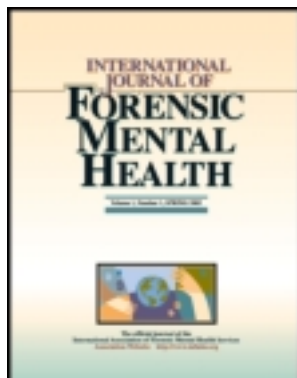


This article was downloaded by: [94.2.106.195]

On: 27 February 2013, At: 16:46

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



International Journal of Forensic Mental Health

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/ufmh20>

Readiness to Engage in Treatments for Personality Disorder

Mary McMurran^a

^a Institute of Mental Health, University of Nottingham, Nottingham, United Kingdom

Version of record first published: 07 Dec 2012.

To cite this article: Mary McMurran (2012): Readiness to Engage in Treatments for Personality Disorder, International Journal of Forensic Mental Health, 11:4, 289-298

To link to this article: <http://dx.doi.org/10.1080/14999013.2012.746754>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.tandfonline.com/page/terms-and-conditions>

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Readiness to Engage in Treatments for Personality Disorder

Mary McMurran

Institute of Mental Health, University of Nottingham, Nottingham, United Kingdom

Treatment non-completion in personality disorder (PD) treatments is prevalent and non-completers show poorer treatment outcomes than completers. Identifying risk factors for non-completion, and particularly causal risk factors, is important to inform criteria for treatment selection, design treatments that are responsive to non-completion risk, and design interventions to minimise non-completion. Risk factors lie in a number of domains, including individual, treatment, and environmental characteristics. A model of Readiness to Engage in Treatment for Personality Disorders is presented to guide research and assessment. Pre-therapy preparation is one potentially valuable approach to improving treatment engagement and retention, and examples of interventions are described. Throughout this review, the relevance of research to forensic services is specifically highlighted.

Keywords: treatment engagement, treatment readiness, personality disorder, offenders

INTRODUCTION

Improving readiness to engage with services for people with personality disorder (PD) is important in terms of both clinical outcomes and service cost-efficiency. This is true for forensic and non-forensic services alike. One research program investigating treatment readiness across services is the CLAHRC-NDL. CLAHRCs are Collaborations for Leadership in Applied Health Research and Care and are jointly funded by the UK National Health Service's (NHS) National Institute for Health Research (NIHR), universities, and local NHS organisations. The aim of CLAHRCs is to "undertake high-quality applied health research focused on the needs of patients and support the translation of research evidence into practice in the NHS" (see www.nihr.ac.uk/infrastructure/Pages/infrastructure_clahrcs.aspx). CLAHRC-NDL operates across Nottinghamshire, Derbyshire, and Lincolnshire (see www.clahrc-ndl.nihr.ac.uk/clahrc/index.aspx). CLAHRC-NDL has five research themes, one of which focuses on mental health. Within the mental health theme, there are four

research projects, one of which is on readiness to engage in treatment of people with PDs. This article provides a summary of our work to date. The project does not focus specifically on forensic services, although it does include them. The aims in this article are to consider why treatment completion is important, to identify risk factors for treatment non-completion, to present a model of readiness to engage in treatment for PD, and to suggest how pre-treatment preparation might improve engagement.

Treatment Non-Completion

Treatment non-completion of persons in PD treatment programs is a significant problem with, on average, 37% of those recruited to treatment finishing prematurely (McMurran, Huband, & Overton, 2010). In a forensic mental health service for personality disordered offenders, a non-completion rate as high as 73% has been recorded (McCarthy & Duggan, 2010). Clearly, non-completion is a matter of concern inasmuch as it compromises service efficiency and cost-effectiveness. There are monetary costs to services of carrying an empty place and opportunity costs to waiting-list patients who could have had a place in treatment; therapy groups can dwindle in number to the point of necessary dissolution, to the disadvantage of patients who may be engaged in treatment; and non-completion can lower staff morale and impact adversely on the organisation's professional

This article is based upon a presentation given at the 2nd Bergen Conference on the Treatment of Psychopathy, Bergen, Norway in November 2011.

Address correspondence to Mary McMurran, Institute of Mental Health, University of Nottingham, Triumph Road, Nottingham NG7 2TU United Kingdom. E-mail: mary.mcmurran@nottingham.ac.uk

reputation. Furthermore, there are societal costs of untreated PD to other people, for example the patient's family members, and other agencies, such as social services and criminal justice. Importantly, overall, treatment non-completers show poorer treatment outcomes than do treatment completers.

In a follow-up study of completers and non-completers of day treatment programs at one year, Karterud et al. (2003) found that non-completers had significantly higher hospitalisation rates (22% compared with 11%). Webb and McMurran (2009) also found higher rates of hospitalization and more hospital days for non-completers of a day program for people with borderline PD (151 days versus 379 days over a 9 month period after acceptance into therapy). Non-completers of an inpatient treatment program for legally detained personality disordered offenders committed more offences in a 5-year follow-up period than did completers (McCarthy & Duggan, 2010). Similarly, in offender treatments, poorer recidivism outcomes have been observed for non-completers compared not only with treatment completers but also with untreated offenders with similar risk profiles (McMurran & Theodosi, 2007).

The adverse outcomes associated with treatment non-completion translate into actual monetary costs. In the study by Webb and McMurran (2009), the hospital costs for non-completers over a 9-month period were three times higher than those for completers (£122,444 compared with £39,187). In a study modelling the economic costs of treatment non-completion of personality disordered offenders treated under the conditions of mental health legislation, Sampson and colleagues (2012) found that, on average, in the first 10 years following discharge, those who did not complete treatment incurred £144,000 more in costs to the NHS and criminal justice system than those who completed treatment. The clinical, service, and societal costs associated with treatment non-completion are strong grounds for attending to this issue, both in research and treatment.

Treatment non-completion by offenders is often viewed as just one behavioral expression of those factors that are associated with risk of antisocial behavior generally. Treatment non-completers in criminal justice programs do indeed score higher on risk measures than do completers (Olver, Stockdale, & Wormith, 2011; Wormith & Olver, 2002). A narrow risk-based approach to treatment non-completion may, however, lead to the exclusion of high-risk offenders; that is, those who are at risk of dropping out are not offered treatment in the first place, even though they are high risk for reoffending. This is clearly undesirable and contrary to the evidence-based risk principle, which states that intensive interventions should be offered to high-risk offenders (Andrews, Bonta, & Hoge, 1990). Furthermore, while there is evidence that high-risk offenders are less likely than lower-risk offenders to start or complete treatment, there is also evidence that recidivism is reduced in very high-risk offenders who do complete treatment (Palmer et al., 2009).

