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MAJOR RESEARCH PROJECT

JON CHATFIELD BA Hons MSc

INVESTIGATING CLIENT DROPOUT FROM PSYCHOTHERAPEUTIC TREATMENTS FOR PERSONALITY DISORDER.

Section A: Psychotherapy dropout from personality disorder treatments: A
review of contextual, interpersonal and therapeutic predictor variables
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SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

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SUMMARY OF PORTFOLIO

Section A provides a critical review of literature pertaining to dropout from psychotherapeutic treatments for personality disorder (PD). It considers the clinical relevance of PD presentations, the impact of treatment dropout on clinical services, and what existing theories might contribute to explanations of the dropout phenomenon. Previous reviews of the literature are presented, alongside a rationale for the current review to conduct an up-to-date investigation of studies exploring contextual, interpersonal and therapeutic predictors of dropout from PD treatments. The review concludes by identifying some research questions that remain unanswered in the extant literature.

Section B presents the findings of a grounded theory study exploring the experiences of clients and therapists of dropout from outpatient psychodynamic psychotherapy for PD. Pre-therapy questionnaires for 20 clients were reviewed to generate hypotheses about the differences between those who dropped out and those who completed, a focus group was conducted with six therapists and six individual interviews were conducted with clients, five of whom had dropped out. The final model is presented in relation to existing theory and research, and the implications and limitations of the study are discussed.

Section C presents a critical and reflective account of the research process, considering areas of learning, how the research may have been conducted differently, and the implications for clinical practice.

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MAJOR RESEARCH PROJECT

JON CHATFIELD BA Hons MSc

SECTION A: PSYCHOTHERAPY DROPOUT FROM PERSONALITY DISORDER TREATMENTS: A REVIEW OF CONTEXTUAL, INTERPERSONAL AND THERAPEUTIC PREDICTOR VARIABLES

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Abstract

The current paper provides a critical review of literature pertaining to dropout from psychotherapeutic treatments for personality disorder (PD). It considers the prevalence and clinical significance of PD presentations, and recent debates about the validity of the diagnosis in its current form. The review then considers the impact of treatment dropout on clients and clinical services, and what existing theories of treatment engagement and therapeutic relationships might contribute to explanations of the dropout phenomenon. Previous reviews of the literature are then presented, alongside a rationale for the current review to conduct an up-to-date investigation of both quantitative and qualitative studies, focussing on the exploration of contextual, interpersonal and therapeutic predictors of dropout from PD treatments in health settings. A total of 19 articles are then reviewed, nine (47%) of which had not been part of either of the two previous reviews identified. The review concludes by identifying some research questions that remain unanswered in the extant literature.

Introduction

Personality Disorder (PD)

It has been estimated that the prevalence of PD in a British community sample is around 4.4%, that they are more common in men than in women (5.4% and 3.4% respectively), and that just under half of those diagnosed meet the threshold for more than one PD subtype (Coid, Yang, Tyrer, Roberts & Ullrich, 2006). One study reported that 24% of all attendees to four GP surgeries met the diagnosis (Moran, Rendu, Jenkins, Tylee & Mann, 2001), despite another finding that the majority of those with PD (81%) do not seek treatment for the disorder itself (Andrews, Issakidis & Carter, 2001).

Rendu, Moran, Patel, Knapp and Mann (2002) reported that clients presenting to primary care with a diagnosis of PD cost on average almost twice as much per year as those without the diagnosis (£3094 vs £1633), although this difference was mediated by higher rates of other mental health problems in the PD group. Nonetheless, there has been much recent interest in diagnosis of the disorder and its various subtypes, and in the development of evidence-based interventions to treat it.

Although there are currently several distinct and separate PD subtypes, such as borderline, antisocial, and schizoid, this conceptualisation has recently come under criticism, given the seemingly large overlap between subtypes, which frequently co-occur. One recent study found significant correlations between two-thirds of all the possible PD subtype pairings (Lenzenweger, Lane, Loranger & Kessler, 2007), which seems to suggest an overarching, more general PD presentation. These issues remain unresolved in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013), in which recommendations from The Personality and Personality Disorders Work Group to shift from the multiple disorder model to a single underlying dimensional model with trait features were ultimately voted against (Hopwood, Thomas,

Markon, Wright & Krueger, 2012). Commentators have called on the next edition of the World Health Organisation's International Classification of Diseases (ICD-11) to adopt this latter model (Frances & Nardo, 2013), and their own PD working group have made similar recommendations (Tyrer, Crawford & Mulder, 2011).

Psychotherapy Dropout

Unplanned client dropout from psychotherapy is variously described in the literature as attrition, premature termination or discontinuation, and its definition varies significantly between studies. Garfield (1994) makes a clear distinction between those clients who refuse treatment altogether, and those who start therapy but then leave without completing. For the purpose of this review, the focus will be on those clients in the latter category.

Although rates vary significantly between studies, one recent meta-analysis of 669 psychotherapy studies estimated an average dropout rate of around 19.7%, although the rate for PD clients was somewhat higher (25.6%; Swift & Greenberg, 2012). It is also worth noting that many, if not the majority, of the studies that make up these meta-analyses are from well-funded, standardised interventions, and that dropout rates tend to be higher in typical outpatient psychotherapy service samples (Lambert & Ogles, 2004). Clients with more complexity and other co-occurring mental health problems are also more likely to be screened out of clinical trials, which is less likely in routine clinical practice (Muran et al., 2009). This is particularly relevant in the case of clients with PD, where the existence of co-occurring diagnoses is prevalent (50-60% in BPD; Grant et al., 2008).

Dropout is a major cause of mental health service inefficiencies, and is associated with poorer clinical outcomes for these clients and negatively impacts upon clinician morale (Pekarik, 1985; 1991). The financial implications for services are also significant, with dropout resulting in therapist 'downtime', and clients who drop out are also more likely to

subsequently overuse services in the future (Reis & Brown, 1999). Webb and McMurrin (2009) reported that increased rates of hospitalisation and more hospital bed days for BPD clients who drop out alone resulted in hospital costs three times greater per individual than that for completers (£39,187 versus £122,444).

A recent review of psychotherapeutic randomised controlled trials (RCTs) estimated that between 57.6% and 67.2% of clients will show clinically-significant improvement within an average of 12.7 sessions, but that a typical client attending an outpatient psychotherapy department will attend, on average, less than five sessions, with only 20% showing significant improvement (Hansen, Lambert & Forman, 2002). However, interventions of a longer duration may be required to impact upon aspects of personality; a study of 854 psychotherapy outpatients found that the number of sessions required to achieve 'characterological' changes were far greater than for acute and even chronic distress symptoms (Hansen et al., 2002). After 52 sessions, less than 60% of clients showed clinically significant improvements in these characteristics.

The impact of dropping out on clients themselves may also be potentially damaging. Follow-up studies indicate that some clients attending only one or two sessions before dropping out may become more symptomatic than those who attend for longer (Pekarik, 1991). One study reported that clients who dropped out from a PD day treatment programme had higher hospitalisation rates than completers (22% and 11% respectively), and scored significantly worse on measures of global functioning, severity, and interpersonal functioning at five-year follow up (Karterud et al., 2003).

Clients with PD often have long histories of feeling rejected and dismissed in relationships and by mental health services, which they bring with them when entering into therapy (Crawford et al., 2007). Experiencing dropout may not only represent a treatment failure, but also a failed relationship, where past patterns may have been unintentionally repeated. In this

way, treatment failure may strengthen dysfunctional interpersonal styles, and decrease motivation to seek out further treatment.

Despite the considerable financial burden and clinical impact of this phenomenon, researchers have traditionally been preoccupied with studying only those who complete treatment. This is particularly the case in RCTs, where intention-to-treat analysis may be used to predict the hypothetical progress of clients who drop out. This precludes any understanding of why some clients drop out and others do not, which could inform adaptations to assessment and treatment protocols to minimise its occurrence. Nonetheless, researchers have more recently begun to express an interest in identifying the causes and prevention of treatment dropout (Ogrodniczuk, Joyce & Piper, 2005), although most studies rely on correlational analysis methods, making it impossible to draw causal conclusions from the findings.

Theories of Dropout

There are a number of theories relating to behavioural change and implementation, and perhaps the best known is the Transtheoretical Model (TTM; Prochaska & DiClemente, 1983). The TTM was developed within the context of addiction services, and proposes that individuals need to progress through six different ‘stages of change’: from Precontemplation, where the individual does not yet recognise that their behaviour is problematic, through Contemplation, Preparation, Action, Maintenance, and finally Termination, where no temptation to return to the old behaviour remains. This model emphasises the clinician’s role in identifying the client’s current stage, and adapting the intervention to meet their needs. Where there is a mismatch between the client and the therapy, dropout is more likely.

Self-determination theory (Deci & Ryan, 2000) holds that intrinsic motivation, derived from a desire to better oneself or one’s situation to enhance self esteem or self worth, is more

likely to result in good treatment engagement than extrinsic motivation. Extrinsic motivation reflects the desires of others, or the individual's desire to either avoid punishment or obtain some external reward. Whilst this theory was developed and applied within the field of health psychology, it would suggest that lower intrinsic motivation would be more predictive of dropout from psychotherapy than a lack of external motivators. However, like the TTM this theory has been developed within a field in which a maladaptive behaviour is clearly identified as needing change. This is not entirely analogous to attendance to psychotherapeutic treatment, given that the initial 'problem' behaviour is not one of non-attendance.

In the field of psychotherapy research, the concept of therapeutic (or working) alliance emphasises the importance of the developing relationship between client and therapist as central to achieving desirable outcomes. Bordin's (1979) pantheoretical conceptualisation of the alliance comprises three elements required to develop a collaborative relationship: (a) an agreement on the goals for therapy; (b) an agreement on the tasks to be undertaken to achieve these; (c) the development of an emotional bond between client and therapist to facilitate the therapeutic process. Although Bordin was originally more concerned with therapy outcome than attendance, poorer quality working alliance has since been strongly associated with treatment dropout (Sharf, Primavera & Diener, 2010).

Whilst not a theory about dropout per se, attachment theory has played a large part in understanding therapeutic relationships, and the development of PD (Bowlby, 1988). Bowlby believed that early mother-child interactions, and the quality of the resulting attachment, had long-lasting effects, and that an 'insecure' attachment could lead to interpersonal difficulties, and increase vulnerabilities to mental disorders such as PD. He emphasised the role of the therapist as a 'secure base' from which the client could feel safe to explore their vulnerabilities, and negotiate therapeutic change. The theory has clear applications in relation

to therapeutic relationships, and as we shall see, theoretically underpins one of the most widely-used treatments for Borderline Personality Disorder (BPD).

