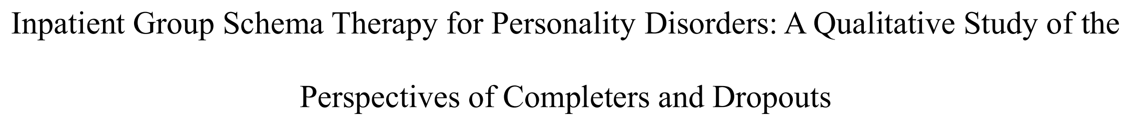

Inpatient Group Schema Therapy for Personality Disorders: A Qualitative Study of the Perspectives of Completers and Dropouts

Bijan Zahmat

University of Twente

Department of Psychology, Health and Technology

10th of November 2021

First Supervisor:
dr.ing. Gert-Jan Prosman

Second Supervisor:
prof.dr. Gerben Westerhof

External Supervisor:
drs. Karin Timmerman

Abstract

Inpatient Group Schema Therapy (GST) has been shown to be effective in the treatment of personality disorders. However, not all patients benefit from it and dropout rates for inpatient GST are estimated at 33%. This is worrisome as dropout is associated with negative treatment outcomes for the individual but also has adverse effects on the group level. One way that can potentially reduce dropouts and improve outcomes of therapy in general is by considering patients' perspectives. This study aims to explore and compare the perspectives of completers and dropouts on inpatient GST, as reported at two to eight years follow-up. Qualitative data from 44 completers and eight dropouts was collected through qualitative questionnaires. Patients had undergone at least six months of inpatient GST. A thematic analysis was conducted. Patients reported benefits related to insight and processing, self-development, affective outcomes, interpersonal relationships, and reintegration into society. Completers and dropouts partially agreed on the helpful factors as they both viewed group factors, therapy components, individuality, and insight as crucial factors. Only completers stated the therapeutic relationship as a facilitative factor. Patients' experiences of the inpatient GST varied to a large extent. A majority of completers was satisfied with the treatment, however, many patients also stated that they benefited from the treatment but that this also came at a certain cost. Patients viewed inpatient GST as an important turning point in their lives, but they did not unequivocally relate the inpatient treatment to positive outcomes alone. On the basis of identified helpful factors and unhelpful factor recommendations were made to improve the existing inpatient GST program.

Keywords: Schema Therapy, group therapy, personality disorder, dropout, qualitative research, perspective

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Introduction

Personality disorders are common mental disorders associated with high individual and societal costs (Lenzenweger, 2008; Soeteman, Roijen, et al., 2008; Soeteman, Verheul, et al., 2008). The worldwide mean prevalence rate of a personality disorder in the general population is reported at 11% (Lenzenweger, 2008). Among psychiatric outpatients, the prevalence of a personality disorder is approximated at 45% making personality disorders one of the most frequent disorders in psychiatric settings (Zimmerman et al., 2005, 2008). Personality disorders are highly comorbid with other mental disorders, such as mood disorders, anxiety disorders, eating disorders, and substance abuse disorders, increasing the extreme distress experienced by affected individuals (Davey, 2014; Samuels, 2011). Compared to those with no mental disorder, patients with personality disorders have a significant reduced life expectancy and an elevated risk of suicide (Doyle et al., 2016; Fok et al., 2012). Personality disorders are associated with a significant impairment in quality of life, social, interpersonal, and occupational functioning. The quality of life experienced by patients with personality disorders is comparable to that of those with severe somatic illnesses underlining the high burden of disease experienced by patients with personality disorders (Soeteman, Verheul, et al., 2008). On a societal level, individuals with personality disorders pose a high economic burden on society, mainly due to high medical costs (including inpatient and outpatient mental health care) and loss of productivity, a burden remarkably higher than for patients with other mental disorders (Soeteman, Roijen, et al., 2008). The high individual and societal burden associated with personality disorders emphasize the importance for effective treatment.

Several evidence-based treatment programs have been developed and proven to be effective in treating personality disorders, including Schema Therapy (ST; Young et al., 2003). ST was developed for treating patients with chronic and severe personality pathology, particularly for those that were nonresponsive to regular cognitive behavioural therapy (CBT). As an integrative therapy, ST includes elements of CBT, attachment theory, Gestalt therapy, and psychodynamic theory. Young et al. (2003) posits that personality pathology in adulthood originates from unfulfillment of basic childhood needs (e.g., safe attachment, affection). ST aims to provide corrective emotional experiences to help patients develop healthier ways to fulfill their emotional needs. The therapeutic relationship plays an important role in this, and is conceptualized as limited reparenting in ST. This entails that the therapist is caring and attuned to the patient, while setting limits and supporting self-expression and autonomy, thus, treating the patient as a good parent would, within professional constraints (Farrel & Shaw, 2018). At the same time, through emphatic confrontation, the therapist sensitively confronts patients with the negative effects of their unhelpful behaviour, thereby highlighting the need for change (Fassbinder & Arntz, 2019). In addition to the therapeutic relationship, ST incorporates behavioural, cognitive, and experiential interventions to break maladaptive enduring patterns (Young et al., 2003).

Central concepts in ST that explain the maladaptive patterns seen in patients with personality disorders are schemas and schema modes. ST postulates that when basic emotional needs are inadequately met in childhood, in interaction with a child’s temperament and early environment, maladaptive schemas may develop (Young et al., 2003). Schemas are knowledge representations which influence cognitions, behaviour, and emotions, and they guide how individuals make sense of themselves and the world around them. When dysfunctional schemas

are activated, they trigger certain intense states and coping responses: overcompensation, avoidance, or surrender (Young et al., 2003). The momentary states triggered by schemas are referred to as schema modes which are defined as emotional, cognitive, behavioural, and neurobiological states that individuals experience at a certain time (Farrel & Shaw, 2018). Unlike schemas, which focus on the trait level, schema modes focus on the state level, and are therefore helpful in explaining the rapidly changing state of patients with complex personality pathology (Young et al., 2003). Accordingly, the approach in ST that is currently widely used is the schema mode model.

The effectiveness of ST based on the schema mode model has been well established. Many studies focused on Borderline Personality Disorder (BPD) and confirmed the effectiveness of outpatient individual ST (Giesen-Bloo et al., 2006; Nadort et al., 2009), outpatient group ST (Farrell et al., 2009), and inpatient group/individual ST (Reiss et al., 2014) for patients with BPD. The focus of ST has also been extended to other personality disorders, and shown to be effective for outpatients with avoidant, dependent, obsessive-compulsive, paranoid, histrionic, or narcissistic personality disorders in a multicenter RCT (Bamelis et al., 2014). Results showed that individual ST was superior to treatment as usual on recovery from personality disorder, showed a lower dropout rate, and was more cost-effective than both treatment as usual and clarification-oriented psychotherapy (Bamelis et al., 2014, 2015). Additionally, inpatient group ST has shown to be effective in improving schemas, schema modes, mental well-being, and symptomatic distress for nonresponsive patients with complex personality pathology, with effects being maintained at 6-months follow-up (Schaap et al., 2016; Wolterink & Westerhof, 2018).