The next sections in this article summarize research that takes a broad perspective on risk factors for treatment non-completion among people in treatment for PD. Integrating these findings so that they make sense for both research and clinical purposes is important, and this will be attempted, with selective emphasis on information of relevance to forensic services.

RISK FACTORS FOR TREATMENT NON-COMPLETION

Before embarking on a review of risk factors, it is worth briefly defining what these are. Murray, Farrington, and Eisner (2009) explain that risk factors are a particular type of correlate. Whereas correlates are variables that are associated with each other in a population at one point in time, risk factors are correlates that predict the outcome of interest. Longitudinal studies are needed to show if the risk variable precedes the outcome. In non-completion research, most variables under study are assessed at recruitment into treatment and later, when people drop out or are expelled from treatment, differences between completers and non-completers are identified. Thus, correlates of non-completion are usually risk factors. However, they are not necessarily *causal* risk factors, which are risk factors that, when changed, cause a change in risk for the outcome. In this section, the focus is on risk factors for non-completion.

In their systematic review of non-completion of personality treatments, McMurran, Huband, and Overton (2010) identified 25 studies in which factors predicting completion status of psychological and psychosocial interventions for PD were studied empirically. They aimed to organize these factors using a framework for understanding attrition outlined by Barrett et al. (2008). This framework defines six broad categories of influence: (1) patient characteristics (e.g., gender, age, sociodemographic factors); (2) barriers to treatment (e.g., accessibility of services, time on waiting list); (3) need factors (e.g., diagnosis, symptom complexity, distress, psychological-mindedness); (4) environmental factors (e.g., treatment type, clinic setting, staff attitudes); (5) perceptions of mental health problems (e.g., the person's understanding of their disorder, cultural attitudes to mental health problems); and (6) beliefs about mental health treatment (e.g., expectations of treatment duration, estimates of therapist competence, expectations of treatment effectiveness).

The first point of note was that none of the identified studies examined service-related barriers to treatment or the client's beliefs about treatment. Only one study examined the service users' perceptions of stigma surrounding mental health problems, but no association with completion status was identified (Rüsch et al., 2008). This tells us very strongly that researchers focus squarely on what the client "is" or "has" in relation to non-completion; researchers appear largely to ignore factors relating to the kinds of treatment on offer, the qualities of the people who are offering them,

and the nature of the context in which treatments are offered, and they also largely ignore matters to do with how service users think and feel about their problems and the treatment they are expected to undertake. This is reminiscent of the invidious approach to understanding motivation for treatment outlined by Miller in 1985. He noted that treatment failures were commonly explained as deriving from negative dispositional characteristics of the client, whereas successes were conveniently attributed to the good qualities of the program or therapist. This trait model of motivation leads not only to blaming the client for poor progress in treatment but also to the failure to examine engagement objectively and empirically as a “dynamic, interpersonal process involving therapist and environmental as well as client determinants” (Miller, 1985, p. 100). Looking at treatment readiness and engagement more broadly directs efforts to improve engagement to a wider range of variables, many of which are amenable to change.

In McMurran, Huband, and Overton’s (2010) review of PD treatment non-completion, the risk factors that were identified fell into the three remaining categories identified by Barrett et al. (2008): (1) patient characteristics, (2) need factors, and (3) environmental factors. These are presented in Table 1. From this list, one might identify the following factors as possibly causally related to treatment completion status among people in treatment for PD: age; education level; childhood experiences; severity of PD; certain personality traits; affective state; problem solving abilities; social competence; intrapsychic defenses; level of experience with therapy; level of community support; and continuity of therapist. Of course, some of these risk factors are static; that is, they are unchangeable, although they perhaps preventable for future generations. Nonetheless, these factors may need to be taken into account as they affect responsiveness to treatment. From a treatment point of view, our interest lies with dynamic (i.e., changeable) causal risk factors. Dynamic causal risk factors are those that, when addressed effectively, will lead to a reduction in the likelihood of treatment non-completion.

The wide range of variables under study suggests a somewhat random approach to identifying what is relevant to treatment non-completion. Drawing this information together would assist with the identification of factors that are logically connected to the outcome (i.e., completion status) such that a causal connection could be hypothesized. This would allow hypothesis-driven research into treatment non-completion. Research could also address contradictory findings between studies with regards to risk factors.

THE TREATMENT READINESS MODEL FOR PERSONALITY DISORDER

In an attempt to gather information about risk factors for treatment non-completion both comprehensively and systematically, we carried out a Delphi survey of clinicians

($N = 55$) and service users ($N = 76$) in specialist personality treatment programs to identify what factors they considered to be important in helping and hindering treatment engagement (Tetley et al., 2012). These services were forensic and non-forensic, community and residential. Our initial interview drew on the literature on treatment non-completion, and the Multifactor Offender Readiness Model (MORM) of Ward et al. (2004). The MORM identifies factors in a range of domains that impact upon therapeutic engagement. Individual factors include: (1) *Cognitive factors*, such as problem recognition, beliefs about the efficacy of therapy, and change self-efficacy beliefs; (2) *Volitional factors*, such as motivation to engage and motivation to change; (3) *Behavioral factors*, such as having the competencies to engage in therapy; (4) *Affective factors*, such as distress, emotional dysregulation, or difficulty experiencing or accessing emotions; and (5) *Identity factors*, such as self-concept, values, desired lifestyle. External factors include: (1) *The circumstances* in which the treatment is being offered (e.g., mandated or voluntary); (2) *The location* of treatment, (e.g., distance of treatment from place of residence); (3) *Opportunities* to engage in appropriate therapy (e.g., time on waiting list); (4) *Availability of resources* for treatment, including skilled experienced staff, and adequate therapy rooms; (5) *Program characteristics*, namely interventions that suit the individual’s needs; and (6) *Interpersonal support*, that is others who support the individual in treatment.

