no data was inconsistent with the final theoretical model. This led to theoretical saturation.

The triangulation of sources (information provided by all three types of informants) and the triangulation of analyses (three expert reviews) allowed for the increased credibility and trustworthiness of our results (Guion, Diehl, & McDonald, 2002). The project received approval from the ethics review board of the hospital where the research took place. All youths, parents, and clinicians involved in the project provided informed consent. As adolescents were no longer receiving treatment, a protocol was put in place to ensure that they obtained help if risk for suicidality was detected during the research interview.

**Final Sample**
Adolescents that met our study’s inclusion criteria, as well as their respective parents and clinicians, were approached about the study by the clinic coordinator. Of the 19 eligible cases, eleven were recruited.

All participating adolescents were female, Caucasian, middle class, and ranged from 13 to 17 years of age. Treatment length varied between 2 to 12 months (M=7.5 months). Alongside BPD, a majority of these adolescents presented with comorbid disorders such as anxiety, depression, and ADHD.
Furthermore, 5 of these youths hailed from a dual parent household, 2 originated from a single parent household, while the remaining 4 originated from blended households. Eleven parents were interviewed in this study, 8 of whom were mothers and 3 of whom were either fathers or stepfathers. Lastly, 13 clinicians from four different backgrounds completed interviews. Indeed, six of these clinicians practiced psychology, three practiced social work, three practiced psychiatric nursing, and one practiced occupational therapy. The therapeutic approaches used included DBT (Linehan, 1993; Miller, Rathus, & Linehan, 2007), Psychodynamic therapy, or non-specific treatment model (Table 1). Overall, our study documents 11 treatment trajectories, 9 of which involved adolescents with BPD who dropped out of treatment.

**Results**

Analysis reveals that well before dropout occurs, different phenomena identified as engagement complications characterize the disengagement process (Table 2). These engagement complications usually take place during treatment and develop according to a specific, three-step sequence. First, negative emotions emerge in either the adolescents or the parents, introducing a "zone of turbulence" whereby treatment trajectories become unstable which then threatens to interfere with therapeutic goals. These emotions then typically lead to treatment interfering attitudes that eventually evolve into openly disengaged behaviours.

**Activation of Negative Emotions**

Results show that the first complication of the disengagement process to appear for adolescents and their parents is the gradual emergence of negative emotions towards the appropriateness of treatment, the therapeutic relationship, or the vicissitudes of treatment.

*Appropriateness of treatment.* Initially filled with feelings of hope, some adolescents and their parents found their experience with care gradually coloured with negative emotions such as disappointment and criticism regarding the treatment itself. Slowly, impressions regarding treatment appropriateness arose. When asked about how the idea to leave treatment first occurred, one adolescent described the irritants that led her to believe that the treatment was not right for her:

It’s just that between appointments I was going through intense emotions... I had things to say and,
at that moment, I would’ve liked to talk about it. But I didn’t have my appointment that day. ... I had to wait to see my therapist before I tell her about something that happened 3 or 4 days before... It wasn’t important anymore... I realized that my visits really didn’t help me... I needed something else!

The treatment offered to this adolescent, which included a weekly psychotherapy session at a predetermined time, was perceived as unsuitable for her needs and led to the conclusion that treatment was not adequate. Negative emotions toward treatment also underlined her mother’s disengagement:

I was a little frustrated because I felt compelled to be there, to go to the meeting with the social worker. I never felt it changed anything whether I was there or not. I think if I would not have gone, it would not have made any difference!

In contrast, positive emotions and confidence toward the treatment paired with early positive reinforcement helped an impulsive adolescent who completed her therapy after a few unsuccessful attempts: “What made me continue this time? I felt I was well taken care of... It started to work right away, things worked, I tried their trick with ice for self-injury, so I told myself, I'll continue [because] it works!”