PD Interventions and Dropout

In order to consider some of the theoretical understandings of treatment dropout for PD clients, three established PD interventions will now be considered.

Dialectical Behaviour Therapy (DBT; Linehan, 1993) combines cognitive-behavioural and mindfulness techniques in an individual and group format, and focuses on treating emotional lability and self-harm/suicidal behaviour, primarily in BPD clients. Linehan suggested that one of the key behavioural ‘mistakes’ made by BPD clients was the premature termination of relationships in response to unbearable emotions, which could also happen in therapy. She drew a distinction between ‘attached’ and ‘butterfly’ BPD clients, believing that ‘butterfly’ clients, having other important relationships outside of therapy, could have difficulties fully attaching to the therapy. Clients are asked to commit to the full program at the start of treatment to enhance adherence, and Linehan conceded that early dropout in particular was a risk for clients who experienced the focus on behaviour change as invalidating.

Transference Focused Psychotherapy (TFP; Clarkin, Yeomans & Kernberg, 2006) is a twice-weekly individual psychoanalytical approach based on Otto Kernberg’s (1984) object relations model of borderline personality organization, which aims to integrate split off parts of the self and object representations as they emerge through transference. Dropout, or the client’s ‘threat to end treatment’, is seen as the greatest danger in therapy, with the exception of harm to self or others. Various reasons for dropout are suggested, such as the client’s dependency on or narcissism towards the therapist, the development of a negative transference, or the client’s wish to protect the therapist from their aggression (Clarkin et al., 2006). The therapist is called upon to draw the client’s attention to the transference process

as early in treatment as possible. Robust initial contract setting is seen as an important strategy to alleviate the risk of dropout.

Mentalization-based treatment (MBT; Bateman & Fonagy, 2012) is a psychodynamic treatment for BPD that, like DBT, combines individual and group therapy in a twice-weekly format. Drawing on attachment theory, it identifies problematic mother-child interactions as the source of difficulties in affect regulation and interpersonal functioning, and emphasises the therapeutic relationship as the primary mechanism of change. In contrast to TFP, it expressly advises against the use of transference interpretations, especially early in treatment. The emphasis is placed on the therapist to be able to monitor and regulate clients' affect, to ensure that they are both appropriately engaged with the therapy, but do not become overwhelmed. Clients may be at risk for dropout when they realise that therapy involves new attachment relationships, and that they will be required to strip away some of the existing strategies they use to prevent becoming emotionally overwhelmed.

Although all three approaches agree on the importance of therapeutic contract setting, they provide few hypotheses about the mechanisms that may underlie treatment dropout. Suggestions differ significantly from one approach to the next; including whether the responsibility for dropout lies with the therapist or the client, and what can be done to prevent it. In addition, given that these treatments were primarily either designed or adapted for BPD presentations, the potential for understanding dropout in PD more generally may have been further diluted.

Existing Reviews

Barnicot, Katsakou, Marougka and Priebe (2011).

This systematic review explored factors predicting dropout in interventions for BPD. The researchers limited their search to interventions that had demonstrated clinical effectiveness

in RCTs. This yielded 44 papers from 41 separate studies, only 11 of which examined predictors of dropout.

The reviewers concluded that there was no association between treatment modality or sociodemographic variables and dropout, and that there was scant evidence for any association of coexisting Axis I and II diagnoses, symptom severity (PD or general psychopathology), length of illness or hospitalisation history with dropout. There was some suggestion that impulsivity, avoidance, trait anxiety and anger may be linked to dropout, and conflicting findings regarding associations between suicidal behaviour, current medication and number of PDs.

Internal psychological processes such as low commitment to change, less internal and more external motivation to change and higher perceived stigma were all associated with dropout in individual papers. Similarly, therapeutic processes such as less affective communication and therapeutic alliance were both associated with dropout in individual studies. The authors highlighted these areas as important for further research, and suggested the need for more explorative qualitative studies to better understand PD dropout aetiology.

McMurrin, Huband and Overton (2010).

This systematic review of 25 studies explored factors predicting dropout in PD interventions, and was not restricted to BPD or clinically-proven interventions, although studies conducted in forensic settings were not excluded.

The reviewers found some evidence that dropout was associated with younger age, lower education and lower occupational status. They also identified lower ‘competence in skills necessary for therapy’ such as social problem solving, persistence, and having avoidance-focussed coping styles as being associated with dropout. They found little information regarding PD type on treatment completion, and like Barnicot et al. (2011), found evidence to

suggest the importance of therapeutic factors such as treatment contracting and the therapeutic alliance.

As the review focussed solely on significant findings, some may be overstated. This is particularly the case for sociodemographic factors, which are collected and included in the analysis of the majority of studies, but very rarely found to be significant. The researchers themselves acknowledged that many studies ran the risk of making Type I errors in exploring large numbers of potential predictors of dropout in a single analysis.

The researchers concluded that the extant literature focussed heavily on aspects of clients' disorders and traits, and suggested further research that aimed to explore the impact of both service-related barriers and client perceptions of treatment on dropout, across PD subtypes.

Rationale for the Current Review

Whilst both previous reviews offer insight into potential predictors of dropout in PD clients, they highlight the limited value in “seeking inherent deficits in the client as explanations for treatment non-completion” (McMurran et al., 2010, p. 285), which is often exploratory and atheoretical. Focussing the current review on contextual, interpersonal and therapeutic factors, across PD diagnoses and in health settings alone, seemed theoretically appropriate given the interpersonal nature of PD clients' presenting difficulties; several such studies have been published since these last reviews were carried out in 2009. The current review will also incorporate qualitative studies to better account for PD clients' subjective experiences of therapy dropout and its consequences.

Methodology

For literature search criteria and methodology, please refer to Appendix A. Of the 19 relevant articles currently reviewed, nine (47%) had not formed part of either the McMurrin et al. (2010) or Barnicot et al. (2011) reviews.

Literature Review

Quantitative Studies

Pre-therapy context.

A small number of studies considered some contextual variables that may have contributed to treatment dropout. One study of 713 mixed PD clients attending a range of different community services (Crawford et al., 2007) found that the rate of dropout was significantly lower for those clients who had referred themselves to therapy, rather than being referred by a professional involved in their care. In another study, 36 women with BPD receiving twice weekly outpatient psychodynamic psychotherapy (Smith, Koenigsberg, Yeomans, Clarkin, & Selzer, 1995) were more likely to drop out if they had not been referred from a long-term inpatient unit, and if they did not continue with their hospital therapist in the community setting.

A study of 111 women with a BPD diagnosis by Linehan et al. (2006) reported that those clients receiving individual treatment sessions by community experts in BPD (practicing a range of treatments other than DBT) were more likely to drop out where they had chosen to change from their original therapist. However, this was not the case in the DBT group, and a potentially large number of nonsignificant predictors were not reported. Another study of 32 BPD clients attending outpatient individual (predominantly psychodynamic) psychotherapy reported that the rate of dropout was significantly higher where there was a gender mismatch between the client and therapist (Nysæter, Nordahl & Havik, 2010). The authors suggest that

the activation of previous difficult or abusive relationships may have had an effect on dropout, but the lack of power in the study and the large number of potential predictors included means that this finding has to be interpreted with some caution.

Perhaps unsurprisingly, a study of 87 mixed PD clients receiving a sixteen-session social problem solving group intervention found that those clients who missed their first session were more likely to drop out (Huband, McMurrin, Evans & Duggan, 2007). The study also found no relationship between the distance travelled to therapy and dropout.

Client interpersonal factors.

A study of 39 mixed PD clients attending outpatient group therapy found that baseline perceived barriers to access, and lower treatment expectations, motivation and quality of relationship with the professional involved in pre-therapy assessment were all associated with subsequent dropout from therapy (Martino, Menchetti, Pozzi, & Berardi, 2012). However, the measure used to assess these variables (Patient's Assessment Evaluation Questionnaire; Chiesa, Martino & Pozzi, 2010) was unvalidated, showed limited internal consistency and comprised only two questions per variable. Over twenty predictors in total were studied, including aggression, impulsivity, clinical and sociodemographic factors.

Ogrodniczuk and colleagues have carried out two studies exploring the role of interpersonal problems in treatment dropout for mixed PD populations (Ogrodniczuk, Piper & Joyce, 2006, Ogrodniczuk et al., 2008). The 2006 study involved 72 clients attending twelve weeks of either supportive or interpretive outpatient group psychotherapy. They reported that lower levels of interpersonal difficulty were associated with treatment dropout in the supportive, but not the interpretative groups. However, dropout was defined as attendance to three or fewer sessions, which is a comparatively exclusive definition, with most other studies generally defining dropout as the decision of the client to leave therapy

prematurely, against therapist advice. The more traditional definition of dropout was used in their second study of 197 clients attending intensive (35 hours per week), 18-week psychodynamic group therapy (Ogrodniczuk et al., 2008). However, in this study, no association was found between interpersonal problems and treatment dropout.

In a similar study of 80 mixed PD clients attending 40 sessions of weekly outpatient individual supportive-expressive psychotherapy, interpersonal problems were found to protect against dropout i.e. the greater the level of interpersonal distress at baseline, the smaller the risk of dropout (Thormählen et al., 2003). However, the researchers defined dropout as including not only those who left treatment on their own initiative having started, but also those who attended no sessions at all. This makes it difficult to compare these results within the context of other studies reviewed, as there are qualitative differences between clients who do not start treatment at all and those who start and then drop out (Garfield, 1994).

The therapeutic relationship.

Eight studies were identified that explored aspects of the developing client-therapist relationship and their potential association with treatment dropout in PD. One early, small-scale study of 14 BPD clients attending one of two 20-month psychotherapy groups involved the analysis of segments of videotaped therapy sessions to identify how therapists' conscious and unconscious behaviours may contribute to therapeutic outcome (Stiwne, 1994). The study made some interesting observations regarding differences between the therapists' behaviour towards those clients who eventually dropped out of therapy, particularly in 'unstable' sessions (those following a break in therapy or change in group membership). In these sessions, therapists were observed to interact significantly less with clients who eventually dropped out, and these clients were more withdrawn in these sessions. Although

the sample size was very small, and the study is exploratory rather than explanatory, this was one of the first significant studies to suggest the importance of therapist and in-therapy factors on psychotherapy dropout in PD populations.