Although ST has shown to be an effective therapy for patients with personality disorders, the treatment may not benefit all patients. One group of patients that may particularly be less likely to benefit are patients who prematurely terminate treatment, that is, dropouts (Swift & Greenberg, 2012). A systematic review of 25 studies on psychosocial treatments for personality disorders found a median dropout rate of 37% (McMurran et al., 2010). Studies on inpatient psychotherapy for personality disorders report a dropout rate of around 30% (Cornelissen et al., 2010; Kooiman, 2008). For outpatient individual ST, the dropout rates seem to be slightly lower at around 27% (Bamelis et al., 2014; Giesen-Bloo et al., 2006; Spinhoven et al., 2007). For inpatient group ST, dropout rates of around 33% were reported (Schaap et al., 2016; Wolterink & Westerhof, 2018). These substantial dropout rates are concerning as treatment dropout in patients with personality disorders is related to poorer treatment outcomes, negative mental health outcomes (e.g., increased hopelessness and suicide attempts), and reduced cost-effectiveness of services (Stratton et al., 2020). In group therapy, treatment dropout has negative effects for both the individual (e.g., less symptomatic improvement, lower satisfaction) as well as the group (e.g., may lead to other members dropping out) (Yalom & Leszcz, 2005). Given the negative consequences of dropout, it is important to gain a better understanding of the factors related to dropout and treatment completion in ST. One way to do this is by exploring the patients' perspective on ST through qualitative research.

Increasingly, the importance of considering the patients' perspective is recognized in psychotherapy research (Macran et al., 1999; Norcross, 2011; Timulak & Keogh, 2017). Also in the Netherlands, patient participation and involvement in mental health care research is emphasized in recent years (Jonkers & Senten, 2016). Examining the experience of patients who underwent psychotherapy can provide valuable information on which therapeutic factors and

components of are perceived as beneficial or problematic, which factors may be related to dropout, and which aspects contribute to more satisfaction among patients (Timulak & Keogh, 2017). Qualitative research encourages patients to reflect more freely on a deeper level, on what therapy actually brought them, hereby complementing patients' responses to standardized quantitative measures on outcomes considered important by the researcher. Accordingly, qualitative research can provide a more balanced understanding of both therapy outcomes and mechanisms of change (Timulak & Keogh, 2017). With regard to the current state of research in the field of ST, several studies have shown its effectiveness, however, less is known on the mechanisms of change from the perspective of patients. To date, only three studies have been published that explored the patients' perspective in ST (de Klerk et al., 2017; Hoekenga et al., 2021; Tan et al., 2018).

These three studies and their methodologies and findings differed from one another in various ways, however, they also shared several commonalities. The three studies all explored the patients' perspective in ST, however, they all used different methods in different settings. De Klerk et al. (2017) conducted semi-structured interviews with 15 patients with different personality disorders that underwent outpatient individual once-weekly ST, and additionally a focus group to gather the perspectives of 8 therapists. Tan et al. (2018) also used semi-structured interviews, however, they included 36 BPD patients that had received at least 12 months of twice-weekly outpatient group ST or combined group-individual ST. Hoekenga et al. (2021) conducted a Q-sort study among 38 patients who had undergone at least six months of inpatient group ST, after which the patients were shortly interviewed on their preferences (brief summary interview included, no excerpts given). The three studies all explored helpful and unhelpful aspects, and provided recommendations to improve the ST protocol. Specific ST techniques, the

theoretical frame of ST, and the therapeutic relationship were found helpful by patients in all three studies. However, several patients in all three studies also considered the therapeutic relationship as an unhelpful or problematic factor. The study by Tan et al. (2018) and the study by Hoekenga et al. (2021) shared some additional similarities in findings. In both studies, the group ST format was considered an important element by many patients, however, patients in both studies also noted the necessity of having a combination of group and individual therapy. Moreover, in both studies patients described gaining insight, improved self-understanding, and emotional processing as important facilitative factors in their ST experience (Hoekenga et al., 2021; Tan et al., 2018).

The current study adds to these previous studies in at least two important ways. First, this study makes a comparison of the experiences of both completers and dropouts. Inpatient group ST shows substantial dropout rates, which can have negative consequences for the individuals involved, the group, and the treatment setting. This qualitative study may provide valuable information on the factors related to dropout and treatment completion. Secondly, this qualitative study is conducted as part of a long-term follow-up study, two to eight years after discharge. Few long-term follow-up studies are conducted on the perspectives of patients on psychotherapy. However, this may have some benefits as this will allow us to understand how patients look back on their treatment over a longer period of time, to gather information on the long-term outcomes and on the transition from inpatient treatment back into society (De Smet & Meganck, 2018).

This study aims to explore and compare the perspectives of completers and dropouts on inpatient group ST, as reported at long-term follow-up. The insight gained through this study may inform interventions and/or recommendations which are tailored to the needs of individuals

in order to improve treatment outcomes, dropout rates, patient satisfaction, quality of care, and cost-effectiveness.

Method

Design

This qualitative study was based on earlier studies conducted at the same setting, which collected self-reported data at the start of the inpatient group ST, after six months, after 12 months (end of treatment), and at six months follow-up (Phagoe, 2018; Schaap et al., 2016; Wolterink & Westerhof, 2018). This study included a long-term follow-up, at two to eight years after discharge. The data used in this study is part of a larger study by Pietersen et al. (in preparation), which was approved by the Ethics Committee of the Faculty of Behavioural Sciences at the University of Twente (request number 18883). Participants participated voluntarily and gave written informed consent.

Materials

At the long-term follow-up, a Qualtrics questionnaire was added including both open-ended and close-ended questions. The present study only examined the open-ended questions, which will be referred to as qualitative questionnaire in the remainder of the study (see Table 1). This study used two waves of data collection. In the first wave, two questions were asked to gather patients’ perceptions on the perceived helpful factors and outcomes of therapy. In the second wave, three questions were added to explore both positive and negative aspects of patients’ experiences.

Table 1

Qualitative Questionnaire Long-Term Follow-Up

First wave:

1. What did you experience as most valuable in the inpatient treatment?
2. What has the inpatient treatment brought you?

Second wave:

1. In general, how do you look back on the inpatient treatment?
2. What did you experience as most valuable in the inpatient treatment?
3. To what extent has the inpatient treatment contributed to where you are in life today?
4. What has the inpatient treatment brought you?
5. If you have any suggestions, additional remarks, feedback and/or comments, please write them down below.

Participants

Participants were recruited from a specialised treatment centre for personality disorders, de Boerhaven Mediant. Here, a 1-year inpatient group ST program is offered for patients with complex personality pathology that were unresponsive to earlier treatments (i.e., outpatient psychotherapy, day-hospital treatment, inpatient treatment; Schaap et al., 2016). For the long-term follow-up, patients were included on the basis of the following criteria: (1) undergone at least six months of inpatient group ST; (2) participated in the study by Schaap et al. (2016) and/or Wolterink and Westerhof (2018). The exclusion criteria were the following (Phagoe, 2018; Schaap et al., 2016; Wolterink & Westerhof, 2018): (1) acute suicidal behaviour; (2) IQ lower than 80; (3) lack of Dutch language proficiency; (4) physical aggression towards others.

The most common personality disorder diagnoses in this setting were borderline, avoidant, dependent or not otherwise specified personality disorder, with frequent comorbidities in mood, anxiety, eating, and substance-related disorders (Schaap et al., 2016; Wolterink & Westerhof, 2018).