The Delphi method aims to achieve consensus on the opinions of experts by employing iterative rounds of structured surveys (Hasson, Keeney, & McKenna, 2000). In this study we opted for two rounds. Participants were initially invited to take part in a semi-structured interview in which they were provided with a definition of treatment engagement and were then asked about the barriers to and facilitators of treatment engagement in their service (Round 1). Prompts were given to ensure their views on a range of domains were accessed. The views expressed in Round 1 were collated into a checklist and returned to the same participants, who were asked to rate their level of agreement with each item (Round 2).

The results of this study were integrated into a version of the MORM model augmented for people in PD treatment—the Treatment Readiness Model for PD. The additional factors not included in the MORM were: (1) *Trait factors*, including having avoidant personality traits, higher levels of psychopathy, and lower levels of impulsivity; (2) *Relating factors*, including an inability to trust others and the ability to build a therapeutic alliance; (3) *Comorbidity factors*, such as having co-occurring Axis I disorders; and (4) *Physical factors*, which related to physical wellbeing, and included sleep deprivation, feeling physically unwell, and having a poor diet. Looking specifically at the information provided by those in forensic services, the following specific barriers and facilitators were seen as relevant: A *resource factor* of being offered treatment in an oppressive therapeutic environment; *Affective factors* of limited emotional

TABLE 1
Variables Associated with Treatment Non-Completion

Patient characteristics	• Younger age (Ogrodniczuk et al., 2008; Smith et al., 1995; Thormählen et al., 2003) • Lower education level (Karterud et al., 2003; Ogrodniczuk et al., 2008) • Lower level of occupation (Chiesa et al., 2000) • Unemployment (Karterud et al., 2003) • Having a juvenile conviction (Copas et al., 1984) • Having parents who divorced before the client was aged 10 (Karterud et al., 2003) • Emotional neglect in childhood (Perry et al., 2007) • Spending less time alone (Gunderson et al., 1989) • Being in a relationship for less than 6 months (Gunderson, 1989)
Need factors	
(a) Diagnoses	• Having more PD diagnoses (Webb & McMurran, 2009) • Meeting a higher number of PD criteria (Karterud et al., 2003) • Personality disorder diagnoses other than borderline (Chiesa et al., 2000) AND more severe borderline PD (Ogrodniczuk et al., 2008) • Diagnosis of obsessive-compulsive PD (Perry et al., 2007) • Severe histrionic or antisocial PD (Ogrodniczuk et al., 2008) • No specific PD (Perry et al., 2007) • Diagnosis of dependent PD (Ogrodniczuk et al., 2008) AND dependent PD not associated (Perry et al., 2007). • Having a PD in Cluster A or B (Thormählen et al., 2003) • Higher levels of narcissism (Horner & Diamond, 1996) • Higher levels of impulsivity (Yeomans et al., 1994) <i>Note:</i> Diagnosis of avoidant PD was associated with <i>treatment completion</i> (Ogrodniczuk et al., 2008)
(b) Emotions	• Less depressed (Gunderson et al., 1989) • No mood disorder (Karterud et al., 2003) • Fewer suicide attempts (Rüsch et al., 2008) • Lower levels of interpersonal distress (Thormählen et al., 2003) AND higher levels of interpersonal distress (Ogrodniczuk et al., 2008) • Higher trait anxiety (Rüsch et al., 2008)
(c) Problem recognition and competencies	• Being in the pre-contemplation stage of change (Soler et al., 2008) • Lower levels of persistence (Alarcón et al., 2005) • Higher levels of avoidance (Alarcón et al., 2005; Rüsch et al., 2008) • Poor rational social problem solving abilities (McMurran et al., 2008) • Higher impulsiveness and carelessness problem solving style (McMurran et al., 2008) • Better social competence (Zorn et al., 2008)
(d) Ego and defences	• Poor ego structure (Copas et al., 1984) • Less primitive defences (Gunderson et al., 1989) • Weaker adaptive defence style (Perry et al., 2007) • Greater denial of need for closeness, conflicts around engagement and abandonment, fear of impulsive breakthrough of negative affect, externalizing defense, projective identification, and depressive self-image (Löffler-Statska et al., 2008).
(e) Co-occurring problems	• Lower general level of functioning (Karterud et al., 2003) • Current or previous substance use (Karterud et al., 2003) • Problems focused in one area (Thormählen et al., 2003) • Increase in antisocial aggressiveness scores over treatment (Ravndal & Vaglum, 1991)
Environmental factors	• Allocation to a one-stage hospital-based treatment (i.e., 1 year inpatient treatment only) compared with a two-stage treatment (i.e., 6 months inpatient treatment followed by 18 months community support) (Chiesa et al., 2000) • Being in a 41-week program compared to an 18-week one (Karterud et al., 2003) • Having little experience with services in the past and having used services less (Ogrodniczuk et al., 2008) • Having spent less time in treatment, and having had fewer previous therapists (Gunderson et al., 1989) • Prior psychiatric hospitalization (Ogrodniczuk et al., 2008) • Not being referred from a long-term inpatient unit (Smith et al., 1995) • Not continuing with a hospital therapist after discharge to the community (Smith et al., 1995) • Poorer quality of treatment contracting (Yeomans et al., 1994) • Poorer therapeutic alliance (Lingiardi et al., 2005; Spinhoven et al., 2007; Yeomans et al., 1994) • Dropping the first therapist allocated (Linehan et al., 2006)

control and poor recognition of emotions; A *cognitive factor* of denial of offending; *Physical factors* of health and wellness; *Trait factors* of higher levels of psychopathy and impulsivity; and a *Relating factor* of an inability to trust others. The findings from our Delphi study have been incor-

porated into treatment readiness model for PD, as shown in Figure 1.