In the same year, a study of 36 women with BPD in twice weekly, open-ended individual psychoanalysis was published that hypothesised a link between therapeutic alliance, the quality of treatment contracting and severity of illness with dropout (Yeomans et al., 1994). While the researchers found no link between PD severity and dropout (with the exception of impulsivity), they found that an overall lower quality treatment contract, weaker therapist contribution to contracting and a lower therapist understanding and involvement were all significant correlates of treatment duration, as rated by independent observers. It is interesting to note that the clients' contributions to contracting and the therapeutic alliance were not significantly correlated with treatment duration. However, treatment dropout was not included as a dichotomous outcome variable in this study, with treatment duration used instead, which limits the study's ability to discriminate between completers and clients who dropped out. Nonetheless, along with the Stiwne study, these early studies suggest the importance of the therapeutic relationship, and the behaviour of the therapist in particular.

A study of 33 women with BPD attending individual psychotherapy of up to five years in duration measured working alliance at six weeks, six months, and then annually (Gunderson, Najavits, Leonhard, Sullivan & Sabo, 1997). The results showed that the working alliance at six weeks, as rated by therapists, was significantly worse in those therapist-client dyads where clients eventually went on to drop out. Although client-rated working alliance at the same point was not significantly worse in the dropout group, it was approaching significance ($p=0.072$, two-tailed). Despite the small sample size, the study reported high to moderate effect sizes for these findings ($d=.82$ and $.63$ for the therapist- and client-rated working

alliances, respectively). These findings were not maintained later than six weeks, suggesting the importance of the therapeutic alliance during the early stages of therapy.

A study of 78 BPD clients receiving either solution-focussed therapy (SFT) or transference-focussed psychotherapy (TFP) in the community (bi-weekly for up to three years) also explored the impact of aspects of the therapeutic relationship on dropout (Spinhoven, Giesen-Bloo, van Dyck, Kooiman & Arntz, 2007). Conducting a survival analysis to estimate the impact that different variables have on changing the odds of eventual dropout, the researchers found that therapists rating worse working alliances and the relationship as distressing and difficult increased the odds of early dropout from TFP within three months (no clients left SFT during this period). Clients' ratings were not available even at this early stage, having already left treatment. However, it was unclear whether therapists had made these ratings in advance of, or subsequent to treatment dropout, which may have impacted upon their perceptions of the relationship. Nonetheless, further analysis revealed that both client and therapist ratings of working alliance and therapist ratings of the client as difficult/distressing at three months was associated with subsequent dropout in both treatment groups.

Two studies conducted by researchers at the Beth Israel Medical Centre in New York have also been carried out, with clients diagnosed with Cluster C (avoidant, dependent and obsessive-compulsive) PDs or PD Not Otherwise Specified (PDNOS), assigned to one of three 30-session outpatient therapies: cognitive behavioural therapy, brief relational therapy and short-term dynamic psychotherapy. The first of these studies involved 48 clients, and found that mean working alliance, as rated by both therapists and clients at the end of the first seven sessions, was significantly lower for those clients who eventually dropped out of treatment (Samstag et al., 2008). However, the definition of dropout used was fairly narrow, defined as having left therapy between the end of the fourth and ninth sessions, which

represents a very limited subgroup of clients who dropped out in a 30-session intervention protocol. Nonetheless, effect sizes were in the moderate to large range, being calculated at .43 and .53 for the therapist and client ratings respectively. The researchers also found that a lack of narrative consistency in the dialogue between and treatment planning of therapist and client, as measured using independent analysis of session transcripts, was also significantly associated with dropout, but that independent ratings of client-therapist ‘interpersonal fit’ (the degree to which client and therapist behaviours complement each other) were not. However, it was unclear that these two measures were theoretically-independent, as they were significantly correlated with one another.

The second study had a larger sample of 128 clients, and reported that better early working alliance, calculated from the average ratings provided by both clients and therapists at the end of each of the first six sessions, was significantly correlated with lower rates of dropout from treatment (Muran et al., 2009). Conversely, therapist and client ratings of session ‘smoothness’ and ‘depth’ were not associated with subsequent dropout. The researchers also explored the role of ‘ruptures’ in the therapeutic relationship, and found that whilst therapist and client ratings of rupture intensity in the first six sessions were not associated with dropout, ratings of rupture resolution were. Given that rupture resolution was significantly correlated with working alliance, the authors suggested that experiencing and resolving ruptures may help to develop the early alliance, which itself impacts on treatment dropout.

An Italian study of 47 mixed PD clients attending long-term individual psychodynamic psychotherapy found that therapists’ ratings of their own understanding and involvement, and opinions about the quality of the consensus with the client over therapy strategy were associated with treatment completion (Lingiardi, Filippucci & Baiocco, 2005). However, comparable results for client responses on the same measures were not reported. There was

also no reported association between therapist and client ratings of the client's working capacity and commitment to therapy; again highlighting the importance of therapist behaviours and interpersonal interactions.

The previously reported Nysæter et al. (2010) study also measured clients' ratings of therapeutic alliance at session three, and compared completer and dropout means. Although this produced a nonsignificant finding, a calculation of the (unreported) p-value does show that their finding was approaching significance ($p=0.056$), despite the limited power achieved with a sample size of 32, and only nine clients who dropped out.

Qualitative Studies

Studies were sought that involved interviews with PD clients about their experiences of dropping out from therapy, or used other qualitative methods to develop understanding about PD treatment dropout. Just three studies were identified, which were limited in their scope and relevance to this review.

One mixed methods study interviewed 18 mixed PD clients who had dropped out from an inpatient service about their experience in the setting, and analysed the results using content analysis (Chiesa, Drahorad & Longo, 2000). Although the majority of the 'problem areas' identified related to aspects unrelated to therapy itself, clients did identify uniformity and rigidity in the provision of treatment as problematic. This prevented clients from feeling as though they were being seen as unique individuals, and was at the expense of feeling contained and understood. However, despite targeting clients who dropped out as the population of interest, data collection and analysis was focussed on identifying 'problem areas', rather than reasons for dropout, and experiences of therapy did not feature prominently in the findings. Although the researchers clearly explained their strategy for data collection and analysis, the narrow focus on problem areas may have meant that additional

useful information in clients' accounts was missed, and respondents were not given the opportunity to validate the researchers' findings (Mays & Pope, 2010).

Hodgetts, Wright and Gough (2007) interviewed five BPD clients that had attended a year-long outpatient DBT program, one of whom dropped out. The transcripts were analysed using Interpretative Phenomenological Analysis. The individual who dropped out found both the group and mindfulness components difficult to cope with. She also cited feeling overwhelmed and unable to share her feelings, being unable to access crisis support due to her enrolment in the program, and the rigidity of the programme as contributing factors to her dropping out. The study validated the coding of transcripts independently, and two of the participants offered respondent validation on the overall themes, but the focus of the study meant that the clients who dropped out were not directly compared to the completers through deviant case analysis, which limited understanding of the dropout phenomenon (Mays & Pope, 2000).

A Norwegian study interviewed eight female clients with BPD who had dropped out of outpatient Foulkesian group analysis, and the twelve group analysts that ran their respective groups (Hummelen, Wilberg & Karterud, 2007). The interview schedule focussed on clients' experience of being in therapy and on the relationships between group members and therapists, and data analysis was informed by the authors' own orientations of self-psychology, group analytical theory and attachment theory.

The analysis yielded ten categories, nine of which both clients and therapists agreed upon. Those most frequently cited were: difficulties with the transition from day treatment to outpatient group; group as too distressing; group as insufficient; being unable to make use of the group; having a complicated relationship to the group. Whilst clients put more emphasis on transitions, emotions arousal and the insufficiency of the group, therapists were more likely to focus on clients' relational problems, and their failure to sufficiently engage or make

use of the group. The study identified themes of separation and loss, the need for affect regulation and containment to help contain groups and develop new attachment relationships, and highlighted differences of opinion regarding dropout between clients and therapists.

The authors drew heavily on psychoanalytical and attachment theory to interpret their findings, which may limit the generalisability of the results, but the use of both therapist and client perspectives (data triangulation) helps to assure the quality of the results. However, the chosen method of data analysis was not made completely clear, which makes it difficult to judge the validity of the study's findings (Mays & Pope, 2010).

Summary and Future Directions

Previous reviews had highlighted the lack of evidence for the predictive value of sociodemographic and clinical factors in PD dropout, with heterogeneous and often contradictory findings. They suggested the potential benefit for focussing on contextual factors, the therapeutic relationship and clients' beliefs about therapy, which formed the basis of the current review, which unlike previous reviews, also included qualitative studies.

Findings regarding clients' interpersonal difficulties were mixed, and studies were often limited methodologically through the inclusion of large numbers of predictor variables, and rarely reporting effect sizes. Several studies suggested the importance of therapeutic factors, particularly treatment contracting, the quality of the therapeutic relationship and working alliance. These latter studies tended to be more hypothesis-driven, with a smaller number of predictors studied, which reduced the chance of finding significant results purely by chance.

Only a very small number of relevant qualitative studies were identified, and only one explicitly interviewed clients who dropped out about the reasons for leaving prematurely. Nonetheless, factors raised by clients seemed to relate primarily to interpersonal elements of the therapy, and to difficulties with the way in which a service or treatment was provided,

reflecting some of the findings in quantitative studies. The significance of interpersonal and therapeutic factors in both the quantitative and qualitative studies reviewed seems to fit with the difficulties associated with PD, and elements of both attachment theory and PD treatment such as MBT and DBT. Nonetheless, the extant theoretical literature as yet offers little explanation for why some people with PD diagnoses drop out of treatment, while others do not.

Based on the findings of this review, the following areas of further research are identified:

1) Investigation of in-therapy variables' contribution to PD dropout

Further quantitative studies are required to add to emerging literature emphasising the importance of the therapeutic alliance and relationship factors. This could be carried out across a range of treatment modalities, to identify the saliency of these factors in different contexts. Hypothesis-driven research with larger populations would help ensure the sensitivity and power of these studies.

2) Qualitative exploration of the experiences of PD clients who drop out of treatment

This research is needed to identify reasons for dropout across modalities and PD diagnoses, to aid the development of useful assessment tools to identify those at risk of dropout, and specific interventions to help retain those at risk. Explanatory theories need to be built around the subjective experiences of these clients, and integrated with existing theory where possible. This may produce novel hypotheses that may be further explored in quantitative research.

3) Evaluations of interventions aimed to reduce dropout in PD populations

Based on the existing and emerging literature, theory-driven interventions could be developed, implemented and empirically evaluated to help reduce dropout rates for PD clients.