A total of 122 patients (100%) who were discharged from the inpatient setting between 2012 and 2018 were approached to voluntarily participate in the long-term follow-up. Of these, 24 patients (20%) did not agree to participate, and 43 of them (35%) did not respond or were unreachable. This resulted in a total of 52 participants (43%) who completed the qualitative questionnaire, and 3 individuals (2%) who completed it partially. These 3 individuals were not included in this study.

Therefore, the final sample consisted of 52 participants (100%), of which 8 (15%) were dropouts (see Table 2). As can be seen in Table 2, a large portion of the participants are female. Furthermore, more completers (63.6%) than dropouts (50%) participated in the second wave, which contained five questions versus the two questions of the first wave. Hence, it is likely that completers are overrepresented as there is more data available from those participants.

Unfortunately, the researcher does not have to access to the characteristics of the initial sample of 122 patients. However, previous studies conducted at the same setting reported a dropout rate of 35% (Schaap et al., 2016) and 32% (Wolterink & Westerhof, 2018). The initial sample of 122 patients in the present study consists partially of the same patients as the participants in the previous studies, supplemented by patients who were discharged from the clinic in the time period after the study by Wolterink & Westerhof (2018). When comparing the relatively low dropout rate of 15% in this study with the dropout rates reported by the two previous studies, it seems highly unlikely that the sample of the current study is representative of

the initial sample of 122 participants. The results should therefore be interpreted more cautiously.

Table 2

Characteristics of Completers and Dropouts

	Completers (*N* = 44)	Dropouts (*N* = 8)
Age of admission (years)	27.0 ± 6.6	25.3 ± 5.6
Gender (female)	32 (72.7%)	6 (75%)
Length of admission (weeks)	51.9 ± 13.2	33.9 ± 5.4
First wave	16 (36.4%)	4 (50%)
Second wave	28 (63.6%)	4 (50%)

Of the 24 individuals (100%) who did not agree to participate, eight (33%) did not provide a reason. Four individuals (17%) indicated they had perceived the treatment as a negative experience, and therefore refused to participate. Three persons (13%) indicated that they did not wish to revisit this period, and two individuals (8%) indicated they were currently in a crisis situation. Other reasons for refusing to participate included: not participating in surveys on principle, recently diagnosed chronic illness, and difficulty with the formulation of questions.

Of the 43 individuals (100%) who did not respond or who were unreachable, for nine individuals (21%) the phone number and/or email address were out of order. Eighteen persons (42%) did not answer the phone despite multiple attempts. In the case of a personalized voicemail message, if possible, a voice message was left in which was referred to the email sent. Eight individuals (19%) agreed to complete the questionnaire after contact by telephone, but eventually did not do so. Six persons (14%) indicated that they were still contemplating to

participate, and one person was in a hectic period and indicated that other concerns had more priority.

Dropout

Dropout was defined as any patient who ended the inpatient treatment prematurely, regardless of the reason of non-completion (McMurran et al., 2010). However, due to the inclusion criteria for the long-term follow-up, all dropouts received at least six months of inpatient group ST.

Data Analysis

A transcript of the open-ended questionnaire was imported in ATLAS.ti, a tool for qualitative data analysis. To ensure confidentiality all names were anonymised. Using ATLAS.ti, a thematic analysis was using an inductive approach (Braun & Clarke, 2006). Hence, the codes were deriven from the data. The coding process was documented to enhance transparency. This process will be described in the following section.

To get acquainted with the data, first, the entire transcript was read freely. Next, based on a segment of the transcript, initial codes were formulated closely to the words used by participants. Using the method of constant comparison, initial codes were renamed and restructured to form categories of codes. Subsequently, transcripts from several participants were coded using this coding scheme. Inclusion and exclusion criteria were formulated for each code. Again, the coding scheme was revised where needed, after which more transcripts were coded. This process of constant comparison and revision of the coding scheme was repeated until the code scheme was saturated. Using ATLAS.ti, for every subtheme it was counted how many participants per subgroup (i.e., completer or dropout) endorsed a certain subtheme.

Results

Various interrelated themes were identified from the statements of patients on their inpatient group ST experience (see Table 3). Firstly, patients mentioned numerous factors they experienced as either helpful and/or unhelpful during therapy. Secondly, patients described the positive outcomes gained from therapy, but they also commented on the negative effects that they experienced. Third, patients made remarks on their overall experience of the therapy. These themes and its subthemes are presented in the following section. Extracts are given of prototypical quotes of the (sub)themes, and moreover, to highlight the diversity within a (sub)theme. The numbers in the text always only refer to participants from a certain subgroup (i.e., completers or dropouts), and the percentages refer to the proportion of that subgroup. The numbers in the text correspond with the numbers in Table 3.

Helpful Factors

The helpful factors were defined as those aspects that patients valued the most. An important criterion for this theme is that patients explicitly stated that they valued this aspect as most valuable or helpful. That is, they referred to the helpful aspect in response to the question: “What did you experience as most valuable in the inpatient treatment?” For this criterion was decided to be able to make a substantive distinction between this theme and other themes, which may show some overlap (e.g., helpful factors and outcomes of therapy). The helpful factors ranged between group factors, components of inpatient GST, individuality, insight, and the therapeutic relationship.

Table 3

Patients' Perceptions of Helpful Factors, Unhelpful Factors, Outcomes of Therapy and Evaluation of Therapy for Inpatient Group Schema Therapy, for Both Completers and Dropouts

Themes	Completers N (%)	Dropouts N (%)
1. Helpful factors		
Group factors	14 (32%)	5 (63%)
Components of inpatient GST	11 (25%)	3 (38%)
Individuality	12 (27%	2 (25%)
Insight	12 (27%)	1 (13%)
Therapeutic relationship	6 (14%)	–
2. Unhelpful factors		
Group factors	7 (16%)	1 (13%)
Intensity of inpatient GST	2 (5%)	–
Management of boundaries	2 (5%)	–
Too great an emphasis on insight	1 (2%)	1 (13%)
Transition after inpatient GST	4 (9%)	–
3. Outcomes of therapy		
Insight and processing	31 (70%)	6 (75%)
Self-development	23 (52%)	2 (25%)
Affective outcomes	13 (29%	3 (38%)
Interpersonal relationships	14 (44%)	2 (25%)
Reintegrating into society	10 (23%)	–

(continued)

Table 3 (continued)

Themes	Completers N (%)	Dropouts N (%)
4. Evaluation of therapy		
Positive evaluation	16 (36%)	–
Ambivalent attitude	14 (32%)	4 (50%)
Negative evaluation	–	1 (13%)

Note. GST, Group Schema Therapy

Group Factors

Patients were most appreciative of group-related aspects, as 14 completers (32%) and five dropouts (63%) reported the group elements as the most helpful aspects of the inpatient GST. Living in a community group setting where patients could share experiences and talk about their problems with their peers proved to be invaluable for patients. Patients felt acceptance and understanding while being in touch with others that were going through similar problems: "*The recognition that there is a problem and that it is not nothing. Getting the feeling that you are taken seriously and that your pain is seen, mainly by the group" (completer42)*. *"The close contact with fellow sufferers, which at least made me think I experienced more understanding" (dropout7)*. Other group aspects that were experienced as beneficial were being in an environment of *"constant feedback" (completer4)*, and being able to *"experience a connection with others" (completer22)*.