**Therapeutic Relationship.** Adolescents with BPD appeared especially attentive and sensitive to the clinician’s attitudes. Silence and the absence of reactions on behalf of the clinician were perceived as acts of hostility, as a lack of interest, or even as rejection, and led to negative emotions towards the clinician. An adolescent who was questioned about her disengagement endorsed such processes. “There were long silences, he [therapist] was barely saying anything, I didn’t feel confident with him. I didn’t like him!”

Negative perceptions regarding the clinician’s competence, personality, or motivations were also identified as a trigger of disengagement. Such perceptions were expressed by a girl who started considering dropping out of treatment: “She [my psychiatrist] only used scientific terms. She didn’t think I was human, always using fancy words! Plus, she wasn’t enthusiastic... She was cold... I don’t understand why she is a child therapist. She’s incompetent and I don’t like her!”

Some adolescents had a hard time continuing treatment when they perceived interventions as an
authoritative relationship rather than a collaborative one. It occurred when they felt that they were insufficiently involved in the decision-making process during treatment planning. This adolescent explains how such a perception played a role in her disengagement:

I was not made aware of the other choices that I could have made... I think the main thing they should do is to present choices. They should have asked me what I wanted. They wanted to try psychotherapy ... I did not like to be forced to speak for an hour! There was nothing that encouraged me to go there...

Clinician’s unfavourable disposition to treat also played a role in the activation of negative emotions in some adolescents. This psychologist reports the impact of a negative experience on the therapeutic relationship during the disengagement process of another youth:

I was also part of the equation explaining her dropout... Treating adolescents with borderline personality disorder is not my forte and that’s why it never really clicked. When I was talking, she would look up at the sky and say: I don’t like your style...

However, our analyses suggest that adolescents with BPD did not always reveal their negative emotions towards their therapist. In these circumstances, the tone of the exchanges left a false impression that all was going well. Consequently, disengagement complications sometimes remained invisible to the clinicians. These two quotes show the answers of an adolescent and his therapist when asked to describe how disengagement unfolded prior to treatment dropout. They illustrate how the clinician was unaware of the negative perception of his patient and how they both had a different reading of the therapeutic relationship. The adolescent mentioned that "It was already quite some time that I no longer had confidence in my therapist and that I felt I had no relationship with him, say, a few months...". In contrast, the therapist expressed that "It was very sudden ... She came in at her appointment and she said, "This is the last time I come ... You are incompetent!"... I was destabilized, especially that the relationship was well established, and that treatment was progressing... "

**Vicissitudes of treatment.** A third source of emotional activation was a growing aversion towards the vicissitudes of treatment. Annoyances associated with the constraints of treatment such as attending regularly, filling observation charts, missing leisure activities, and talking about painful memories
gradually built up. This adolescent described how she first started to consider stopping treatment altogether: "I would spend an hour in the bus, an hour in her office... I could’ve just talked to my friends. I felt like I was wasting my time." The time spent on transport appeared as too costly for her when compared with the benefits of meeting with her therapist.

Realizing how unmotivated or hostile their adolescent was towards treatment, some parents felt disappointed and gave up when they perceived that they were the only ones making an effort, and that their sacrifices were therefore useless. This mother explains how she started disengaging by withdrawing emotional support from his daughter: "She did not want to go to her therapy sessions. There comes a time where you say; look, don't go and that's it! "

Conversely, some adolescents realized that they had to deal with treatment alone and that their parents were not engaged nor supportive. Ensuing feelings of discouragement and helplessness triggered disengagement in the adolescent, even if they were initially convinced about treatment importance and efficacy, as the following account illustrates:

I was so disappointed. I would come back from therapy and my mother never asked me how it went. She would say I was old enough to go on my own...! I believed the treatment would help me. If she had been there more, I would've continued, I’m sure.