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MAJOR RESEARCH PROJECT

JON CHATFIELD BA Hons MSc

SECTION B: UNDERSTANDING PREMATURE TERMINATION FROM PSYCHODYNAMIC PSYCHOTHERAPY FOR PERSONALITY DISORDER: A GROUNDED THEORY APPROACH

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Abstract

Dropout from therapy for personality disorder (PD) represents a clinically-important but poorly understood phenomenon in the existing literature. The present grounded theory study explores the experiences of clients with PD, and their therapists, of treatment dropout from a National Health Service outpatient psychotherapy service, specialising in psychodynamic interventions for PD. Pre-therapy questionnaires for 20 clients were initially reviewed to generate hypotheses about the differences between clients who dropped out and those who completed treatment, before a focus group was conducted with six therapists to explore their beliefs about and experiences of client dropout. Finally, six individual interviews were conducted with clients with PD, five of whom had dropped out from therapy at the host service. The final model highlighted the importance of clients' treatment expectations, how they perceived their therapist's behaviour, and their interpersonal history in making decisions about whether to stay in or drop out of therapy. The impact of therapy endings upon clients is also discussed, as well as therapists' beliefs about managing complex clients, both individually and within a team, under current financial and clinical pressures. The findings are then discussed in relation to existing theory and research, and the clinical implications and limitations of the study are presented.

Introduction

Personality Disorder (PD)

PD occurs in around 4.4% of the British population (Coid et al. 2006), and presentations are often complex, with high rates of co-occurring mental health diagnoses (Grant et al. 2008). Diagnosis of the disorder and its ten conceptually-distinct subtypes (e.g. antisocial, borderline) remains contentious, particularly with respect to its categorical nature, the reporting of significant overlap between the majority of subtypes (Lenzenweger, Lane, Loranger & Kessler, 2007), and suggestions of there being limited clinical evidence for some of the subtypes (Hopwood et al., 2012).

Most of the research into the effectiveness of psychological treatments has been focussed on Borderline Personality Disorder (BPD); those diagnosed experience difficulties regulating mood and maintaining relationships, and often engage in self-harm. A recent Cochrane review (Stoffers et al., 2012) concluded that there was sufficient evidence to suggest the effectiveness of Dialectical Behaviour Therapy (DBT; Linehan, 1993), with several other ‘promising’ interventions requiring further research. The number of available randomised controlled trials (RCTs) had quadrupled since the last review carried out in 2002 (Binks et al., 2006), highlighting the recent emphasis in developing and evaluating PD treatments.

However, RCTs often exclude clients with complex presentations, and exclusion rates of clients with multiple diagnoses may be as high as 70% (Westen & Morrison, 2001). This may limit the relevance of these studies to community services serving ‘real life’, complex clinical samples. In addition, RCTs rarely follow up clients who drop out, instead estimating their progress had they stayed in therapy (intention-to-treat analysis), which precludes further understanding of the dropout phenomenon.

Psychotherapy Dropout

Dropout has long been recognised as a significant problem for psychotherapy services, with rates estimated at around 20%, and higher in PD populations (25.6%; Swift & Greenberg, 2012). Dropout affects services' effectiveness and efficiency, and clinician morale (Pekarik, 1991). Clients who drop out are less likely to see positive clinical outcomes, particularly in PD populations, where longer interventions are required to have clinically-significant effects (Hansen et al. 2002; Stoffers et al. 2012). In addition, dropout from PD treatments is associated with higher rehospitalisation rates (Webb & McMurrin, 2009), lower levels of functioning and greater symptomatology (Karterud et al. 2003), and may reinforce already-existing negative perceptions of mental health services (Crawford et al. 2007).

Models of behaviour change from health psychology and addiction research, such as the Transtheoretical Model of Change (TTM; Prochaska & DiClemente, 1983) have been applied to help understand psychotherapy dropout. However, disengaging from therapy is not entirely analogous to engaging in a 'problem behaviour', such as using illegal substances or smoking tobacco, and as such these models have limited relevance to the field of psychotherapy research.

Recent reviews of studies assessing predictors of dropout in PD (Barnicot, Katsakou, Marougka & Priebe, 2011; McMurrin, Huband & Overton, 2010) conclude that research to date has focussed overwhelmingly on client sociodemographic and clinical factors, "seeking inherent deficits in the client as explanations for treatment non-completion" (McMurrin et al. 2010, p. 285), which have proved to have poor explanatory value. In addition, these explorations are often not hypothesis-driven, with a large number of predictors included, increasing the risk of Type I errors. The reviewers reported encouraging findings in the small numbers of studies exploring the therapeutic relationship and clients' views about therapy, recommending further quantitative and qualitative research in these areas.

Therapeutic Alliance and Attachment

The quality of the client-therapist relationship is considered a crucial contributor to outcome in psychotherapeutic interventions (Roth & Fonagy, 2006), and a recent review of 11 relevant studies found that poorer quality therapeutic alliances had a moderately strong relationship with dropout ($d=.55$; Sharf, Primavera & Diener, 2010). This relationship was particularly strong in treatments of a longer duration, such as those accessed by clients with PD.

Attachment (Bowlby, 1988) is one component of this developing alliance, as demonstrated in a recent meta-analysis of 17 studies demonstrating an association between attachment security and therapeutic alliance ($r=.17$; Diener & Monroe, 2011).

Attachment's relationship to therapeutic alliance has clear implications for therapy with clients with PD, and their ability to remain in therapy, as can be seen in some of the main modalities currently used to treat BPD: DBT posits that invalidation during childhood makes it difficult for the developing infant to learn to monitor and regulate affect; schema-focussed therapy (SFT; Young, Klosko & Weishaar, 2003) emphasises that where a child's emotional needs are not met, maladaptive schemas, coping styles and modes can develop; mentalization-based treatment (MBT; Bateman & Fonagy, 2012) highlights problematic mother-child interactions as the cause of difficulties in affect regulation and interpersonal functioning; and transference-focussed psychotherapy (TFP; Clarkin, Yeomans & Kernberg, 2006), like attachment emerged from object relations theory, and aims to integrate split-off parts of the self that emerge through transference. However, despite the recent focus on the development of BPD interventions, an explanatory theory of why some clients with PD drop out from therapy is lacking.

Existing Qualitative Studies

There have been a small number of recent qualitative studies exploring the experience of clients who drop out from PD treatments. Chiesa, Drahorad and Longo (2000) interviewed 18 clients who dropped out from a mixed PD inpatient population about their experience of the setting, but did not enquire specifically about therapy, which as such did not feature prominently in the findings. Hodgetts, Wright and Gough (2007) interviewed five BPD clients about their experiences of a year-long outpatient DBT program, but only one of these had left prematurely, and they did not ask specifically about dropout.

A Norwegian study interviewed eight female BPD clients who had dropped out of outpatient group analysis, along with their therapists (Hummelen, Wilberg & Karterud, 2007), and did ask about dropout, focussing their questions on clients' relationships with therapists and other group members. They identified group-related factors such as finding the group distressing and insufficient, feeling unable to use it, and having a complicated relationship with it. However, these findings are most relevant to group therapy, making it difficult to generalise the findings to individual interventions. In addition, the authors did not explore links to historical relationships, or attempt to develop a theory of dropout that could be tested and refined through additional research.

Rationale for the Present Study

Dropout is an important and poorly-understood clinical phenomenon in PD populations, and these clients are rarely consulted about their experiences. PD is an inherently interpersonal disorder, and while the therapeutic relationship has proved a promising predictor in quantitative PD dropout studies, tools to measure it have not been developed specifically for this population, and studies often rely on clinician judgements alone, rarely following up those who have dropped out. Although historical sociodemographic factors are frequently

included as potential predictors of dropout, the history of clients' interpersonal relationships is rarely considered.

The present study aimed to explore the circumstances surrounding 'real life' PD clients leaving a community-based psychodynamic psychotherapy service, within the context of current therapeutic and past interpersonal relationships. By utilising detailed pre-therapy client questionnaires, alongside a therapist focus group and individual client interviews, the study aimed to develop a preliminary theory to understand the dropout phenomenon.

Research Questions

1. What do samples of therapists and clients perceive to have been the causes of clients terminating prematurely?
2. How did PD clients describe their interpersonal relationships during childhood and prior to therapy, and what if any connections were made with the therapeutic relationship?
3. How do therapists describe their experience of clients who drop out of therapy, and their understanding of, and how they worked with PD clients?

Methodology

Participants

Participants comprised 21 (15 female) previous attendees to individual or group therapy at a UK National Health Service secondary care community psychotherapy service, specialising in psychodynamic interventions for PD, and six therapists who either currently or had previously worked at the service. The service had recently employed a CBT therapist, who took part in the focus group, but had not worked with any of the clients who participated in this study. Clients were seen at the service for individual psychodynamic therapy of up to a

year. The groups were slow-open group analytic groups of up to two years' duration. Interventions were psychodynamically-oriented, and the psychotherapists' approach was informed by the workings of Melanie Klein, Wilfred Bion and Donald Winnicott. The team's clinical psychologist also practised psychodynamically, although also incorporated elements of systemic therapy in her work. Psychodynamic approaches such as these have been showed to be effective in treating PD in a previous meta-analysis, yielding a large overall effect size (1.46; Leichsenring & Leibing, 2003).

The service assessed PD using the Personality Diagnostic Questionnaire-4th Edition Plus (PDQ-4+; Hyler, 1994, Appendix B), and where a PDQ-4+ was not available, client files were reviewed to identify existing PD diagnoses. Further details of the six clinicians and the subsample of six clients (all of whom had received psychodynamic psychotherapy) interviewed individually are given in Appendices C and D.

Design

The study utilised a non-experimental qualitative design with three stages: a review of pre-therapy questionnaire data; a focus group with clinicians; and individual interviews with selected clients. Data were analysed using constructivist grounded theory methodology (GT; Charmaz, 2006), and clients were selected for interview using theoretical sampling.

Pre-therapy Questionnaires, Interviews and Focus Group

The pre-therapy client questionnaire (Appendix E) is a comprehensive, eleven-page qualitative and forced-choice self-report of clients' views on their problems, therapy, relationships and employment. Given the sensitive nature of this questionnaire, responses were made anonymous, and data were only used for initial hypothesis development in the study.

The therapist focus group schedule explored therapists' experiences of conducting therapy with clients with PD, and their beliefs about dropout, in line with the study aims (Appendix F). It was informed by the analysis of the pre-therapy client questionnaires, and developed in consultation with research supervisors.