The model incorporates a range of factors identified through quantitative and qualitative research as associated with treatment engagement. This model may clarify the

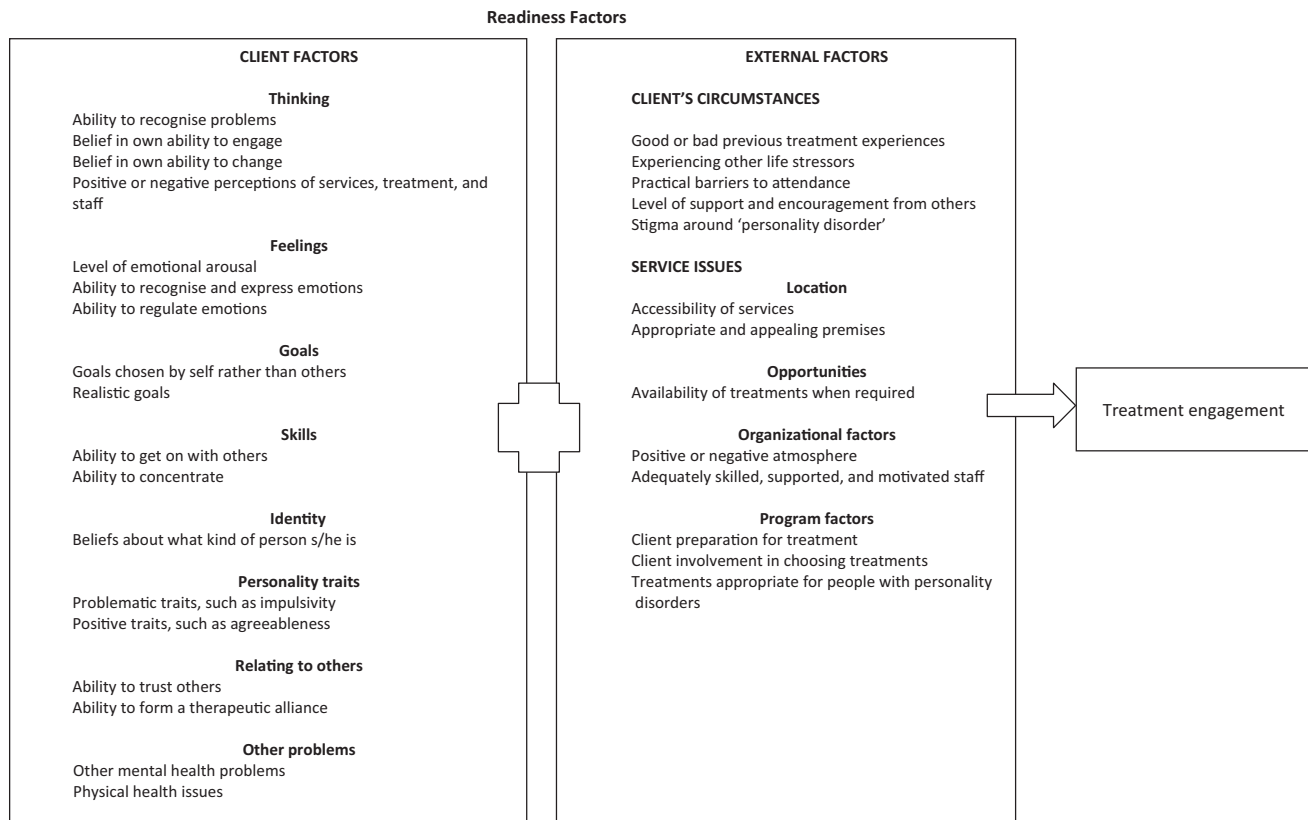


FIGURE 1 Treatment Readiness Model for Personality Disorders

agenda for empirical research examining which factors are predictive of engagement, and which factors, when changed, improve engagement. Meanwhile, the model could be clinically useful in guiding individual assessment and formulation of engagement.

THE RELEVANCE OF PERSONALITY DISORDER TO TREATMENT NON-ENGAGEMENT

The preceding sections summarize the factors implicated in non-engagement and engagement in PD treatments identified in a systematic review and a Delphi survey. The purpose in this section is to selectively focus on the relevance of these risk factors to professional practice in forensic settings.

Personality Disorder

Having a PD diagnosis, and in particular having more complex PD, is identified as a risk factor for non-completion of personality disorder treatments, yet there is variability in relation to which specific PDs are more strongly associated with treatment non-completion. If we turn to predictors of non-completion of offender treatments, a meta-analysis by Olver et al. (2011) showed strong associations between

personality disorder and treatment non-completion. The difference in attrition rates between those with any personality disorder compared with those without was 20%, and the difference for a psychopathy diagnosis was 29%, a PCL-R-score psychopathy 18%, and antisocial personality disorder 14%. Personality disorders were among the most strongly correlated factors in this meta-analysis, which included previous offending, substance use, and unemployment.

There is clearly a role for educating criminal justice and forensic mental health staff in how to work with offenders with personality disorder. In England and Wales, the joint Department of Health and Ministry of Justice 'Personality Disorder Knowledge and Understanding Framework' program aims to do just this (see www.personalitydisorderkuf.org.uk). However, categorical diagnoses tell us little about why people do not engage in treatment and what we might do to improve engagement. To do this, it is more useful to study traits and the processes by which traits might hinder engagement.

Respect, Consideration, and Mutuality

It is noteworthy that the majority of the risk factors for treatment non-completion relate to matters other than PD diagnoses *per se*. People diagnosed with PD who are offered treatment want to receive appropriate treatment when they

actually need it, in a convenient location, in a pleasant environment, and from adequately skilled, supported and motivated staff. Barriers to attendance and engagement require attention, and these include practical problems as well as physical and mental health problems that may interfere with engagement. Engagement is impeded if there is lack of clarity about the treatment on offer, no negotiation of treatment options, and poor treatment contracting. These matters ought to be attended to in therapies with any client group, yet failure to give them due recognition may produce particularly disruptive outcomes with antisocial or psychopathic individuals. Those people with constellations of traits that include anxiety, impulsivity, irritability, and narcissism are likely to respond to perceived disrespect, lack of control in a situation, and confusion about what is expected of them with anger, blame, and summary termination of therapy. Creating the conditions that may elicit such responses clearly jeopardises engagement with therapy.

Therapeutic Alliance

Evident too from the research is that certain personality disorder traits interfere with the processes of therapy. The capacity to build a therapeutic alliance is one important aspect of the treatment of antisocial or psychopathic individuals. The quality of the therapeutic alliance is associated with therapy outcome in general (weighted $r = .22$; Martin, Garske, & Davis, 2000). One identified class of barrier to treatment engagement among people with personality disorder was difficulty relating to others, which included problems trusting others and forming a therapeutic alliance, and there is evidence that a poor therapeutic alliance is associated with non-completion of personality disorder treatments (Barnicot et al., 2011).