**From Emotions to Treatment Interfering Attitudes**

The activation of negative emotions led to a second engagement complication characterized by numerous interfering attitudes towards treatment continuation for both the adolescent and the parents. One adolescent explained how her non-cooperative attitude manifested by hostility, splitting, and mood-dependent behaviours was associated with her disengagement process:

I like Dr. X who treated me for three weeks during my stay in hospital. I wanted him to be my doctor forever! [...]. I was really arrogant [with Dr. Y]! I acted so that the relationship would go cold. I was really rude! The most unpleasant possible... I was going to my appointment and telling them to f*** off. I wanted them to decide to end the treatment!

Exasperated by the adolescent’s excessive behaviour and the sacrifice treatment requires, even motivated parents adopted behaviours that disrupted the continuation of treatment. The following
account by a psychologist illustrates how one mother's insufficient support becomes counterproductive for treatment continuation, and how this attitude led to treatment interfering attitudes in her daughter:

One day, the mother phoned to tell me her daughter didn’t want to go to her appointment, and that she had insisted her daughter went. She was angry at her daughter because she wouldn’t accept help and that’s why her problems are never solved. “I won’t drive her. She needs to get organized on her own.” So it took her daughter two hours to get to her appointment. She was tired and unhappy. That’s when she started reading during the sessions... She quit the treatment a few weeks later...

If hostility in adolescents with BPD was a signal of their weakening engagement, apparent competency was also a warning sign of an imminent dropout. Shortly after seeking help for their distress in a pressing manner, some adolescents came to treatment saying that their symptoms disappeared and that their problems were suddenly solved. They presented themselves as more adapted than they really were by underestimating the difficulties still at hand. Apparent competency was linked to disengagement, as the girl below eloquently explained: "It’s the second time I’ve done that... I believe I’m better. I stop treatment without the specialists’ approval... I had a new boyfriend... I told myself that finally, it means I’m a normal person!"

Exposure to painful feelings and memories are an inevitable part of therapy. Experiential avoidance was another treatment interfering attitude highlighted in our interviews. This adolescent describes how, these inevitable vicissitudes of psychotherapy impacted her engagement: "I was tired of going there just to talk about my problems... I didn’t want to talk about it anymore! It made me feel even worse! I wish we had done fun things instead!"

**The Ultimate Phase: Disengagement Behaviours**

Negative emotions and treatment interfering attitudes give way to behaviours that are more symptomatic of disengagement. In this third engagement complication, the intensity of emotions seemed to subside, but this apparent respite in fact foretells imminent dropout. For example, disengagement behaviours appeared as irregular therapy attendance by a family that previously attended religiously. These behaviours were also displayed through the instrumentalization of the
therapy or of the clinician where participating families started conceptualizing treatment solely as a means to an end. Indeed, treatment became more of a formality than a real commitment, and was continued only for its secondary benefits such as missing school or appearing to comply with parents or authorities. Both the clinician and treatment were thus devalued and considered useless, and eventually abandoned, as one psychologist expressed while describing one adolescent’s last moments in therapy: "She asked me why she should come here to find out things she already knew... She displayed all sorts of behaviours that meant: You’re nothing... You’re useless."

Self-treatment behaviours such as changing medication dosage, addressing difficulties with friends instead of with clinicians, or completely hiding a problem were also indicative of a shift towards disengagement. Furthermore, these behaviours were sometimes perceived as acts of autonomy by parents and even reassured them. This was the case of a father who believed his daughter’s symptomatic improvement and pseudo-adaptation, consequently leading him to minimize the need for further treatment. No longer willing to take part in the therapeutic process or to collaborate with the team, this father concealed that his child had stopped taking medication, thus becoming an accomplice to her disengagement from treatment:

My daughter reduced her medicine intake herself when she started to want to drop out of her treatment. She would say: “I’m not taking it anymore.” We convinced her to reduce and not to stop altogether ... She stopped progressively, and decided not to take it anymore. Since she was doing well, we had nothing to say...