Components of Inpatient GST

Eleven completers (25%) and three dropouts (38%) reported certain components of the inpatient treatment as most helpful. Generally, these patients appreciated the therapy-related aspects. Completers valued both mandatory components such as Schema Therapy, group

therapy, and the length and intensity of the treatment, as well as optional components such as individual sessions with psychotherapist and trauma therapy. Dropouts found the optional components most beneficial, such as individual therapy and elective modules. The appreciation of individual sessions was also explicitly stated by this dropout, who found the *"conversations with peer workers with lived experience" (dropout4)* most helpful. One patient highly valued that one of the staff members challenged his behaviour, which allowed him to break through maladaptive patterns: *"The 1-on-1 PB (i.e., personal guidance) conversations with sociotherapist (i.e., psychiatric nurse) who did figure me out, and dared to confront me" (completer23)*. The inpatient therapy setting was considered helpful as it was regarded as an ideal environment to practice alternative behaviour: *"The simulation of your problems in everyday life are put under a microscope in therapy. [...] The space to experiment in this and grow as a result" (completer7).*

Individuality

Fourteen patients found aspects relating to their own individuality and uniqueness as a person most helpful during their therapy, of which 12 completers (27%) and two dropouts (25%). This subtheme is characterized by patients' autonomy, their desire to be able to express who they are to others, and by feeling accountable for their actions.

Several patients valued their own motivation and personal goals, and to have learned to stand on their own feet. One patient mostly appreciated her *"own motivation and work attitude" (completer29)*. Another patient mentioned how she valued to have addressed those aspects that were important to her as an individual: *"That I was able to tackle everything that was necessary for me to move forward in life" (completer14)*. Someone else was happy to have learned the skill to solve situations independently: *"In hindsight, the part that you had to solve a lot by yourself*

within the group, and you learn to ask for help in this. I also liked the fact that the staff did not immediately come up with a solution, but they first let me think about finding a solution. As a result of this I learned this skill and it really helps me a lot. To think in possibilities, and to think outside the box" (completer24).

Other patients described how helpful it was for them to share with others what they were experiencing inside: *"I learned to express myself. I can communicate much better with people now. I had never learned to do that. Especially, at those moments when things are not going well" (completer39). "The space to be myself and to express myself" (completer34).* One of the dropouts also valued to have learned to express herself, and she recognized the importance of *"putting it [her thoughts and feelings] up for discussion with others" (dropout3).*

Some patients found it most helpful that they had to *"take responsibility" (dropout7)* for their therapy. Others appreciated the sense of accountability that was triggered as they knew that they *"could not get away from therapy" (completer33)*. Knowing that they could not easily engage in avoidance seemed to instill a feeling of responsibility in these patients. This is also highlighted by this excerpt, as one person mostly valued "*the fact that it is made as difficult as possible to work around your problems" (completer13).*

Insight

Twelve completers (27%) and one dropout (13%) regarded an increase in insight as most helpful during the inpatient ST. This subtheme is characterized by gaining awareness and a deeper understanding relating to oneself, others, or the world in general. Some patients appreciated the improved self-knowledge: *"I have come to know myself. Knowing who I am, and why I do the things I do" (completer17)*. Several other patients particularly valued the insight gained by applying key ST concepts (e.g., schemas, schema modes) on both their past and

current life situation: *"Realizing in which situations the schemas are most present, and where they originate" (completer36).* Remarkably, only one of the dropouts regarded the extent to which ST provided insight as the most helpful aspect of therapy. She described how introspection helped her to gain a better understanding of herself and the world around her: *"You are sort of challenged to reflect on yourself. […] That is how you start to better understand yourself, feelings, events, but also others" (dropout3).*

Therapeutic Relationship

Six completers (14%), and none of the dropouts, reported the therapeutic relationship as a pivotal factor in their therapy. The compassionate engagement and support of therapists who looked after the patients in a caring, humane way proved to be priceless for these patients. Having someone that tended to their physical and emotional needs was greatly appreciated by some patients: *"I always had the feeling that the people who worked there had my best interest at heart, [they] were also very humane and had real personal attention and care for me. I was not a number but a person they wanted to help. I was taken care of and I was in safe hands" (completer10).* Another patient acknowledged how experiencing unconditional support turned out to be a corrective experience for her: *"You could really trust people and people were really there for you unconditionally. Something I have not experienced before" (completer19)*. It is noteworthy that none of the dropouts reported this aspect as most helpful.

Unhelpful Factors

Although patients in this study were not explicitly asked which aspects they experienced as unhelpful, a relatively small portion of patients mentioned factors they considered to be hindering during or after inpatient GST. These unhelpful factors related to group factors, the

intensity of the treatment, the management of boundaries, the large focus on insight, and the transition after inpatient GST.

Group Factors

Seven completers (16%) and one dropout (13%) reported factors related to the group to be unhelpful. Patients deemed there was too much priority on group aspects which gave them a feeling of missing out on therapy tailored to their individual needs: *"I often found being in the group overwhelming, and often the emphasis was on the living climate. This made it difficult for me to get to my own part and I missed individual therapy" (completer38)*. Others experienced a loss of privacy: *"I felt that too much had to take place in the group, and you had too little privacy" (completer35)*.

Some patients expressed to have felt unsafe in the (living) group during their inpatient treatment: *"The living group is way too large. You [staff] want to create a kind of pressure cooker effect. But in retrospect I experienced it as unsafe. There are many people with various issues, with short fuses and strong emotions in a small space" (completer35)*. Patients mainly attributed the feeling of unsafety to the size of the group (e.g., *"the chaos of the large group"; completer22*), the diversity in mental health problems that patients are experiencing, adverse events (e.g., self-harm or suicidal attempt), and insufficient enforcement of boundaries by staff.

A few patients expressed their dissatisfaction in the management of urgent or severe issues of fellow group members. One patient was unhappy that *"many clients had to put their therapy aside (including myself) due to urgent and extreme problems with other clients who got priority" (completer27)*. She acknowledged that it was normal that these things happened, however, the frequency seemed to get out of hand from her viewpoint. Another patient also shared her discontent: *"I also experienced it as unhealthy that group members very much 'had' to*

take over the care from the sociotherapists. [...] If a group member could not get out of bed because of her conversion disorder, the group had to deal with this. [...] This happened frequently and the care for certain group members really got a bit out of hand (completer35).

Some patients found it unhelpful that some patients who might have been more avoidant or introverted seemed to get less attention from staff compared to their peers: *"It is really too easy for many to avoid or just go unnoticed during therapy. [...] I always found it sad and sometimes even painful to see when someone did not get the attention they deserved or needed, for whatever reason. Especially when the whole group was together because that is where you can make such great process" (dropout7). "It was noticeable that the ones who were jumping on the tables did get the extra attention and the ones who were more withdrawn did not. Very unfortunate" (completer22).*

Intensity of Inpatient GST

Two completers (5%) did not experience the high intensity of the overall inpatient treatment as useful. Their main objections stemmed from having very limited space to withdraw from the group to unwind, and recharge oneself. During the majority of the day, the patients are expected to be among their group members, and in addition to all the therapies during the day, they are occupied with household duties and committee work. These two patients clearly did not agree with this type of schedule: *"I found all the committees to be purely time filling. You are busy enough there with all the house chores and therapies. People who are at home also try to take more rest in the evenings" (completer35). "There was no opportunity to retreat to recharge or take a rest. We slept with 2 people in a room and only from 9:30 in the evening you had access to it. I don't think it's right to put pressure on people 24 hours, so to say, over an average period of a year. [...] In addition, all kinds of processes take place on a personal level, I found*

the situation at that time not very humane and dignified. I could not have imagined this during the intake" (completer22).