Ross, Polaschek, and Ward (2008) have produced a multifactorial model of the therapeutic alliance in offender treatment. Factors that influence the therapeutic alliance include systemic factors as well as characteristics of both the therapist and client. In offender treatments, the actual or perceived mandatory nature of treatment is one potential obstacle to developing an alliance and engaging in treatments. A meta-analysis of treatment outcomes in mandatory versus voluntary offender treatments showed that voluntary treatments produce the best recidivism outcomes (Parhar et al., 2008). Ross et al. (2008) suggest that clients may not separate the therapist from the 'system' and hence, in mandatory treatments, the ability to form a bond is impeded. However, in a study of high-risk psychopathic male prisoners convicted of violent offences, Polaschek and Ross (2010) have produced evidence that the therapeutic alliance can improve over time and that improvements are associated with change on the Violence Risk Scale (Wong & Gordon, 2006). Thus, steps need to be taken to ensure that interventions that are entered into on terms that may not be entirely voluntary become truly collaborative enterprises through negotiating goals, methods, and outcomes.

The difficulties in forming a collaborative therapeutic alliance with violent men with antisocial personality disorder are articulated by Davidson et al. (2010). In their treatment group, childhood abuse or neglect often was often seen to lead to beliefs of vulnerability and powerlessness, and compensatory behavioral strategies of aggression and blame were adopted. Maladaptive beliefs needed to be challenged so that clients began to recognise that the way forward was to take responsibility for their own difficulties and accept that their current coping strategies were not helpful. However, challenging maladaptive beliefs was often taken as a criticism, which led to therapists feeling that they were being punitive. Enquiries about violence could lead to emotionally-charged therapy interactions, which had to be carefully managed. Furthermore, when a therapeutic alliance began to develop, this was an unusual degree of intimacy for many of the men and professional boundaries were hard to manage. Forgetting the risk of violence was a potential pitfall for therapists, resulting from the creation of an empathic formulation of the individual's problems within a positive therapeutic relationship. These therapy issues need to be addressed through therapist education, training and supervision. That is, the therapist needs to have the knowledge and skills necessary for conducting therapy with antisocial individuals. However, the client also needs essential therapy skills.

Therapy Skills

An interaction between personality traits and the social environment over the lifespan can create problems or lead to deficits that impede engagement in therapy. For example, Linehan's (1993) theory of borderline personality disorder (BPD) holds that there are biologically-based vulnerabilities in the emotion regulation system which, in an environment that pervasively punishes, invalidates, or neglects this emotional vulnerability, will, over time, result in BPD. Similarly, impulsivity is hypothesized to interact with poor behavioral management over the lifespan to interfere with the acquisition of good social problem-solving skills, which leads to dysfunctional ways of operating in everyday life, and may contribute to a diagnosis of PD (McMurran, Egan, & Duggan, 2005). Problems such as these are often the targets of therapy itself (Huband et al., 2007; Linehan, 1993). However, there is scope for preparatory work that addresses deficits that arise from lack of knowledge and experience of therapy (Ogrodniczuk et al., 2008). This will be covered in the next section on pre-treatment preparation.

PRE-TREATMENT PREPARATION

Pre-treatment preparation is one approach to reducing treatment non-completion. While many therapies explicitly incorporate strategies aimed at keeping people engaged in treatment (e.g., Bornovalova & Daughters, 2007), it is clear that

preparing people before treatment begins also has the potential to improve engagement. Indeed, pre-treatment preparation may help individuals who are at risk of non-completion feel that they have some control over therapy by starting only when they feel ready. If this reduces treatment non-completion, then it may serve to avoid potential adverse outcomes. We do not know if treatment non-completion is a causal risk factor for poorer treatment outcomes, but there are plausible logical connections between non-completion and poor outcomes for some groups (McMurran & Theodosi, 2007). Removal from a treatment program may, in some cases, lead to anti-therapy attitudes and a reaction against change. For example, expelling people whose behavior is difficult or who cannot engage sufficiently well may be to expel people for exhibiting the very problems that led them into treatment in the first place, and this may damage their confidence in the ability of therapy to help them. Interruption of a treatment program may mean that difficult issues have been raised but the individual has not yet learned the skills for coping with these issues, consequently leaving them vulnerable to distress. When a person elects to discontinue treatment prematurely, this may mean that he or she has been confused, lacking in confidence, or feeling worthless. All of these possibilities could lead to deterioration in psychological and behavioral wellbeing.

A variety of strategies can be used prior to entry into treatment proper. Ogrodniczuk, Joyce and Piper (2005) list *role induction*, where referrals are educated about the rationale of the therapy, the nature of the treatment process, expectations for improvement, and the patient and therapist responsibilities; *vicarious therapy pre-training*, where recorded examples of therapy are discussed with the potential patient; and *experiential pre-training*, where the individual is engaged in a simulation of therapy. In addition to this are brief *psychoeducational interventions* to develop skills and attitudes that will help the person make best use of therapy.

Despite the potential value of pre-treatment preparation in reducing treatment non-completion, there are few evaluations of these specifically in PD treatments. Only two studies were identified in a recent review (McMurran, Huband, and Overton, 2010), and both related to residential therapeutic communities (Birtle et al., 2007; Chiesa, Wright, & Neeld, 2003). Birtle et al. (2007) described an open-ended weekly preparation group prior to admission during which participants were informed about the therapeutic community experience, built a therapeutic alliance, and strengthened peer support. After the introduction of the preparation group, the proportion of those dropping out reduced from 20% to 5% in the first week and from 48% to 18% within a month, and the mean stay increased from 107 to 145 days. Chiesa et al. (2003) addressed the problem through pre-admission treatment target setting, visiting the unit, a new admissions group, and allocation of a patient 'buddy.' The dropout rate of 31% within the first 14 weeks after admission was subsequently reduced to 24%.