The client interview schedule (Appendix G) explored clients' experiences of therapy, focussing particularly on the client-therapist and other interpersonal relationships, again in line with the study's aims. A service user consultant with lived experience of PD diagnosis was consulted in the development of the initial interview schedule, to ensure that the questions asked were appropriate and relevant, and to help ensure that the procedure would minimise the risk of participants experiencing distress. Whilst retaining its core areas of questioning, the interview schedule evolved in response to emerging hypotheses, in line with GT methodology (Charmaz, 2006).

Both the focus group and individual interview schedules were semi-structured, with open-ended questions to collect high-quality subjective data. Questions focussed on participants' experiences and actions taken, and avoided leading questions and implicit assumptions (Charmaz, 2006).

Procedure

Therapists were contacted by the service lead, seeking consent to recruit their previous clients, and to invite therapists to take part in a focus group (Appendices H and I). Potential client participants were selected and sent an opt-in letter (Appendix J) with information about the research (Appendix K). Clients participating in interviews received additional information and completed further consent forms (Appendices L and M).

Selection of potential client participants aimed to fill quotas for the final sample as such: 80% clients who dropped out, 20% completers; 90% psychodynamic treatment, 10% other;

90% individual therapy, 10% group. This matched the project aims for a clinically ‘real’ sample, and GT methodology, which aims to target a heterogeneous sample. Initially targeting those who had completed therapy most recently, 123 letters were sent out to all 92 clients who had dropped out and 31 completers who had left the service since January 2005 (see Figure 1, below). Of the 26 responses (21%), 23 consented to their pre-therapy questionnaires being accessed, and 19 consented to being contacted for interview. 12/92 (13%) clients who had dropped out consented to participate compared to 11/31 (35%) completers. Two consenters (both clients who had dropped out) had no PD diagnosis recorded, and so were excluded, giving a final sample of 21: 10 clients who had dropped out and 11 completers. A member of the host service attempted telephone contact to an additional 62 clients who had dropped out who had not responded to the invitation letter, but no additional clients gave consent to participate.

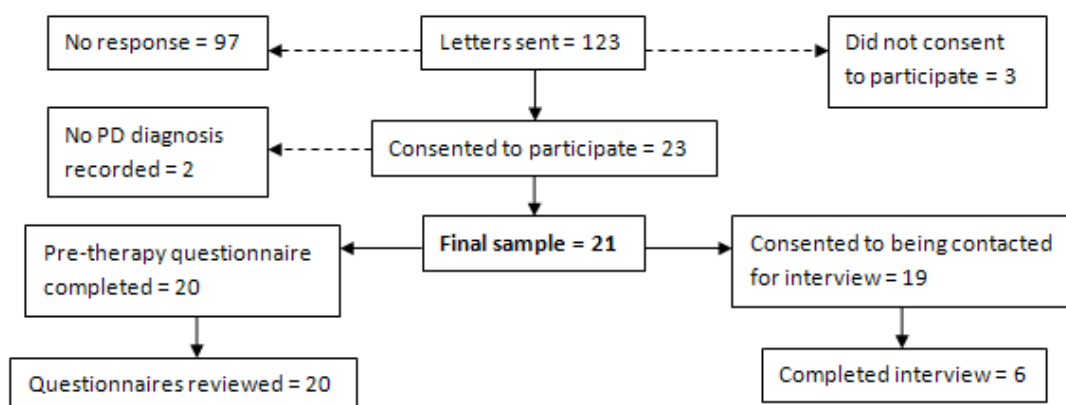


Figure 1. Flow chart of sampling process

In the first stage of analysis, clients’ responses to the pre-therapy questionnaire were reviewed using an informal content analysis to compare clients who dropped out with completers on areas such as recent self-harm and previous therapy, and subjective observations were also recorded in memo form (Appendix N).

Six clinicians then attended the focus group, which lasted 90 minutes, and was audio-recorded and transcribed. Clinicians were asked not to provide any information that could lead to any clients being identified.

Following this, six individual interviews were conducted with previous clients from the service (five clients who had dropped out and one completer), either at the host service or over the telephone, lasting between 15 and 60 minutes each, with median length of 38 minutes. Attempts were made to interview all nine clients who had dropped out that had consented to be contacted for interview.

Data Analysis

Constructivist grounded theory (GT; Charmaz, 2006) was used to collect and analyse the data, which aims to understand the sample studied by constructing theory based on the researcher's own and others' experiences. Its methods are systematic, yet flexible, and allowed for the various different types of data collected in this study to be combined.

Grounded theory analysis comprises three main stages:

- 1) Initial coding – focus group and the interview transcripts were coded line-by-line, looking to identify participants' actions in the data (Appendix O)
- 2) Focussed coding – this involves using more abstract codes to explain large 'chunks' of data; moving between different data sources to check codes' validity
- 3) Theoretical coding – in moving from codes to categories, relationships between categories are put forward and tested against the entire data set, to give the emergent theory explanatory value

Theoretical memos were conducted throughout each stage of the analysis (Appendix P), to promote hypothesis-generation, facilitate thinking, and define and clarify emerging codes and categories.

Quality Assurance

A bracketing interview (Rolls and Relf, 2006), lasting around 45 minutes, was conducted by one of the principal researcher's colleagues prior to data collection, which explored the researcher's experiences, preconceptions and predictions about the research. A research diary was also kept throughout the process, to maintain self-reflexivity in the process of data collection and analysis (Appendix Q).

Data were collected from three different sources; a process of data triangulation, to add reliability to the research findings (Kimchi, Polivka, & Stevenson, 1991). Verbatim quotes were also included to develop and explain the model (Appendix R) and to demonstrate its sufficiency (Williams & Morrow, 2009). Supervision was sought throughout the data collection and analysis process, and excerpts of transcripts were shared and discussed, to help audit the data analysis process (Elliott, Fischer, & Rennie, 1999). Finally, all participants were given the opportunity to respond to the findings (Appendix S), helping to ensure that final model accurately represented participants' experiences and beliefs.

Ethical Considerations

NHS Ethics approval was granted for the study (Appendix T), and both the British Psychological Society's and Health and Care Professional Council's codes of conduct for ethical research were adhered to (BPS, 2010; HCPC, 2012). A service user consultant was involved in determining the design of the study, in order to ensure that the study was clinically-relevant and minimised distress to participants.

As not all clients in the sample had been informed about their PD diagnosis, the disorder was not mentioned in any of the recruitment material, nor directly referred to in interviews or correspondence with participants, to mitigate the risk of causing distress.

Results

Figure 2 shows the resultant GT from analysis of therapist focus group and subsequent client interview transcripts. The model shows clients' journeys from the initial referral, into the therapeutic relationship, through the process of considering whether or not to continue, and into the ending context. The therapist context is considered separately, as much of their discussion related to professional issues outside of the immediate therapeutic relationship.

Note: unless explicitly stated, both client and therapist participants are referring to individual, psychodynamic psychotherapy. For Cathy, who attended both individual and group therapy, clarification is provided. Clive was the only client interviewed who had completed therapy.

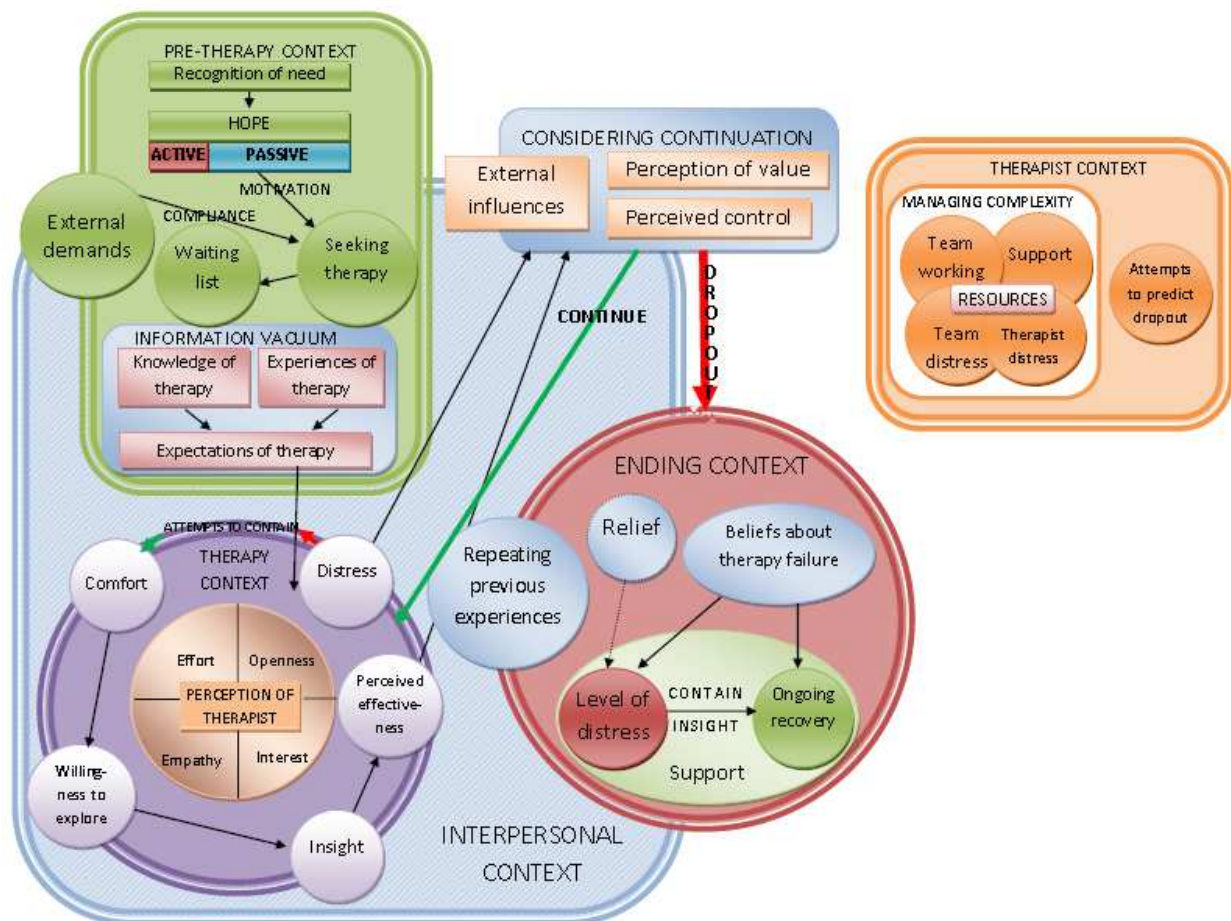


Figure 2. Final GT model of client and therapist experiences of dropout from therapy for PD

Pre-therapy Context

Hope.