Management of Boundaries

Two completers (5%) commented on *"the many rules you had to follow" (completer22).* One of them particularly found it hindering that the clinical staff insufficiently enforced the boundaries. She felt that this negatively contributed to the sense of safety in the (living) group: *"There were too few boundaries set by the team, and everyone could just do whatever they wanted. I really experienced this as unpleasant. [...]. As a result, tensions rise even higher" (completer35).*

Too Great an Emphasis on Insight

When looking back, one completer (2%) and one dropout (13%) express their viewpoints on the large focus on insight during the inpatient ST. These patients appreciated the gained insight, but they believed there could be a better balance between insight on the one hand, and experiential work and practical tools on the other hand: *"In treatment, there is too much focus on talking and not enough on feeling and processing" (completer28)*. One dropout regretted not to have learnt adaptive emotion-regulation skills when experiencing strong emotions: *"My experience with schema therapy is that it focuses primarily on insight, recognizing patterns and self-reflection. [...] What I personally lacked is that I learned too few practical things that help me when I am 'in the moment' of intense emotions" (dropout7)*.

Transition after Inpatient GST

Four completers (9%) shared something about how difficult it was for them to make the transition after the inpatient treatment had ended. For some patients, the transition from the safe, protected community of the inpatient setting back into society was a very challenging one:

"Because of the gap that is created between the safe environment within the four walls of the clinic and society, I have had great difficulty re-grounding myself in society" (completer28). Others commented on the importance of appropriate aftercare for inpatients: *"After the inpatient treatment I very much missed a proper treatment and care. The day treatment I received at the […] did not match in any way. This all resulted in an extreme relapse of anxiety and depression in the first year after the clinical treatment" (competer19).*

Outcomes of Therapy

The large majority of the patients reported on beneficial outcomes of their inpatient therapy. Only one dropout mentioned no beneficial outcomes whatsoever. Nevertheless, some patients, also reported on adverse therapy outcomes. The outcomes of therapy were divided in five categories: insight and processing, self-development, affective outcomes, interpersonal relationships, and reintegrating into society.

Insight and Processing

Thirty-one completers (70%) and six dropouts (75%) reported benefits in acquiring insight, applying these insights to cope more adaptively, and the processing of past events. Patients described how the inpatient GST helped them to get to know themselves better. They became more aware of their own thoughts, feelings, and behaviour, and where these originated. Knowledge on the theory of ST provided patients with insight into their pitfalls and maladaptive patterns, but it also equipped them with skills to manage situations more adaptively: *"Gaining insight into my own behaviour and thoughts. Where it comes from, and how I can use it differently to approach it in a healthy adult way" (dropout4).* Gaining valuable insight on themselves allowed patients to counter maladaptive schemas and modes as they occurred in future situations: "*I left the clinic with the thought 'I may do it differently, I can do it differently, I*

am going to do it differently!' Which makes me try to break loose from problematic patterns. I still regularly repeat these words when, for example, I am troubled by persistent old negative beliefs. Or when I catch myself in old (automatic) schematic behaviour" (completer23). The inpatient treatment also helped patients with the processing of unpleasant memories and traumas. Several patients described how the therapy helped them to release and accept the past: *"I have been able to let go of everything in the past, which allows me to accept how I am in life and live on with myself" (completer14).* Although for some patients the treatment helped them to work on processing their traumas, for one patient it had the opposite effect: *"I learned why I do certain things and minor skills that can help. However, it has also given me another trauma [due to being bullied]" (completer21).*

Self-Development

Twenty-three completers (52%) and two dropouts (25%) experienced a change in self-development as a result of the inpatient ST. Patients noticed changes in self-confidence and self-esteem. Also, numerous patients described how the inpatient treatment provided them with a foundation for the future.

Roughly a quarter of both the completers and dropouts reported an increase in self-confidence after ST. They described how they felt stronger, more independent, and ready to take on life. For a number of patients, ST helped them to gather the courage to express themselves: *"I am more myself now: From not expressing and showing anything at all, to having the courage to express what is going on inside me, what I feel and what I want" (completer32).* Despite that quite some patients experienced an increase in their self-confidence, one completer took a major hit to her self-confidence: *"Due to the inpatient therapy at the [name of treatment centre], I have*

had to learn from the ground up to trust my feelings and intuition, to trust that I can function, and to trust that others will not belittle me if I express my opinion" (completer42).

For eight patients (7 completers; 1 dropout), the inpatient ST led to an increase in their self-esteem, that is, their overall sense of self-worth: *"I feel like a valuable human being again who can give a lot of love but who also needs love herself" (completer18)*. Patients described how their self-image improved as they learned to appreciate themselves, and one dropout mentioned that his *"self-hatred [became] slightly less extreme" (dropout7).*

Nine completers referred to the inpatient ST as a base which provided them with a foundation for what is yet to come in their lives. *"I feel like the inpatient treatment has given me a second chance at life. I am a different person, have finally found more of a foundation in myself that I was allowed to build upon during the inpatient treatment" (completer34).* For several patients, the therapy served as an initiation for further mental health treatment: *"It has served as a good opening for my mental health treatment in general. It has introduced me to many things that I was never aware of" (completer27).* In this sense, for some patients the inpatient ST served as a starting point towards processing their traumas.

Affective Outcomes

Thirteen completers (29%) and three dropouts (38%) commented on changes that they experienced in relation to their emotions. Of these, 11 completers and one dropout reported positive affective outcomes, and two completers and two dropouts reported negative affective outcomes. Patients described how ST led them to experience more positive emotions, such as joy, amusement (e.g., through play) and peacefulness. Several patients also reported increased life satisfaction, which is demonstrated by a quote from one patient who described that the inpatient ST brought her *"a different, more beautiful, more comprehensive life" (completer34)*.