Other interventions have been tested for acceptability, but not yet their effect on retention in treatment. Education about PD, instilling beliefs about capability for change, and building a therapeutic rapport has been found to improve pre-treatment knowledge and working alliance with detained personality disordered offenders (Banerjee et al., 2006). McMurran and Jinks (2012) have developed and piloted a pre-treatment intervention for people high on alexithymia. The aims are to teach how emotions can be useful in solving problems; to teach how emotions are identified; to help people to begin recognising their own and other people's emotions through guided experiential components and mindfulness techniques; and to practise the skills of discussing emotions in preparation for therapy. A pilot study with detained personality disordered offenders showed improved interest in emotions as a source of useful information (McMurran & Jinks, 2012).

One other pre-treatment intervention that is currently being evaluated in a PD service is a goal-based motivational interview (McMurran, Cox, et al., 2010; McMurran et al., 2012). This is based upon the identification of the client's valued goals, obstacles to goal attainment, and clarification of how therapy might help overcome obstacles and so attain goals. The theoretical framework used is the Theory of Current Concerns (Klinger & Cox, 2011), in which each goal pursuit corresponds to an internal state called a 'current concern.' Current concerns are identified in an interview called the Personal Concerns Inventory (PCI) (Cox & Klinger, 2011). The PCI identifies 11 life areas in which most people aim for satisfaction through goal-setting and striving: (1) Home and household matters, (2) Employment and finances, (3) Partner, family and relatives, (4) Friends and acquaintances, (5) Love, intimacy and sexual matters, (6) Self changes, (7) Education and training, (8) Health and medical matters, (9) Substance use, (10) Spiritual matters, and (11) Hobbies, pastimes, and recreation. These life areas are highly similar to the 'primary human goods' (i.e., valued aspects of human functioning and living) identified in Ward and colleagues' good lives model of offender rehabilitation (Ward & Brown, 2004; Ward & Stewart, 2003).

Current concerns are rated on scales of value, attainability, control and commitment, which provides information about a person's motivational structure, which may be adaptive (i.e., characterised by high perceived likelihood of goal attainment, expected happiness when goals are attained, and commitment to goal striving), or maladaptive (i.e., characterised by high commitment to goals low in importance or low commitment to goals high in importance, or expecting no great amount of happiness at goal achievement), and which are predictive of readiness to change and change in problem behaviors. This motivational structure has been replicated with offenders (Sellen et al., 2009).

Although the PCI is an assessment of goals and motivational structure, the experience of clarifying one's goals and values can be beneficial in itself, and there is some evidence

that engaging in the interview may motivate offenders to enter treatment (Theodosi & McMurran 2006). We aimed to capitalize on this effect by developing the PCI procedure into a more fully rounded motivational interview and evaluating its effect on treatment non-completion. Our research aimed to test the acceptability of the PCI among service users and staff in a PD treatment service and to gather information to inform the design of a randomized controlled trial (McMurran, Cox et al., 2010). There are indications from our study that those who received an interview of about 90 minutes duration show greater clarity in their therapy goals, better attendance at therapy sessions, and better treatment engagement as rated by staff (McMurran et al., 2012). Views gathered from participants in this study indicated that they benefited from the specific effects of the PCI, namely goal clarification, and also from the general effects, such as becoming familiar with the therapy venue and personnel and having a chance to discuss engagement issues.

CONCLUSION

Treatment non-completion by people in PD treatment is associated with poorer clinical outcomes. Identifying risk factors for treatment non-completion is important. The Treatment Readiness Model for Personality Disorder presented here may help guide this work. These risk factors may be static or dynamic, with different implications for how the information is used. Static risk factors may be used to inform selection criteria, and they bear implications for the design and delivery of treatments to meet responsivity needs. By contrast, dynamic risk factors are open to change. Pre-treatment preparation is one approach to changing risk factors and evaluations of such programs are necessary to establish their impact. There remains the question of whether dynamic risk factors are at least contributory causal factors in producing poorer outcomes. It may be that those with greater levels of pathology do not complete treatment and it is the level of pathology, not treatment non-completion, which explains poorer outcomes. This question can be addressed by examining whether improved retention in treatment leads to improved outcomes for those at high risk of non-completion. Of course, the beneficial effects of treatment engagement and treatment completion are predicated on the understanding that treatment is effective, which is a separate and crucial research area.

REFERENCES

Alarcón, M.B., Salcedo, M.T., & Fernández, B.C. (2005). Apego al tratamiento psicoterapéutico grupal en pacientes con trastorno límite de la personalidad: Estudio piloto en pacientes de 18 a 24 años. *Salud Mental*, 28, 52–60.

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior*, 17, 19–52. DOI: 10.1177/0093854890017001004

Banerjee, P., Duggan, C., Huband, N., & Watson, N. (2006). Brief psychoeducation for people with personality disorder: A pilot study. *Psychology and Psychotherapy: Theory, Research and Practice*, 79, 385–394. DOI: 10.1348/147608305x57987

Barnicot, K., Katsakou, C., Marougka, S., & Priebe, S. (2011). Treatment completion in psychotherapy for borderline personality disorder: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, 123, 327–338. DOI: 10.1111/j.1600-0447.2010.01652.x

Barrett, M. S., Chua, W., Crits-Christoph, P., Gibbons, M.B., Casiano, D., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy Theory, Research, Practice, Training*, 45, 247–267. DOI: 10.1037/0033-3204.45.2.247

Birtle, J., Calthorpe, B., McGruer, F., Adie, L., McCullagh, G., & Kearney, S. (2007). Preparing to go to Main House: This week, maybe next week! *Therapeutic Communities*, 28, 127–136.

Bornoalova, M.A., & Daughters, S.B. (2007). How does Dialectical Behaviour Therapy facilitate treatment retention among individuals with comorbid borderline personality disorders and substance use disorders. *Clinical Psychology Review*, 27, 923–943. DOI: 10.1016/j.cpr.2007.01.013

Chiesa, M., Drahorad, C., & Longo, S. (2000). Early termination of treatment in personality disorder treated in a psychotherapy hospital: Quantitative and qualitative study. *British Journal of Psychiatry*, 177, 107–111. DOI: 10.1192/bjp.177.2.107

Chiesa, M., Wright, M., & Neeld, R. (2003). A description of an audit cycle of early dropouts from an inpatient psychotherapy unit. *Psychoanalytic Psychotherapy*, 17, 138–149. DOI: 10.1080/1474973031000105294

Copas, J. B., O'Brien, M., Roberts, J., & Whiteley, J. S. (1984). Treatment outcome in personality disorder: The effect of social, psychological and behavioural variables. *Personality and Individual Differences*, 5, 565–573. DOI: 10.1016/0191-8869(84)90031-X

Cox, W. M., & Klinger, E. (2011). Measuring motivation: The Motivational Structure Questionnaire and Personal Concerns Inventory and their variants. In W. M. Cox & E. Klinger (Eds.), *Handbook of motivational counseling: Goal-based approaches to assessment and intervention with addiction and other problems* (pp. 161–176). Chichester: Wiley-Blackwell.