Discussion
The objective of this study was to understand how adolescents with BPD shift from engaging in a treatment to gradually disengaging from it, to describe how such processes unfold, and to identify specific warning signs of imminent dropout. Our results suggest that dropout is preceded by the development of engagement complications, which may sometimes go unnoticed. These will unfold according to a three-step sequence starting with the emergence of negative emotions associated with certain aspects of treatment, followed by treatment interfering attitudes and openly disengaged behaviours. These engagement complications lead the way towards the development of a “zone of
turbulence” which creates a vulnerable and unstable therapeutic process. The disengagement process highlighted in this research indicates that, like adults, the treatment of adolescents with BPD is interspersed with complications from emotions and attitudes that may result from BPD symptomatology (Gabbard & Horowitz, 2009). Core BPD features, such as impulsivity, difficulty to tolerate painful affects and a need for immediate gratification (Rusch, Boeker, et al., 2008), can make adolescents with BPD impatient to find relief. Such impatience eventually leads to the premature conclusion that treatment is inappropriate and fails to meet their needs. Furthermore, our results also suggest that factors such as insufficient treatment planning might promote the emergence of engagement complications in the course of treatment. A more thorough preparation for treatment where the motivation underlying therapeutic choices, treatment duration, and theory of change specific to the therapeutic approach are explained could help to attenuate negative emotions related to appropriateness of treatment.

In line with other adolescent clienteles (Cordaro et al., 2012; Garcia & Weisz, 2002), therapeutic alliance appears as an important issue for adolescents with BPD. Constructively engaging in therapy may conflict with an adolescent’s striving for autonomy (Oetzel & Scherer, 2003). However, because of the abandonment fears and sensitivity to rejection associated with BPD, this aspect might be more crucial in the disengagement process of adolescent with BPD. Due to the known attachment difficulties (Levy, Beeney, & Temes, 2011), and frequent experiences of abuse and neglect (Ibrahim, Cosgrave, & Woolgar, 2018), these youths may take more time than other young patients to develop an alliance with clinicians. Therefore, confrontational situations may occur earlier in the treatment process when the therapeutic alliance is not yet strong enough to counterbalance them.

Our results suggest that failure to consider the nature and disposition of clinicians also promotes the rise of negative emotions towards clinicians in adolescents with BPD. Successful treatment in adults with BPD was found to be associated with the therapist’s quality of communication (Meehan, 2007), their technique (Yeomans, Gutfreund, Selzer, Clarkin, & Hull, 1994), the therapist’s successful regulation of counter-transference (Bessette, 2010), and their perceptions of individuals with BPD (Aviram, Brodsky, & Stanley, 2006). Sensitivity to relational distance appeared important in the
activation of negative emotions towards clinicians for adolescents in our study. Indeed, Bateman and Fonagy (2004) stressed the perils of too much neutrality on behalf of the clinician when working with patients who have BPD. Rather, adolescents prefer to experience a balanced relationship with their psychotherapist characterized by emotional closeness and mutuality, along with clear and explicit boundaries for the therapeutic space (Binder, Moltu, Hummelsund, Sagen, & Holgersen, 2011).

Finding such an appropriate balance proves to be trickier with reactive BPD adolescents, for whom individuation is more complicated (Westen, Betan, & Defife, 2011). Our results suggest that the development of negative emotions towards clinicians could be reduced with a treatment orientation that systematically specifies and discusses the boundaries of the therapeutic relationship, establishes collaboration by informing the youth of different treatment options and giving them an active role in decision-making. DBT, an evidence-based treatment for BPD, stresses such an alliance with patients and their families by recommending that therapists take on the role of an ally throughout the therapeutic relationship (Linehan, 1993).