Others noticed that negative emotions decreased as they experienced less sadness and less fear. However, this was not the case for all patients. One completer was not able to benefit much from the treatment: *"[I] am still in the same situation in terms of feeling" (completer43).* One of the dropouts expressed to have deteriorated from the inpatient treatment: *"[The therapy brought me] very little I ended up worse"* (dropout1). Some patients also commented on feeling emotionally supported or the lack thereof. For one person, merely experiencing that she was noticed and that her emotional needs were met, by *"being seen and heard" (completer8)*, was an important outcome of therapy. However, some also experienced a lack of emotional support at times: "*The end of the treatment was abrupt and in that I did not feel supported/heard at all (dropout3)"*. Numerous patients reported improvements in emotion-regulation as a result of the ST. Several of these patients described how inpatient ST allowed them to reconnect with their emotions, express their emotions and find healthier ways of coping with their emotions: *"I was able to find peace by letting go of my mistrust of everything and everyone, and with that also the fear, anger, and stress. Of course, it is not completely gone, but in comparison it is as different as night and day" (completer19).*

Interpersonal Relationships

Fourteen completers (44%) and two dropouts (25%) reported changes in interpersonal relationships. These patients made remarks on how their inpatient treatment helped them to gain more trust in other people, cooperate with others, and open themselves up to be able to connect with other individuals. Generally, this resulted in improvements in social interactions as was highlighted by this patient: *"I have a much better and more open contact with my environment. They know what is going on with me and therefore give me more of the space that I need to recover" (completer39)*. For others, this also led to other interpersonal outcomes such as new or

closer friendships, a new relationship partner, and/or an improved relationship with parents. Living in an inpatient group setting where one is constantly communicating with other individuals helped one of the dropouts to feel more assertive and become *"a bit more resilient in contact with others" (dropout3).* One patient also described how the inpatient ST helped her to gain a better understanding of where she stands in relation to others. This helped her to find out which kind of people she would like to be as a part of her life: *"In interaction with other people I have learned to sense well with whom you want something and with whom you do not" (completer35)*.

Reintegrating Into Society

Ten completers (23%) reported outcomes related to returning back into society. None of the dropouts made remarks on outcomes associated to rejoining society. This theme was mainly characterized by patients' comments that revolved around moving on in society, completing one's studies and/or finding a new job: *"Due to my inpatient treatment, I got my life back on track, [and I] now have a nice job" (completer18)*. Other patients described how after the inpatient ST they were able to reenter society, find their own place to live, find volunteer work that they could engage in, and more generally find their position in society: *"I eventually became a more stable person who functions relatively well in society" (completer12)*.

Evaluation of Therapy

Positive Evaluation

Sixteen completers (36%) rated their general experience of the inpatient GST as clearly positive. Overall, these patients were satisfied with their experience and viewed the therapy as useful and informative. For many completers the treatment was a crucial turning point in their lives. Inpatient GST provided patients with the skillset to break maladaptive patterns which

allowed them to do things differently in the future: *"It encouraged me to make many new and different choices in life. It was the starting point" (completer23).* A number of patients truly considered it to be a life-changing experience: *"I don't know where I would have been had I not received inpatient treatment. The treatment has given me my life back" (completer10).* Patients expressed their deep gratitude for the inpatient ST: *"The best choice in my life, life changing! Very positive and grateful for the opportunity it has given me" (completer34)*.

Ambivalent Attitude

Fourteen completers (32%) and four dropouts (50%) expressed both positive and negative aspects of their inpatient experience. These patients varied strongly in describing their overall experience of the therapy. Their responses ranged from having quite positive to rather negative views. Nevertheless, most of them shared that the inpatient GST helped at least to a certain degree.

Many of these patients described their experience in the inpatient setting as difficult and intense, but also as a period of time that brought them significant benefits: *"I call it a good hell. I got a lot out of it … But it was also hell" (completer19)*. This was also the case for one of the dropouts: *"Intense, but overall, fairly positive … If I had not undergone treatment, I am convinced that I would have been in much worse condition now (dropout7)"*. Despite the difficulties faced, patients with mixed feelings nonetheless expressed their gratitude for the inpatient treatment: *"Heavy period … If I didn't have the treatment, along with all the preliminary phases, I would not be here anymore" (completer26)*.

Patients shared their ambivalence and also emphasized that the benefits came at a high cost: *"I learned a lot from it, but I have also been very much damaged by it" (completer42)*. Other patients mentioned few positive aspects and held overall quite negative perceptions of the

inpatient GST. For them, the treatment *"did more harm than it did good" (dropout6)*. These patients were generally dissatisfied with the inpatient GST experience: *"An experience I do not want to go through again. I would not choose to do this again" (completer22)*.

Negative Evaluation

One dropout (13%) did not experience any positive aspects at all (dropout1).

Discussion

The aim of this study was to explore and compare the perspectives of both completers and dropouts on inpatient group ST, as reported at long-term follow-up.

Main findings

Helpful Factors

The results indicate that patients were highly appreciative of aspects related to the group format. Both completers and dropouts valued group experiences, such as sharing, receiving feedback, feeling connected to others, and recognizing that others have gone through similar problems. These group factors resemble some of the therapeutic factors (e.g., interpersonal learning, cohesiveness, universality) for group psychotherapy outlined by Yalom and Leszcz (2005). This finding is also in line with a recent study by Hoekenga et al. (2021), which was conducted at the same treatment center as the current study. These authors explored patients' perspectives of inpatient GST using a Q-sort method, and found three groups with somewhat different perspectives. One group of participants particularly valued group factors, such as living together, instillation of hope, and feeling connected with others (Hoekenga et al., 2021). Likewise, in a qualitative study on the perceptions of BPD patients on group or combined group-individual ST, group experiences were generally rated as positively (Tan et al., 2018).

The second helpful factor related to certain components of the inpatient GST. Dropouts seemed to especially appreciate optional components in which they had more freedom to make personalized choices regarding different parts of their treatment. In the study by Hoekenga et al. (2021), it was found that one group of participants found individual support, the freedom of choice, and the connection with others particularly important. The dropouts in the present study seem to have some characteristics in common with the group described by Hoekenga et al. (2021), as the dropouts considered the contact and connection with group members and the optional components of the inpatient GST as largely helpful. In contrast to the dropouts, the completers in the current study valued both mandatory as well as optional components of the inpatient treatment program. The finding that quite a number of participants mentioned some form of individual therapy as most helpful is important to note. This emphasizes that patients consider individual support to be a crucial factor in addition to group ST, a finding which was also reported in the study by Tan et al. (2018).

Another facilitating factor described by patients related to aspects of patients' individuality. Completers regarded their own motivation and personal goals as highly useful during the inpatient GST. Patients' individuality may possibly partially be linked to patients' preferences, which refers to what patients would want the therapy to look like if the choice would be up to them. Research has shown that taking into account patients' preferences is associated with lower dropout rates and better treatment outcomes (Norcross, 2011). Additionally, in the current study both completers and dropouts appreciated to have learned to express themselves, and found it helpful that they had to take responsibility for their own therapy process. This is in line with a study on therapists and patients' perceptions on change

mechanisms in group psychotherapy, where patients reported their self-responsibility as the most helpful factor during therapy (Schaffer & Dreyer, 1982).

An additional helpful factor reported by many participants was the increase in insight. Particularly completers, and to a lesser extent dropouts, considered the gained insight by applying key ST concepts (i.e., schemas, schema modes) on both the present as well as the past to be a crucial element of the inpatient treatment. Patients' perceived usefulness of the theoretical frame of ST is consistent with findings in previous studies that examined patients' perspectives (de Klerk et al., 2017; Hoekenga et al., 2021; Tan et al., 2018). Applying and discussing the schemas and schema modes with others allowed patients to understand the origin of their thoughts, feelings, and behavioural patterns. In turn, the increased insight helped patients to better understand themselves, others, and the world around them. A study by Johansson et al. (2010) found that an increase in insight mediated interpersonal functioning in the long term, indicating it as a key mechanism of change in psychodynamic therapy.