When discussing what brought them to therapy, clients often noted a recognition of their needs:

“One of the reasons that I sought therapy was because obviously, I wanted to get better, and, I knew it was, I had a very unhealthy lifestyle” (Cathy)

This was seen by therapists as an internal shift or moment of insight:

“Someone suddenly being able to see further ahead in their lives and realising, ‘This has got to change.’” (Norma)

Specific and active hopes were rare, with clients more likely to want to receive a general solution:

“Just for it to help, really, to help me to cope with my problems and, um, dunno, fix me.” (Sally)

External demands.

For some clients, hopes were limited as a direct result of being compelled by others to attend therapy:

“I didn't really have any [hopes or expectations], if I was honest, I was kind of pushed into it by my CPN [...] people telling me I had to go. That's why I went.”
(Sarah)

Internal hope and external demands were rarely independent processes, because it was common even for those who actively sought therapy to feel like they had little control over the kind of support received. This may have affected their motivation to engage fully with therapy, which is something that therapists touched on in relation to some clients:

“[...] the very passively aggressive people, who come along, erm, but they don't really ever engage. They're going to stick in, but they're not going to be able to, or willing to do any work on themselves (Norma)

Waiting list.

Being placed on a waiting list was a source of frustration for most clients, due to their immediate needs not being met:

“The waiting is the worst part [...] Because it's, you go to your GP because you need that help, and then they'll turn round and say to you “Right, we'll refer you”, but then it could be six months.” (Sally)

For one client, the long waiting time enhanced her motivation and commitment to keep attending therapy, but also left her feeling let down when the therapy was unsuccessful:

“I mean, you wait six months for an appointment [inaudible]. And you know, you just end up feeling worse out of it. Just a waste of time.” (Lisa)

Expectations of therapy.

Expectations were influenced by clients' knowledge and experience of therapy, although these factors were limited by a lack of available information.

Knowledge of therapy.

Most clients knew little about how psychodynamic therapy was conducted. Some relied on popular culture depictions of therapy to have some idea of what to expect:

“I didn't even know what it was about, I thought it was the textbook, laying on the couch and let's talk about thoughts and feelings.” (Sarah)

Experiences of therapy.

Those clients who had previously had counselling or psychotherapy used these experiences to guide their ideas about what to expect from therapy. For some, this also impacted upon the hopes that they held about therapy:

“I've been through some counselling psychotherapy before, nothing's really helped in the past so I wasn't really expecting, erm, a great deal out of it.” (Clive)

Reviewing the questionnaire data also indicated that those who completed therapy had more previous experience of therapy than those who subsequently dropped out.

Information vacuum.

There was a lack of information provided about the therapy clients would receive, which made therapy difficult to predict:

“It just wasn't what I was expecting but obviously I had no experience of knowing what to expect and I wasn't given any. There was no leaflet sent out...” (Miranda)

This unawareness regarding how therapy would be conducted could even extend to those professionals who had referred clients to the therapy in the first place:

“He said that wasn't his specialist field so he couldn't really say what should and shouldn't go on in that session.” (Miranda)

Given this lack of information, clients may have been more likely to interpret the (purposely benign) therapeutic frame in a negative light, confirming: “an expectation of something quite hostile” (Rob), as will be seen in the next section.

Therapy Context

This area of the model refers to the clients' experiences of being in therapy sessions, including the content, and their thoughts, feelings and behaviours.

Perception of therapist.

Clients made judgments of therapists on four broad domains:

Interest.

Clients wanted to see that therapists were both interested in their work, and in the client as a person. Long silences could be interpreted as a lack of interest:

“[...] she never said a word to me all the way to her room, no chit chat, nothing.

She didn't address me by name once during the consultation.” (Miranda)

Therapists recognised a need to be more active than they would traditionally be in psychodynamic therapy, avoiding silences and demonstrating curiosity:

“I think I was probably more active with people who already come with that diagnosis because the whole process of engagement is so difficult.” (Bernadette)

Openness.

Clients wanted clarity about what was expected from them, how therapy would work, and why therapists were adopting particular techniques. Therapists could be deemed to be withholding information or explanations, by giving ambiguous answers to questions about process:

“I said, ‘You know, one of the things I hate is the first 10 minutes,’ and she sort of said [...] ‘It gives you time to adjust to your surroundings.’ And I, I thought, ‘Well, it's just a room.’” (Clive)

Therapists expressed an intention to share the rationale for and mechanisms of therapy at the start of therapy, setting boundaries, and preparing clients for potential difficulties:

“Explain to them exactly what you're aiming to do. I think that promotes a sort of engagement at that level, which hopefully will help hold you when you get into the more emotional work.” (Rob)

Empathy.

Clients wanted therapists to demonstrate human qualities that lend themselves to relationships such as being warm, demonstrating concern, and asking about how they were.

Therapists felt that this was particularly important when working with clients with PD:

“They tend to come with a fairly sort of, an expectation of something quite hostile [...] unless you demonstrate that you're friendly.” (Rob)

However, this was not generally the experience of most clients interviewed:

“I found it very, sort of, cold. There was no real warmth [...] It wasn't a warm environment.” (Clive)

“I thought, “Why am I going to you? You're supposed to be making me feel better and you're not, you're just sitting there and you seem more depressed and fed up than I am.”” (Sally)

Effort.

Clients wanted to know that their therapists were working hard to make the therapy work, and therapists expressed an intention to be more 'active' than they would be normally:

“You've [interviewer] said more in a couple of seconds! Do you know what I mean? I just felt, you know, 'totally overpaid and underworked'.” (Lisa)

Clients' experiences of therapy sessions.

Distress.

Negative interpretations of the therapist's or other group members' behaviour was upsetting for clients, especially where they judged them to be critical, disinterested, rude, withholding or undermining:

"I went out feeling very distressed" (Miranda)

Therapists seemed to subscribe to the belief that activating a certain amount of interpersonal distress was necessary in order to progress in therapy:

“Paradoxically, symptoms might go up if you are getting anywhere meaningful.”

(Norma)

Attempts to contain.

Therapists worked to ensure that this distress was contained at levels manageable for the client, and subsequently explored in therapy. This seemed to be particularly about

encouraging thinking, stepping back from emotional situations and appealing to the therapeutic relationship:

“You’re trying to encourage thinking, mentalizing, so you might need to bring someone into the reality of: ‘What are we doing here?’” (Norma)

Comfort.

Clients needed to feel comfortable and trusting within the therapeutic context, and felt that this was a key skill for therapists:

“I mean, because they're supposed to make you feel comfortable and things so that you do get things off your chest and I felt really uncomfortable.” (Lisa)

This was clearly recognised as an important factor by therapists, who emphasised the therapeutic relationship as being the main mechanism for change:

“It’s about, you know, our relationship rather than also what they may bring or their history [...] it’s just to keep it very slowly going in the now, and connected to us.” (Olivia)

Willingness to explore.

Where clients did not feel sufficiently safe and connected to the therapist, they felt less able or willing to explore the issues that had brought them to therapy:

“It [group therapy] was very difficult for me, very difficult. I found that I ended up basically, saying nothing.” (Cathy)

An unwillingness to share may also have represented in some cases an attempt to regain some control over the therapy sessions, particularly for Sarah, who had felt coerced to attend:

“I didn't like it; I didn't like someone trying to probe into me, 'cause I didn't want to be there anyway.” (Sarah)

In some cases, the act of sharing alone had a cathartic effect.

“I got a lot of things off my chest that I’ve never told anybody [in individual therapy], so that was good, yeah.” (Cathy)

Insight.

Clients valued therapy where it gave them a new perspective, which added to their understanding about themselves and others.

“There was a couple of times when, erm, I suppose the penny dropped [...] I sort of thought, ‘Yeah ok, that makes sense now, I understand that.’” (Clive)

Perceived effectiveness.

Clients’ judgements about the therapy’s current effectiveness were made based on insight or learning, but estimations of potential effectiveness were also made: for example, long silences in sessions were identified by some clients as being indicative of the lack of potential progress:

“In the end I thought ‘No, this [group therapy] isn’t working’. So I stopped going.” (Cathy)

Considering Continuation

There were several considerations regarding whether or not clients chose, or were able to continue with therapy.

Perception of value.

Clients made assessments of the therapy to date and on its likely future value, based on its perceived effectiveness, and the distress it caused. Clients also took into consideration whether or not the therapy might change:

“This is about my seventh time and you do this [remain silent] every time I come in.” (Clive)

Some clients perceived more potential value in the therapy based on the amount of effort they had already expended upon it, such as having to wait on a waiting list.

Perceived control.

Clients only returned to therapy if they perceived they had a choice. Intolerable levels of distress, or interference by other mental health difficulties could reduce a client's perceptions of control over attendance.

“When I'm out anywhere, my primary thought is: 'I've got to get home'. So it makes it very very difficult. And that's why I didn't complete the course [of group therapy].” (Cathy)

Even Clive, who completed therapy, was unable to attend every session, because: “Sometimes, it was purely because I just couldn't face it.” However, he expressed a desire to continue therapy, but had little control over its provision:

“I probably felt like I could have done going more but it was just more the fact that you was only allocated so many sessions and your time's up.” (Clive)

External influences.

The client may perceive responsibilities to others as having particular influence over their continued attendance:

“My family. They said 'Cathy, you've got to do it, you've got to go [to individual therapy]. You can't go on like this'”. (Cathy)

One client felt that he had to continue attending therapy sessions in order to be seen to be complying with what had been offered:

“I felt I had to go to get to the, the next stage [...] if I didn't turn up they'd be like, 'Well we're offering you the help, and you're turning it down,'” (Clive)

In addition, Clive chose not to ask for another therapist, in order to avoid repeating his story “like a tape recorder that keeps on repeating over and over and over again what has happened to me.”

Another client relied on her mother to help her assess the impact that therapy was having on her:

“My mum was like: ‘Your attitude’s really changed’ within the sort of hour or so that I was in there [therapy session]. She was like: ‘You seem worse every time you go there.’” (Sally)

Ending Context

Relief.

Some clients identified a temporary and immediate alleviation of distress having left therapy:

“Well, in some ways I was quite pleased it had finished, because I hated, sort of, going there.” (Clive)

Beliefs about therapy failure.

Clients varied regarding to whom they allocated the blame for the failure of the therapy; themselves or the therapist. For those who took responsibility themselves, feelings included guilt, regret and self criticism:

Sarah: “Yeah, it was my fault, so if I'd have cooperated I would have got a lot out.”