According to Binder et al. (2011), the perception that clinicians are comfortable in their role promotes youth engagement. However, feelings of incompetence paired with difficulties in tolerating the risk of suicide continue to be very frequent in therapists who work with BPD populations and adolescents (Bodner, Cohen-Fridel, & Iancu, 2011; Stewart, Manion, & Davidson, 2002). Our results suggest that the presence of such dispositions may cause engagement complications, and that these will likely promote treatment dropout amongst adolescents with BPD. Therefore, an improved awareness of clinicians’ a priori negative expectations could help promote treatment continuation. Evidenced based treatment for BPD, such as DBT and Mentalization based therapy, recommend the enhancement of clinician motivation and their perceived capabilities to treat BPD through the use of a support network to provide feedback, encouragement, and continued skill-building (Bateman & Fonagy, 2004; Koerner & Linehan, 2012; Walsh, Ryan, & Flynn, 2018). An example of such a support network is the use of consultation teams where clinicians treating suicidal adolescents discuss cases and validate their peers, while providing ongoing assistance and encouragement (Miller et al., 2007).
disengagement process of adolescents with BPD. While other young patients accept the sacrifices inherent to any treatment, our results suggest that adolescents with BPD might show less tolerance and equate treatment irritants with the treatment’s value. This ignites negative emotions, and creates an alienating experience of treatment. This later engagement complication also proves to be the consequence of some manageable obstacles. Addressing obstacles such as issues of accessibility and scheduling prior to the start of treatment may avoid offering unrealistic treatment regimens to families, and help those involved learn to anticipate the challenges of treatment. Chanen & McCutcheon Chanen (2008) suggest being flexible and curious about perceived barriers to treatment. In addition, if explanations about therapeutic processes fail to be provided, it becomes very difficult for adolescents and their parents to believe that discussing problems with a therapist – and inevitably being faced with discomfort – would eventually help them feel better, and that the benefits of therapy would counterbalance all of its associated costs. Indeed, higher levels of experiential avoidance found in adolescents with BPD features (Schramm, Venta, & Sharp, 2013) may make them particularly vulnerable to developing negative emotions toward the vicissitudes of psychotherapy. Contrary to the results of Frankel (2009), emotional avoidance in adolescents of our study did not prove to be a strategy in the service of maintaining the relationship and the treatment and are rather congruent with the results obtained from adults with BPD. Furthermore, Liddle (1995) recommends avoiding the assumption that youths and families know how to profit from treatment, and instead suggests that they should first be “socialized to therapy”.

Treatments that begin in urgent circumstances, as is often the case for adolescents with BPD (Chatagner et al., 2015), may take a few shortcuts and omit to provide sufficient orientation to families about the therapeutic process. However, considering higher risks of dropout amongst adolescents with BPD, our results highlight that good practices should include a discussion on all the imponderables that may occur during the normal therapeutic process. Notably, the eventuality that the adolescent considers quitting therapy should be discussed when preparing youths with BPD for treatment. In collaboration with the adolescent and the parent, an agreement on reengagement strategies could be elaborated prior to the start of treatment. This type of discussion could apply to all
imponderables that may occur during the normal therapeutic process.

Child psychiatry clinics must offer treatment to diverse clienteles. When these services are insufficiently adapted to BPD adolescents’ needs, it may reinforce perceptions that treatment does not work, that the clinician is incompetent, or that fully committing to treatment is too difficult. Whereas the majority of adolescents with other diagnoses cope sufficiently well with the contingencies inherent to treatment, the engagement of reactive youths with BPD can weaken as soon as the first irritants appear. As suggested by participants who didn’t dropout, the treatment for adolescents with BPD should include some early reinforcement or gratification – especially at the beginning of treatment where intrinsic motivation and therapeutic alliance are weak – in order to ensure that the positive experiences of treatment outweigh the negative ones. Indeed, such reinforcement or gratification may help halt the development of negative feelings towards treatment and their treating clinician.