A last facilitative factor described by only completers was the therapeutic relationship. Patients valued the genuine, compassionate, and unconditional engagement and support they received from therapists. Having someone that tended to their emotional and physical needs was something that patients had not experienced in their lives prior to the inpatient treatment. Being cared for in such a humane way proved to be a corrective experience for patients. This is in line with the therapeutic relationship in ST, which is theorized as limited reparenting. That is, the therapist has a caring attitude towards patients to provide corrective emotional experiences for unmet core childhood needs, within professional constraints (Young et al., 2003). The importance of the therapeutic relationship for patients in (group) ST is in line with previous literature (de Klerk et al., 2017; Hoekenga et al., 2021; Tan et al., 2018). Notably, none of the

dropouts in this study mentioned to have valued the contact with therapists. This raises the question how the dropouts perceived the therapeutic relationship. It may be argued that a lower quality of therapeutic relationship is related to higher dropout rates. Indeed, in a recent qualitative study on outpatients' perspectives on ST that included four dropouts, in the interviews two patients reported the therapeutic relationship as a hindering factor, and in fact also as the reason to prematurely terminate therapy (de Klerk et al., 2017). Moreover, a study on adolescents with personality disorders following an intensive MBT group psychotherapy program found that decreases in the therapeutic relationship in the last three sessions were predictive of dropout (Hauber et al., 2020).

Unhelpful Factors

Although many patients experienced the group format as a strength, some patients also experienced difficulties related to the group. These patients felt that too much priority was given to group aspects. Some felt unsafe within the group, for example, due to the size of the group or adverse events with group members. Others expressed their discontent concerning the frequency patients had to provide care for group members that were going through urgent or severe issues. Also, a few patients regarded it as unhelpful that more withdrawn and avoidant patients seemed to get less attention from therapists compared to their more active counterparts. From the perspective of one patient, the clinical staff insufficiently managed the boundaries which was experienced as highly unhelpful and negatively impacting patients' sense of safety within the group climate. In the study by Tan et al. (2018), the authors identified some factors that were disruptive for the group climate. In their study, some group members also experienced a sense of unsafety during ST, however, that may have occurred for different reasons than in the current study. Patients felt unsafe as a consequence of conflict within the group which led some group

members to feel discouraged to keep on sharing sensitive information regarding themselves (Tan et al., 2018). An important difference between their study and the current one is that they explored the experiences of outpatients receiving twice-weekly group ST, which is an entirely different setting compared to an impatient setting in which patients remain for five days and five night a week. Nevertheless, whether it be in an outpatient or inpatient group it is crucial that group members feel sufficiently safe and supported to be able to explore uncomfortable issues within the group (Yalom & Leszcz, 2005).

Other unhelpful factors related to the intensity of the treatment, the large focus on insight, and the transition after inpatient treatment. Some patients found the high intensity of the inpatient treatment unhelpful. They experienced limited time and space to recharge oneself, and perceived little value in practical tasks such as committee work. This is in agreement with findings from Hoekenga et al. (2021), as participants in that study rated practical tasks among the least appreciated aspects of the inpatient GST.

In addition, a few participants in the current study asserted that the inpatient treatment had too great an emphasis on insight. One patient emphasized this by conveying he had gained much clarification on a cognitive level, however, insight alone did not solve his problems. These patients valued the insight gained, however, they argued that they could have benefited more from a better balance between insight and experiential work. This is a rather interesting finding as the inpatient GST contains many experiential therapies, such as drama therapy, art therapy, psychomotor therapy, along with experiential ST-specific techniques such as imagery rescripting and chair dialogues. This begs the question how patients experienced these experiential techniques and therapies. Unfortunately, none of the patients in the current study shared their perspectives on the experiential elements of GST elaborately. In contrast, Hoekenga et al. (2021)

found that one group of patients particularly appreciated ST-specific techniques which helped them to gain insight and process unpleasant emotions. In line with Hoekenga et al. (2021), other qualitative studies on (group) ST found that patients' perceptions of imagery rescripting were mostly positive (de Klerk et al., 2017; Tan et al., 2018). Nevertheless, another study that explored BPD patients' experiences with imagery rescripting found that patients initially reported high emotionality and exhaustion, however, this was followed by improvements in emotion regulation, interpersonal relationships, and increased insight of schemas in the long term (Schaich et al., 2020).

It should be noted that the unhelpful factors described above were reported by a relatively small proportion of all participants, as these aspects were mentioned by only eight completers and one dropout. An explanation for this might be the low dropout rate of 15% in the study sample, compared to the dropout rate of 32% and 35% in previous studies at the same setting (Schaap et al., 2016; Wolterink & Westerhof, 2018). Moreover, the questions of the first wave mainly elicited the positive experiences of patients, and not the negative experiences. Nonetheless, these objections should be taken seriously but also interpreted with some caution. It may be that some patients' perspectives on the unhelpful aspects are overrepresented whereas those from others remained covert. For example, one might expect the dropouts in particular to describe more unhelpful factors considering these patients did not complete the inpatient therapy; moreover, research suggests that dropouts are generally dissatisfied with the group therapy experience (Yalom & Leszcz, 2005).

Outcomes of Therapy

The results showed that patients stated several different type of outcomes as a result of the inpatient GST, which consisted of changes in relation to insight and processing, self-

development, emotions, interpersonal relationships, and reintegration into society. The large majority of reported changes were positive outcomes, however, a small number of patients also described adverse treatment outcomes. These qualitative outcomes are strongly in line with quantitative outcomes reported in earlier studies at the same inpatient setting as the current study, which showed that inpatient GST is effective in improving schemas, schema modes, mental well-being, and symptomatic distress, with effects being maintained at six months follow-up (Schaap et al., 2016; Wolterink & Westerhof, 2018). The reported benefits by patients in the current study are in agreement with the gains reported by BPD patients in the qualitative study by Tan et al. (2018), which included increased insight, improved emotion regulation, improved self-confidence, and increased cognitive flexibility in terms of perspective-taking and self-compassion. In the present study, the increased perspective-taking was reflected in the improvement of interpersonal relationships, and self-compassion was represented in the subthemes self-development and affective outcomes.

Patients reported also on some negative effects that they experienced, including damaged trust, traumatization, feeling unsupported, and lack of improvement or worsening of symptoms. These resemble some of the adverse treatment outcomes reported in the literature (Roback, 2000). Of the negative effects in this study, a loss of trust and a lack of perceived support was also reported in the study by Tan et al. (2021).

When examining the outcomes of therapy for completers versus dropouts, the results point in the expected direction. In comparison to completers, dropouts reported fewer positive outcomes in relation to self-development, emotions, interpersonal relationships, and societal reintegration. Additionally, dropouts reported relatively more negative treatment outcomes.

Clearly, this supports the notion that premature termination of treatment is unhelpful for patients and may potentially be harmful, as is also suggested by literature (Yalom & Leszcz, 2005).