Davidson, K., Halford, J., Kirkwood, L., Newton-Howes, G., Sharp, M., & Tata, P. (2010). CBT for violent men with antisocial personality disorder: Reflections on the experience of carrying out therapy in MASCOT, a pilot randomized controlled trial. *Personality and Mental Health*, 4, 86–95. DOI: 10.1002/pmh.94

Gunderson, J. G., Frank, A. F., Ronningstam, E. F., Wachter, S., Lynch, V. J., & Wolf, P. J. (1989). Early discontinuance of borderline patients from psychotherapy. *Journal of Nervous and Mental Diseases*, 177, 38–42. DOI: 10.1097/00005053-198901000-00006

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing*, 32, 1008–1015. DOI: 10.1046/j.1365-2648.2000.01567.x

Horner, M.S., & Diamond, D. (1996). Object relations development and psychotherapy dropout in borderline outpatients. *Psychoanalytic Psychology*, 13, 205–223.

Huband, N., McMurran, M., Evans, C., & Duggan, C. (2007). Social problem solving plus psychoeducation for adults with personality disorder: Pragmatic randomised controlled trial. *British Journal of Psychiatry*, 190, 307–313. DOI: 10.1192/bjp.bp.106.023341

Karterud, S., Pederson, G., Bjordal, E., Brabrand, J., Friis, S., Haaseth, Ø., Haavaldsen, G., Irion, T., Leirvåg, H., Tørum, & Urnes, Ø. (2003). Day treatment of people with personality disorders: Experiences from a Norwegian treatment research network. *Journal of Personality Disorders*, 17, 243–262. DOI: 10.1521/pedi.17.3.243.22151

Klinger, E., & Cox, W. M. (2011). Motivation and the goal theory of current concerns. In W. M. Cox & E. Klinger (Eds.), *Handbook of motivational counseling: Goal-based approaches to assessment and intervention with addiction and other problems* (pp. 3–47). Chichester: Wiley-Blackwell.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

- Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., Korsland, K. E., Tutek, D. A., Reynolds, S. K., & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behaviour therapy vs therapy by experts for suicidal behaviours and borderline personality disorder. *Archives of General Psychiatry*, 63, 757–766. DOI: 10.1001/archpsych.63.7.757
- Lingiardi, V., Filippucci, L., & Baiocco, R. (2005). Therapeutic alliance evaluation in personality disorders psychotherapy. *Psychotherapy Research*, 15, 45–53. DOI: 10.1080/10503300512331327047
- Löffler-Statska, H., Rössler-Schüle, H., & Skale, E. (2008). Prädiktoren des Therapieabbruchs in psychoanalytischen Behandlungen von Patienten mit Persönlichkeitsstörungen. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, 54, 63–76.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438–450. DOI: 10.1037/0022-006X.68.3.438
- McCarthy, L., & Duggan, C. (2010). Engagement in a medium secure personality disorder service: A comparative study of psychological functioning and offending outcomes. *Criminal Behaviour and Mental Health*, 20, 112–128.
- McMurran, M., Cox, W. M., Coupe, S., Whitham, D., & Hedges, L. (2010). The addition of a goal-based motivational interview to standardised treatment as usual to reduce dropouts in a service for patients with personality disorder: A feasibility study. *Trials*, 11, 98. DOI: 10.1186/1745-6215-11-98
- McMurran, M., Cox, W. M., Whitham, D., & Hedges, L. (2012). The addition of a goal-based motivational interview to treatment as usual to reduce dropouts in a personality disorder treatment service: Results of a feasibility study for a randomized controlled trial. Paper under review.
- McMurran, M., Egan, V., & Duggan, C. (2005). Stop & Think! Social problem-solving therapy with personality disordered offenders. In M. McMurran, & J. McGuire (Eds.), *Social problem solving and offending: Evidence, evaluation, and evolution* (pp. 207–220). Chichester: Wiley.
- McMurran, M., Huband, N., & Duggan, C. (2008). A comparison of treatment completers and non-completers of an inpatient treatment programme for male personality disordered offenders. *Psychology and Psychotherapy: Theory, Research and Practice*, 81, 193–198. DOI: 10.1348/147608308x288672
- McMurran, M., Huband, N., & Overton, E. (2010). Non-completion of personality disorder treatments: A systematic review of correlates, consequences, and interventions. *Clinical Psychology Review*, 30, 277–287. DOI: 10.1016/j.cpr.2009.12.002
- McMurran, M., & Jinks, M. (2012). Making your emotions work for you: A pilot brief intervention for alexithymia with personality disordered offenders. *Personality and Mental Health*, 6, 45–49. DOI: 10.1002/pmh.170
- McMurran, M., & Theodosi, E. (2007). Is treatment non-completion associated with increased reconviction over no treatment? *Psychology, Crime and Law*, 13, 333–343. DOI: 10.1080/10683160601060374
- Miller, W. R. (1985). Motivation for treatment: A review with special emphasis on alcoholism. *Psychological Bulletin*, 98, 84–107. DOI: 10.1037/0033-2909.98.1.84
- Murray, J., Farrington, D. P., & Eisner, M. P. (2009). Drawing conclusions about causes from systematic reviews of risk factors: The Cambridge Quality Checklists. *Journal of Experimental Criminology*, 5, 1–23. DOI: 10.1007/s11292-008-9066-0
- Ogrodniczuk, J. S., Joyce, A. S., Lynd, L. D., Piper, W. E., Steinberg, P. I., & Richardson, K. (2008). Predictors of premature termination of day treatment for personality disorder. *Psychotherapy and Psychosomatics*, 77, 365–371. DOI: 10.1159/000151390
- Ogrodniczuk, J. S., Joyce, A. S., & Piper, W. E. (2005). Strategies for reducing patient-initiated premature termination of psychotherapy. *Harvard Review of Psychiatry*, 13, 57–70. DOI: 10.1080/10673220509056429
- Olver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology*, 79, 6–21. DOI: 10.1037/a0022200
- Palmer, E. J., McGuire, J., Hatcher, R. M., Hounsborne, J. C., Bilby, C.A.L., & Hollin, C. R. (2009). Allocation to offending behavior programs in the English and Welsh probation service. *Criminal Justice and Behavior*, 36, 909–922. DOI: 10.1177/0093854809338889
- Parhar, K. K., Wormith, J. S., Derksen, D. M., & Beauregard, A. M. (2008). Offender coercion in treatment: A meta-analysis of effectiveness. *Criminal Justice and Behavior*, 35, 1109–1135. DOI: 10.1177/0093854808320169
- Perry, J. C., Bond, M., & Roy, C. (2007). Predictors of treatment duration and retention in a study of long-term dynamic psychotherapy: Childhood adversity, adult personality, and diagnosis. *Journal of Psychiatric Practice*, 13, 221–232. DOI: 10.1097/01.pra.0000281482.11946.fc
- Polaschek, D.L.L., & Ross, E. C. (2010). Do early therapeutic alliance, motivation, and stages of change predict therapy change for high-risk psychopathic offenders? *Criminal Behaviour and Mental Health*, 20, 100–111. DOI: 10.1002/cbm.759
- Ravndal, E., & Vaglum, P. (1991). Changes in antisocial aggressiveness during treatment in a hierarchical therapeutic community: A prospective study of personality changes. *Acta Psychiatrica Scandinavica*, 84, 524–530. DOI: 10.1111/j.1600-0447.1991.tb03188.x
- Ross, E. C., Polaschek, D.L.L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior*, 13, 462–480. DOI: 10.1016/j.avb.2008.07.003
- Rüsch, N., Schiel, S., Corrigan, P.W., Leihener, F., Jacob, G.A., Olschewski, M., Lieb, K., & Bohus, M. (2008). Predictors of dropout from inpatient dialectical behaviour therapy among women with borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 39, 497–503. DOI: 10.1016/j.jbtep.2007.11.006
- Sampson, C., James, M., Huband, N., Geelan, S., & McMurran, M. (2012). Cost implications of treatment non-completion in personality disorder. Paper under review.
- Sellen, J. L., McMurran, M., Theodosi, E., Cox, W. M., and Klinger, E. (2009). Validity of the offender version of the Personal Concerns Inventory with adult male prisoners. *Psychology, Crime and Law*, 15, 451–468. DOI: 10.1080/10683160802356712
- Smith, T. E., Koenigsberg, H. W., Yeomans, F. E., Clarkin, J. F., & Selzer, M. A. (1995). Predictors of dropout in psychodynamic psychotherapy of borderline personality disorder. *Journal of Psychotherapy Practice and Research*, 4, 205–213.
- Soler, J., Trujols, J., Pascual, J. C., Portella, M. J., Barrachina, J., Campins, J., Tejedor, R., Alvarez, E., & Pérez, V. (2008). Stages of change in dialectical behaviour therapy for borderline personality disorder. *British Journal of Clinical Psychology*, 47, 417–426. DOI: 10.1348/014466508X314882
- Spinhoven, P., Giesen-Bloo, J., van Dyck, R., Kooiman, K., & Arntz, A. (2007). The therapeutic alliance in schema-focused therapy and transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, 75, 104–115. DOI: 10.1037/0022-006X.75.1.104
- Tetley, A., Jinks, M., Huband, N., Howells, K., & McMurran, M. (2012). Barriers to and facilitators of treatment engagement for clients with personality disorder: A Delphi survey. *Personality and Mental Health*, 6, 97–110. DOI: 10.1002/pmh.1176
- Theodosi, E., & McMurran, M. (2006). Motivating convicted sex offenders into treatment: A pilot study. *British Journal of Forensic Practice*, 8, 28–35. DOI: 10.1108/14636646200600017
- Thormählen, B., Weinryb, R. M., Norén, K., Vinnars, B., Bågedahl-Strindlund, M., & Barber, J. P. (2003). Patient factors predicting dropout from supportive-expressive psychotherapy for patients with personality disorders. *Psychotherapy Research*, 13, 493–509. DOI: 10.1093/ptr/kpg039
- Ward, T. and Brown, M. (2004). The Good Lives Model and conceptual issues in offender rehabilitation. *Psychology, Crime and Law*, 10, 243–257. DOI: 10.1080/10683160410001662744

- Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and Violent Behavior, 9*, 645–673. DOI: 10.1016/j.avb.2003.08.001
- Ward, T. and Stewart, C. A. (2003). Criminogenic needs and human needs: A theoretical model. *Psychology, Crime, and Law, 9*, 125–143. DOI: 10.1080/1068316031000116247
- Webb, D. J., & McMurrin, M. (2009). A comparison of women who continue and discontinue treatment for borderline personality disorder. *Personality and Mental Health, 3*, 142–149. DOI: 10.1002/pmh.69
- Wong, S.C.P., & Gordon, A. (2006). The validity and reliability of the Violence Risk Scale: A treatment-friendly violence risk tool. *Psychology, Public Policy, and Law, 12*, 279–309. DOI: 10.1037/1076-8971.12.3.279
- Wormith, J. S., & Olver, M. E. (2002). Offender treatment attrition and its relationship with risk, responsivity, and recidivism. *Criminal Justice and Behavior, 29*, 447–471. DOI: 10.1177/0093854802029004006
- Yeomans, F. E., Gutfreund, J., Selzer, M. A., Clarkin, J. F., Hull, J. W., & Smith, T. E. (1994). Factors related to drop-outs by borderline patients: Treatment contract and therapeutic alliance. *Journal of Psychotherapy Practice and Research, 3*, 16–24.
- Zorn, P., Roder, V., Soravia, L., & Tschacher, W. (2008). Evaluation der “Schemazentrierten emotiv-behavioralen Therapie” (SET) für Patienten mit Persönlichkeitsstörungen: Ergebnisse einer randomisierten Untersuchung. *Psychotherapie, Psychosomatik Medizinische Psychologie, 58*, 371–378. DOI: 10.1055/s-2007-986333