Cathy: “I actually felt guilty. I did feel guilty [leaving group therapy]. ‘Cos I know that [therapists] go through years and years of training, and I was lucky to be offered it.”

On the other hand, those who blamed the therapist felt angry, disappointed and dissatisfied, particularly where hopes and expectations had failed to be realised:

“I was pissed off, to be honest with you, I thought I'd get some sort of switching off, something out of it... Do you know what I mean? Get things off my chest.”

(Lisa)

However for some, in the longer-term, taking personal responsibility for recovery did foster feelings of autonomy, self-determination and motivation to try new things, even if this was in the context of a system that had proved unable to help:

“I think it made me realise that all the problems were in my head. And that it's me that's got to deal with it at the end of the day.” (Cathy)

Level of distress.

Clients' reactions to ending therapy varied significantly, although all experienced some distress. Experiencing an increase in symptoms was common, and where clients had opened up in therapy, it was not uncommon to feel exposed:

“We were finished and I was like, well, I've got all this emotion or can of worms, you know, and I was just being put to the side.” (Clive)

Some expressed their distress very actively through suicidal behaviour and hospitalisation, while others retreated from the world completely.

“Erm, the thing is I think that my problems are so deep-rooted; I just went back to being a hermit, basically [after leaving group therapy].” (Cathy)

Support.

The level of support that was available and sought by clients in the wake of leaving therapy was important in helping them make sense of the ending, and subsequent attempts to engage with their ongoing recovery:

“I didn't really have any support at all. From anybody. I think that's one of my main problems with it [leaving group therapy].” (Cathy)

For those clients for whom social and professional support was positive, stable and ongoing, the distress seemed better contained over time:

“Well, um, it left me feeling very, very negative, [...] if it hadn't been for Dr X [psychiatrist] pulling me up...” (Miranda)

One client was told that she could return to therapy if she felt she needed it, which provided some comfort:

“I've still kind of got that support, but I haven't, if you know what I mean?”
(Sally)

Ongoing recovery.

Each individual varied significantly in terms of how easily they found it to reengage with their recovery. Some returned to their GP to ask for different treatment or medication, whilst some sought comfort elsewhere, like on the internet:

“To me, that [the ending of the therapy] was like, well, ‘Right, I've tried that, that's not helping, they're not going to help me. What can I do for myself?’”
(Sally)

Therapists also wondered whether, despite dropping out, clients may be able to take something away from seemingly ‘unsuccessful’ therapies:

“I think there are some who, yes, incrementally, something developmental is happening.” (Bernadette)

Repeating previous experiences.

Some clients were able to identify how the experience of leaving therapy was reminiscent of other interpersonal experiences in their life, and may have confirmed their existing ways of seeing the world:

“Interviewer: And did [...] that ending, did it remind you of other things that have happened in your life before?”

Sarah: Yeah, [...] my relationship with my so-called mother [...] comments that she'd be there for me and stuff and she really didn't. She's too hooked up on drugs and alcohol.”

Therapist Context

Given the divergence between therapists' and clients' experiences of therapy, therapists and services are considered separately here, with the overall emphasis of the model being focussed on client experiences, in line with the project aims.

Attempts to predict dropout.

Therapists, on the whole suggested that it was very difficult to be able to make predictions about who might drop out from therapy, given the complexity of the client group:

“One of the features of the kind of patients we're talking about is they often come with a massive diagnostic stuff trailing behind them [...] [the] predictability of the work in some of the patients we have is actually very poor.” (Carl)

Although there was a suggestion that there was a distinction to be made between those clients with a BPD diagnosis and those with other PD diagnoses:

“I think BPD are much more difficult to hold [...] the chances of them suddenly dropping out, very near the beginning are much higher in BPD.” (Rob)

Therapists hypothesized that clients could be very afraid of changing, particularly when they had been relying on their ways of coping with and seeing the world for so long:

“I wonder whether it's sort of a fear of change [...] ‘If I'm gonna change from being like this to being something different over here, I've got to give this up.’”

(Neil)

Resources.

Therapists were clearly concerned about the impact that financial and clinical pressures in the public health service would have upon teams' and clinicians' ability to manage complex and challenging PD clients in the future:

“It’s the big worry about cuts, and it’s the big worry about training, and lack of supervision that really you are talking about people who’ve never really had an opportunity to be contained in a way that’s safe and allows them to develop”

(Norma)

The amount of resources available was a crucial factor in allowing the team to manage their own distress, support each other, and work together as a coherent and consistent team around the client, as will be discussed below:

Therapist distress.

Therapists admitted that it was often very difficult to work with clients who were expressing and sharing difficult experiences and emotions:

“There’s a kind of, a weight of people pushing stuff into you all the time.” (Carl)

And that they could often be made to feel as though they were being unhelpful or unskilled:

“I was thinking about how hard it can be, to be really working with somebody and be the bad one, you know, be the useless one.” (Norma)

Therapists also seemed to feel emotional pain in response to an unexpected dropout from therapy:

“Which sometimes can be quite painful and shocking, where you feel that you’ve actually some kind of relationship with someone, and then they, they might disappear.” (Bernadette)

Support.

Therapists identified the importance of support from colleagues through supervision, consultation, and from their experiences of their own previous or ongoing therapy to help them make sense of their work with PD clients:

“It also demands that the professionals erm, have good supervision really because [...] you might need to be able to be helped to think about what’s going on between you” (Norma)

Team distress and team working.

The experience of distress within the multi-disciplinary community team was closely linked to the distress felt by individual clinicians, where it was felt that clients could be engaged in a process of ‘splitting’. There was an emphasis on the need for teams to be working together with a client, to ensure a consistent approach:

I think the actual approach is less important than that sense of working together.
(Rob)

In this way, and by being open and honest about this with clients, it was hoped that the team could offer something to clients akin to “a family setting where people actually thought about them” (Norma). However, it was also acknowledged that a client splitting a team could be used to the therapist’s advantage to build a good relationship with that client, at least in the short term.

Interpersonal Context

This area refers to the wider interpersonal experiences of the client; an accumulation of their past and present relationships. It is a core part of the model, as it can impact, and be impacted by several other important areas, as has already been seen in previous sections. It can be

activated during therapy, particularly when the therapist's behaviour is interpreted as being reminiscent of previous relationships:

“My father passed away 10 years ago, so most of the time I was talking to her [therapist] my dad had already passed away but I still had that sort of air of the naughty boy.” (Clive)

It may be that, in the absence of ‘data’ about the therapist, such as when experiencing a psychoanalytic frame or ‘blank slate’, clients relied on previous relationship experiences to anticipate the therapist's intentions.

Therapists also emphasised the importance of external interpersonal relationships to help support the client outside of what can be at times difficult and distressing therapy sessions:

“I think if they've got no sort of relationships that are working [...] it's very difficult to [hold them] [...] they haven't got anywhere else to go to.” (Rob)

Making sense of dropping out, particularly without sufficient support, could also be experienced as a repeating pattern of interpersonal relationships, such as when Sarah felt promises had been broken like her mother had in the past, and Clive felt powerless to receive any more sessions:

“My father, [...] when he took his own life I felt again, it was taken out of my control [...] when those sessions finished I felt it was all out of my control, I didn't have any real choice in the matter.”

Cathy felt immense guilt at leaving group therapy, which also got her in touch with earlier feelings attached to significant interpersonal relationships:

“When my children were very small, and I was in an abusive relationship, and they went to live with their dad. And that impacted me greatly [...] yeah, that caused a lot of guilt as well.”

In this way, the ending of therapy, without an opportunity to fully explore the circumstances, could strengthen existing ways of relating to and perceiving others.

Model Summary

The emerging model identifies some of the important areas that contribute to treatment dropout from psychodynamic therapy for clients with PD diagnoses. Prior to therapy, help-seeking could arise from internal hope or as the result of coercion from others. Being placed on a waiting list could affect how therapy was eventually approached, and a lack of information or experiences of therapy could make it difficult to form accurate and realistic expectations of therapy.

Clients wanted their therapists to make an effort, and be open, empathic and interested. Where clients felt comfortable to explore their difficulties, they were more able to gain insight and perceive the therapy as effective. Where they experienced distress in the absence of meaning, they would be less likely to want to continue; a decision based on the current and future value of therapy, clients' perceived control over attendance and the impact of external influences. Although some clients felt initial relief at ending therapy, beliefs about the nature of the ending could cause distress, and could be reminiscent of previous difficult endings. The ongoing personal and professional support of others could help to contain this distress and make meaning from the experience, and continue to engage in an ongoing recovery.

Therapists felt that it was difficult to predict dropout in this client group, but highlighted the need for services to provide teams with resources to allow them to manage distress, support each other, and manage the clinical complexity that they were presented with.

Although none of the clients responded to invitations to give their opinions about the final model, two therapists did provide feedback. This suggested that they were satisfied with the

final model, and had welcomed the opportunity to learn more about the experiences of clients who drop out from therapy.

Discussion

The present study explored the experiences of clients with PD of being in, and leaving psychodynamic therapy, and therapists working with this client group. The following section will review some of the main findings of the model developed, suggesting their clinical significance and how they relate to existing research.

Information Vacuum

Clients commonly felt poorly-informed about what to expect from therapy, and it was common for clients to interpret the therapists' (possibly ambiguous) behaviour as persecutory or rejecting, associating these relationships with those from their past. Clients who dropped out of therapy appeared to have less experience of receiving formal psychotherapy treatments than those who completed treatment, based on the review of pre-therapy questionnaires.

Preparatory work with clients with PD prior to starting therapy could help to reduce uncertainty and ambiguity, by sharing the rationale and mechanisms by which the therapy can be effective. This kind of preparation has been shown to be effective in reducing psychotherapy dropout in previous reviews of the literature (Reis & Brown, 1999; Oldham, Kellet, Miles & Sheeran, 2012) by helping to align therapist's and client's expectations for therapy, particularly for client groups traditionally associated with higher risks of dropout (Walitzer, Dermen & Connors, 1999).

As therapists in this study suggested, preparatory work is also an opportunity to prepare clients for the distress associated with the evocation of difficult previous relationships. This approach seems analogous to the interpretations of therapeutic transference employed early

on in TFP (Kernberg & Caligor, 2005), but there should be an additional emphasis on education about the rationale for the therapy and potential pitfalls. MBT also incorporates a mapping of important relationships during assessment (Eizirik & Fonagy, 2009), which would also be an opportunity to discuss with clients the potential for these relationships to be evoked in therapy.

A review of previous therapeutic relationships may also be helpful at this stage, to explore what the client has taken away from each of these experiences, and helping them to make meaning where an ending was sudden, distressing or confusing.