Evaluation of Therapy

With respect to patients' evaluations of their overall experience of the inpatient GST, a clear distinction can be made between the perspectives of completers versus dropouts. Completers, on the one hand, were largely divided between patients who rated the treatment as distinctly positive and those who experienced more ambivalent attitudes. The positive evaluations reflected completers' satisfaction with the treatment as they described how it proved to be a turning point in their lives, a real life-changing experience for some, for which they were highly grateful. Nevertheless, many completers also expressed ambivalent attitudes towards the inpatient treatment. These patients experienced benefits to some degree but also emphasized that these benefits came at a high cost (e.g., damaged trust, traumatization). These findings are only partially in line with the study by Hoekenga el al. (2021), who found that completers were generally satisfied with the treatment. Nevertheless, the present study provides a more nuanced view of patients' perceptions on inpatient GST.

The perspective of dropouts, on the other hand, was mostly characterized by ambivalence with statements more weighted towards negative aspects of the inpatient experience. With the exception of one dropout, who looked back fairly positively, the other dropouts with ambivalent attitudes generally expressed dissatisfaction with the inpatient GST experience. One dropout reported an entirely negative evaluation, however, this patient did not provide any additional explanation.

It should be noted that not all participants provided a general evaluation of the therapy. Those patients who reported briefly on (un)helpful factors or the perceived outcomes of therapy,

and thus did not clearly express their opinion on their overall experience were not coded for this theme. This choice was made to refrain from making assumptions as much as possible and to stay close to the words of participants.

Limitations and Strengths

This is the first qualitative study that examined and compared the perspectives of both completers and dropouts with personality disorders who underwent inpatient GST. As a part of a larger long-term follow-up study, this study investigated how patients reflected on their inpatient group ST experience as they looked back on their treatment which ended two to eight years prior. This study made use of a qualitative questionnaire which had its benefits but also its limitations. Benefits of this instrument included the simple construction and its cost-effectiveness to implement (Rodgers, 2015). The most important advantage of this method was its accessibility for participants as it allowed to collect qualitative data from a relatively large sample, which included the participation of eight dropouts, a group that may be challenging to recruit for more elaborate qualitative methods for obvious motivational reasons. For example, it may be that these dropouts would be less willing to participate when approached for an in-depth interview, as was also the case in a study on outpatients' perspectives on ST for personality disorders (de Klerk et al., 2017).

Nevertheless, the use of a qualitative questionnaire also has its disadvantages as the collected written data is likely to be less rich compared to other methods such as interviews, mainly due to a lack of interaction between participant and researcher (Rodgers, 2015). This was also the case in this study as some participants responded briefly to the questions which made it sometimes more difficult to interpret the intended meaning (e.g., helpful factor or outcome of therapy), as there was no option to ask for elaboration from patients. In these cases, it was

decided to code the responses mainly on the basis of the question asked due to a lack of contextual information.

Another methodological weakness was that the present study used two waves of data collection with unidentical qualitative questionnaires, resulting in unequal portions of participants, and also unevenly divided portions of completers and dropouts, receiving two or five questions. The second wave included three additional questions that aimed to elicit both positive and negative aspects of clients' experiences, to reduce the potential positive bias in the formulation of the questions in the first wave. Nevertheless, patients in the second wave logically provided richer data, and thus made a larger contribution to the final coding scheme.

Moreover, selection bias likely occurred as it is highly probable that the individuals who chose not to participate had more negative views of their inpatient experience compared to participants in this study, as was also mentioned when describing the recruitment process. Additionally, it was a limitation that the coding process was conducted by a single researcher, with some consultation with the supervisors, which may have resulted in researcher bias as this did not allow computation of inter-code reliability (Noble & Smith, 2015).

Also, the findings of this study may have limited generalizability to other settings. The findings were based on a sample that included many more female than male participants, and it was conducted at an inpatient setting where besides group ST patients followed several other therapies (e.g., art therapy, psychomotor therapy).

Clinical Implications

Based on the analysis of the experience of patients, several recommendations can be made to further optimize the inpatient GST in the future. Partially, these recommendations followed from the unhelpful factors described by patients.

More Tailoring to Individual Needs

Despite the fact that many patients saw the group format as a strength, the importance of paying sufficient attention to the individual needs of patients was also emphasized. Both completers and dropouts considered individual support as an essential element in addition to the group format. Moreover, patients suggested to pay sufficient attention to the needs of members who stay more in the background of the group. Also, a recommendation was made to make more use of treatment goals that are tailored to the individual.

Less Talking and Insight, More Experiential Work

Patients appreciated the insight gained through ST. Nevertheless, some patients considered there was too great an emphasis on insight, and recommended to create a better balance between talking and gaining insight on the one hand, and experiential exercises and techniques on the other hand. Also, a suggestion was made for more practical emotion-regulation skills when being in the moment of intense emotions.

Maintaining Safe Environment

Patients highlighted the importance of maintaining a safe environment. Patients remarked that clinical staff insufficiently enforced the boundaries. This was also found in the study by Hoekenga et al. (2021). Others raised their objections that quite frequently patients had to care for fellow group members with urgent and severe issues. Specific recommendations made to counter these issues were maintaining consistent boundaries by clinical staff, and paying considerable attention to the selection process of new patients.

Option to Rest or Less Practical Tasks

Patients expressed their annoyance regarding all of the duties and responsibilities on top of the intensive treatment program. Hoekenga et al. (2021) also found that practical tasks were

rated among the least helpful aspects. Patients stressed the importance of having the possibility to take some rest away from the group to be able to recharge oneself.

Proper Aftercare and Expectation Management

Patients emphasized the importance of receiving appropriate aftercare. For some patients, reintegrating back into society after inpatient treatment is a large and difficult step to take. Other patients experienced inadequate aftercare which led to relapses. Patients emphasized the importance of providing proper aftercare in the period immediately following an intensive inpatient treatment program. Besides providing proper aftercare where possible, it also seems important to manage the expectations of patients throughout inpatient treatment adequately as unrealistic expectations may lead to disappointment and lower satisfaction with the treatment.

Suggestions for Future Research

Future qualitative research may benefit from in-depth exploration of several aspects of the inpatient experience on group ST that were not fully revealed in the current study. It is suggested to conduct semi-structured interviews with both completers and dropouts to gather patients' experiences in more detail. Interviews will allow the researcher to ask for an explanation of patients' responses which can help to pinpoint the actual reasons behind patients' perspectives (Rodgers, 2015). This will provide more valuable feedback that can be used to better identify helpful aspects and problematic aspects, which can lead to better recommendations for improving the inpatient treatment. Topics that seem particularly relevant to investigate in more detail are patients' perspectives on the unhelpful aspects, specific ST experiential techniques, the therapeutic relationship, and reasons for dropout. Additionally, it is suggested to conduct semi-structured interviews with therapists to study their views on the helpful and unhelpful aspects, effects of therapy, and therapeutic relationship.

Conclusion

In conclusion, this study examined and compared the perspectives of completers and dropouts with personality disorders on inpatient group ST, as reported at long-term follow-up. The identified helpful and unhelpful factors provided valuable feedback from patients which can be used to make improvements to the current inpatient group ST program. The patients in this study all had complex personality pathology, and were unable to adequately benefit from previous treatments. Despite the fact that in the current study patients experienced many improvements, their general experiences of the intensive inpatient treatment varied to a large extent. A majority of patients who completed the treatment was satisfied with the treatment, however, many patients also emphasized that they benefited from the treatment to some degree but that this also came at a certain cost. Patients viewed inpatient group ST as an important turning point in their lives, but they did not unequivocally relate the inpatient treatment to positive outcomes alone.

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