Treatment engagement requires that adolescents, parents, and clinicians share a common theory and understanding of the problem. Parental attributions in relation to their offspring’s problem have been shown to have a major impact on whether or not the parent willingly participates in the therapeutic process (Mah & Johnston, 2008; Sawrikar & Dadds, 2018). Our results show that parents’ lack of empathy and support could be related to a fundamental misunderstanding of their child’s pathology. Furthermore, the attribution of hostile intentions behind their adolescent’s excessive behaviours may lead parents to adopt counterproductive attitudes. Indeed, parental misunderstanding of the problem produces emotions and attitudes that interfere with the continuation of treatment. Parental perceptions being an important factor in treatment completion (Halaby, 2004; Robbins et al., 2006), proper orientation to treatment, including thorough education on BPD, might help them understand the foreseeable challenges of therapy with their adolescent and prevent engagement complications.

Our data shows that clinicians sometimes experience a blind spot phenomenon where they fail to recognize the symptoms of disengagement. This can be explained by the fact that adolescents with BPD, along with their parents, do not always express their discomfort towards receiving care. It was shown that such a phenomenon is even more pronounced when disengagement results from negative
feelings towards the treatment (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; Todd, Deane, & Bragdon, 2003; Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010). Our findings corroborate other research, which shows that treatment dissatisfaction is frequently used by patients to justify dropping out. Yet, such negative feelings towards treatment remain rarely recognized by clinicians (Hunsley, Aubry, Verstervelt, & Vito, 1999; Westmacott et al., 2010). In addition, the difficulty to assess the real level of engagement in adolescents with BPD is increased by the fact that it can fluctuate according to their mood, identity, interpersonal, and behavioural instability, and suddenly vanish at the slightest incident. Consequently, when it comes to the treatment of these youths, the symptoms of disengagement may often go unnoticed, and opportunities for appropriate action to be taken in order to prevent dropout are missed. The treatment disengagement process identified in this study could help clinicians overcome the blind spot phenomenon by enhancing perceived capacities for early detection of engagement complications, ultimately reducing the high occurrence of treatment dropout amongst adolescents with BPD. Proactive and systematic monitoring of satisfaction with the treatment and the therapeutic relationship could help defuse the potential engagement complications revealed in our study. Finally, trajectories of adolescents who completed their treatment also highlighted that their engagement can be supported by positive reinforcements, including explicit recognition of their efforts and progress. In line with our results, the subjective experience of successful treatment outcomes was also recognized as a facilitator for adolescent engagement (Gearing, Schwalbe, & Short, 2012).

**Paradigm Shift: Treatment Dropout as a Process**

While most of the existing studies on treatment dropout examine static variables present before treatment, our results show that some factors appearing throughout treatment play an important role. Our study highlights the relevance of examining treatment dropout as a process rather than as a dichotomous variable because the identification of such has the potential to strengthen the depth of our knowledge around treatment disengagement. Indeed, subjective accounts provide new information on events and obstacles that appear throughout the course of treatment. Such information remains limited in studies that only consider pre-treatment variables, or where dropout is
regarded solely as an outcome. By clarifying how the participation of adolescents with BPD in
treatment evolves from engagement to disengagement, and ultimately to termination, other dropout
determinants could eventually be brought to light.

Limitations
The limitations of this study must be addressed. First, 42% of the adolescents invited to speak about
their treatment dropout declined. Some did not want to dwell on the treatment received in child
psychiatry while others clearly expressed no desire to have any more contact with the care setting. It
is likely that these adolescents would have described different dropout processes from those
described by youths who agreed to participate. Also, the fact that dropout cases only involved female
adolescents represent a limit to the understanding of disengagement process. Male adolescents with
BPD might have demonstrated different disengagement complications and profiles. Nevertheless, the
results remain relevant for clinical purposes because people with BPD who seek treatment are mostly
females (Skodol & Bender, 2003). Lastly, recruitment was limited to one outpatient clinic. The
recruitment of patients from various treatment settings with different care management processes
would have been preferable, as it would have further enlightened the disengagement process. It
should be noted that our research design was not intended to compare the effectiveness of various
treatment models for BPD. Caution must be exercised when extrapolating results to evaluate the
effectiveness of specific approaches in preventing treatment dropout. A maximum of information was
shared to let readership judge whether results are transferable to other contexts.

Conclusion
Engagement complications which arise during therapy illustrate how the initial engagement of
adolescents with BPD and of their parents for treatment is neither static nor certain, but subject to
fluctuating emotions and perceptions. This implies that engagement can never be taken for granted
and must constantly be monitored during the therapeutic process. Maintaining the engagement of
adolescents with BPD should be a therapeutic objective akin to reducing symptomatology or
improving psychosocial functioning, and should therefore be given the same attention.

Understanding disengagement processes would benefit from further study to elucidate which care-
setting responses should be mobilized once engagement complications have risen. Such a study could specify the mechanisms at play in the late dropout of adolescents with BPD, and highlight proper strategies to re-engage them. Finally, this qualitative study emphasizes the necessity of a collaborative process with this clientele. As such, an open, supportive, and meaningful therapeutic relationship holds promise for increasing treatment effectiveness in a group of adolescents who continue to require high levels of mental health needs.

Declarations

Ethics approval and consent to participate

Ethics approval (Comité d’éthique de la recherche, centre de recherche de l’Hôpital Rivière-des-Prairies #08-10P) and consent to participate were obtained.

Consent for publication

Not applicable

Availability of data and materials

The datasets during and/or analyzed during the current study available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors contributions

LD: designed the study, collected and analyzed data and drafted the work
MS-J: designed the study, designed the study and substantively revised the work
LP: substantively revised the work
M-ML: substantively revised the work

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Tables

| CASES | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  | 11  |
|-------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Dropout | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No  | Yes | No  |
| Gender, Age | 0.13 | 0.16 | 0.14 | 0.13 | 0.10 | 0.14 | 0.15 | 0.17 | 0.16 | 0.17 | 0.17 |
| Family structure | Single-parent | Blended | Dual-parent | Blended | Single-parent | Blended | Dual-parent | Dual-parent | Dual-parent | Dual-parent | Blended |
| Treatment | Partial DBT | Pharmacotherapy | Non-specific | Pharmacotherapy | Pharmacotherapy | Psychodynamic | Partial DBT | Partial DBT | DBT | Psychodynamic | Psychodynamic |
| Modalities | Individual | Group | Individual | Parental guidance | Individual | Group | Individual | Parental guidance | Individual | Group | Parental guidance |
| Duration of treatment | 6 months | 8 months | 9 months | 4 months | 7 months | 4 months | 5 months | 9 months | 12 months | 9 months | 9 months |
### Table 2: Engagement Complications

| CATEGORIES                                 | DIMENSIONS                                      |
|--------------------------------------------|-------------------------------------------------|
| Activation of negative emotions            | Appropriateness of treatment                    |
|                                            | Therapeutic relationship                        |
|                                            | Vicissitudes of treatment                       |
| Treatment interfering attitudes of adolescents | Hostility towards clinicians                   |
|                                            | Splitting                                       |
|                                            | Mood-dependant behaviours                       |
|                                            | Active passivity                                |
|                                            | Apparent competency                            |
|                                            | Experiential avoidance                          |
| Treatment interfering attitudes of parents | Insufficient support                            |
|                                            | Failure to make the adolescent accountable      |
|                                            | Complicity in disengagement                    |
|                                            | Hostility towards clinicians                    |
| Disengagement behaviours                   | Irregular attendance                            |
|                                            | Instrumentalized relationship                   |
|                                            | Self-treatment                                  |
|                                            | Hiding information                              |
|                                            | Not using help                                  |
|                                            | Refusing help                                   |

Figures
Figure 1

Model of Engagement and Dropout of Adolescent with BPD
Figure 2

Units of analysis