The Therapeutic Relationship

Clients highlighted the importance of a relationship with their therapist that is non-threatening and unambiguous, offered in a supportive and comfortable environment in which to build trust. The importance of the quality of this relationship cannot be overlooked, and is in keeping with both attachment theory (Bowlby, 1988) and the psychotherapy outcomes literature (Lambert & Barley, 2001). However, there was a clear discrepancy between the intentions of therapists interviewed and clients' experiences, which may reflect a change in working therapeutically with clients with PD in recent years, partly perhaps due to the recent surge in published studies of PD interventions. These discrepancies also highlight it is important for therapy services to routinely seek feedback from their clients, and use this to change how services are provided, in line with current Department of Health policies such as *Equity and Excellence: Liberating the NHS* (2010).

Clients' experiences of distress in sessions, and therapists' intentions to help to contain this seem to closely match goals posited by both DBT and MBT approaches: helping clients to monitor and regulate affect. In addition, existing approaches all aim to develop insight in relation to interpersonal relationships, as emphasised in the final model of the current study.

Interpersonal Networks

The importance of utilising support outside of the therapeutic relationship also featured in the model, and was endorsed by both therapists and clients. As such, undertaking therapy with clients with PD should aim to engage supportive family members and friends at an early stage. This is addressed in the ‘pretreatment programme’ of MBT (Bateman & Fonagy, 2012), but it is also important that this support is maintained after the ending of therapy. Clients may also need some ongoing support when placed on a waiting list, as this caused distress and frustration for clients in the current study, and has been associated from dropout from treatment in research (Clough & Casey, 2011).

The distress of the therapy ending was contained in part for some participants by continued contact with an understanding referring GP or psychiatrist. However, despite therapists endorsing a joined-up, consistent multidisciplinary approach to support clients with PD, some clients reported a gap in service provision following the ending of therapy, which could feel unsupportive and isolating. Again, whilst this may reflect a recent change in service provision, it is important that therapists maintain a dialogue with referrers about treatment, whilst preserving an appropriate level of client-therapist confidentiality, negotiated in collaboration with the client. This may help to mitigate the increased risk of hospitalisation that has been found for clients with PD who drop out of therapy (Webb & McMurrin, 2009).

Making Meaning of Endings

The emerging model showed that dropout from therapy will not always be completely negative, just as completing a course of treatment will not always be wholly positive. However, where clients were unable to make meaning of the ending, they could resort to blaming the therapist, the service or the self, all of which may cause distress. In addition, this

may have meant that pre-existing problematic perceptions of interpersonal relationships were reinforced, rather than being addressed in therapy.

As above, this means that personal and professional support networks need to be in place to help clients make sense of their therapy experiences, as meaning-making is an important part of recovery (Pettie & Triolo, 1999). This may be particularly salient where dropout has precluded this process from happening during therapy. This requires that other professionals are informed about the rationale for therapy, as well as the client's progress and outcomes.

It is important that clients feel confident in the treatments they are referred to, and that care-coordinators are well-informed about these treatments, and continue to stay in contact with clients throughout, and following interventions. Therapists may also choose to liaise with referrers as therapy reaches its conclusion, to discuss plans for ongoing support following therapy completion. It is important that clients have a say in the treatment they receive, as providing them with this choice has been shown to be one of the most effective strategies to help reduce psychotherapy dropout (Oldham et al., 2012).

Therapist Context

Therapists expressed clear concerns about the impact of financial restrictions on their ability to contain complex clients within therapy and the wider team. Good supervision, consultation and emotional support were identified as necessary to facilitate effective work with this client group, and a lack of resources could impact the quality of support available, whilst simultaneously increasing the size and severity of clinical caseloads. If clinicians do not feel that they have the resources available to work with clients with PD, then there is a risk that they will reject the client altogether, facilitating their dropout from services, leaving needs unmet, and reinforcing feelings of rejection and mistreatment (Davison, 2002).

Further Research

Given the difficulties encountered in the current study, future research would benefit from recruitment of participants prior to starting therapy, perhaps facilitated through establishing collaborations between research and clinical teams (Butterfield, Yates, Rogers & Healow, 2003). This would allow approaches to be made to participants immediately following dropout, minimising any deterioration of memory, and enabling the exploration of how reactions to endings change over time.

Additionally, an exploration of the factors that impact upon the quality of endings could be conducted, as this study has suggested the importance of ongoing support and developing insight, whilst demonstrating that dropout experiences can have positive effects.

Finally, a trial that offered follow-up appointments for both clients who drop out and completers could assess any mitigation of distress from leaving therapy, and the circumstances that may facilitate or prevent it. These studies would continue to focus attention on predictors of dropout that are more within the control of professionals and services, rather than the traditional emphasis on stable client characteristics or external events (Walitzer et al., 1999).

Limitations of the Study

Limitations of sample.

There is likely to be a selection bias in terms of those who chose to take part in the study, as only a small proportion (13%) of contacted clients who had dropped out consented to take part in the study, despite significant efforts at recruitment.

In addition, as only a small and specific sample was studied, caution should be used in attempting to generalise the findings to PD populations. Nonetheless, utilising a real-life

clinical sample does add ecological validity to the theoretical generalisability of the findings (Jensen, Hoagwood & Trickett, 1999).

Limitations of scope of study.

By addressing the limited exploration of clients' experiences of dropout in the existing literature, this study's focus on therapists' experiences of the work was restricted.

Considering the dyadic nature of individual therapeutic relationships, it would prove useful to explore this further in future studies.

Interviewees were not asked explicitly about the diagnosis of PD for ethical reasons, as not all had been formally given their diagnosis. As such, it is possible that an important factor was not represented in the final model, particularly given the stigma associated with the diagnosis.

Whilst efforts were made to assure the quality of the data collection and analysis processes, the expectations and preconceptions of both the researcher and participants will also have impacted upon the construction of the final model.

Conclusions

This study aimed to utilise client and therapist experiences to develop an initial model to explain the phenomenon of dropout from therapy by clients with PD in a routine clinic setting. The findings emphasise the importance of clients' history of interpersonal relationships on therapy experiences, and suggest therapists may consider utilising pre-therapy psychoeducation and preparation, adopting an active, empathic and comforting therapeutic style, and extending social and professional networks to help clients make meaning from their therapy experiences, particularly where they end prematurely. Although there were some methodological limitations with regard to the study's sample and scope, the

final model contributes to ongoing research into the quality of therapeutic experiences in clients diagnosed with PD, extending it to routine practice.

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MAJOR RESEARCH PROJECT

JON CHATFIELD BA Hons MSc

SECTION C: CRITICAL APPRAISAL

Word count: 1970

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2013

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1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

The process has offered me the opportunity to completely design and carry out a research project of this scope, which has required a wide range of different skills at each stage: thoroughly reviewing the extant literature; formulating research questions; preparing for both Salomons' research panel and the NHS ethical review; recruiting and interviewing participants; and conducting a grounded theory (GT) analysis to construct a new theory. The process gave me ultimate responsibility to ensure that the project was carried out appropriately, and required me to negotiate with a wide range of other interested parties – internal and external supervisors, service managers and clinicians, ethics boards, review panels, service user consultants and participants – and ensure that they were all satisfied with how the project was conducted, whilst maintaining the focus and clinical relevance of the final assignment.

Designing a research project based around a particular qualitative approach was a useful learning experience, and it enabled me to reflect on my own epistemological beliefs throughout the process. Conducting a bracketing interview before beginning data collection allowed me to explore my own preconception and beliefs about what I thought the study's findings may be, but it also allowed me to reflect on my own relationship to what constitutes 'truth' or 'reality'. I realised that whilst my views towards personality disorder (PD) and mental health more generally have become more social constructivist in direction throughout the doctoral course (which has involved questioning the appropriateness of certain diagnoses altogether), I also retained a certain amount of pragmatic critical realism in my belief that there was some tangible knowledge in the world that I hoped to discover or reveal in carrying out the research. I believed that this knowledge could not be easily measured quantitatively or

reduced to numbers, but was to be found by exploring the individual perspectives of clients themselves. I hoped that this could be helpful in improving the services that clients diagnosed with PD receive. Whilst I wanted to keep the perspectives of clients at the core of the study, I recognised that it was also important that their experiences were represented in a way that could influence professional audiences. Furthermore, therapists' experiences and beliefs would also prove helpful in adding flesh to the bones of the research.

The exploratory nature of the study, coupled with an interest in exploring often-ignored client perspectives of the therapy process, set up the rationale for utilising a qualitative methodology. GT was chosen due to its flexibility in being able to utilise various different kinds of data, as were collected in this study, offering an opportunity to increase the validity of the results through data triangulation from the perspectives of both clients and therapists (Kimchi, Polivka, & Stevenson, 1991). In addition, unlike other qualitative methodologies, GT allows for the construction of new explanatory theory based on the sample studied (Charmaz, 2006), which seemed highly appropriate given the lack of any existing theoretical framework to explain the phenomenon being studied.

Conducting the GT itself was a very steep learning curve for me, but although the amount of data collected seemed vast, I noticed that I was able to situate myself in the data and feel my way around it with greater ease as time went on. Nonetheless, I recognised that it was also important to use data assurance strategies to enhance the validity of the analysis, and for it to be auditable by others (Mays & Pope, 2000). For example, in addition to conducting a bracketing interview (Rolls & Relf, 2006) and utilising multiple sources to triangulate the data, I kept a reflective diary to engage in an ongoing critical and questioning dialogue with myself about the decisions made and conclusions I came to. I also found the process of keeping theoretical memos as I conducted the analysis particularly helpful, as I was able to return to them over time to assess how my understanding of the data had developed and how

the most salient categories had emerged (Charmaz, 2006). It was also very helpful to draw on both a peer GT supervision group and my own individual research supervision to share portions of coded transcripts, to ensure that I was staying close to the experiences that participants were expressing, and not imposing my own preconceptions onto the analysis.

2. If you were able to do this project again, what would you do differently and why?

Given the difficulties encountered in recruiting clients who had dropped out of therapy, I would aim to try and recruit potential participants prior to starting therapy, ideally at assessment. I feel that this could be facilitated by developing an ongoing collaborative research relationship with the host service. This would appear to be mutually-beneficial, as the research team would have ready access to participants, and the clinical team would be able to demonstrate an engagement with research, and be shown to be committed to receiving and responding to client feedback. In order to facilitate this process, I would possibly try to identify a researcher based within the service, or at least the local trust, with which to collaborate on the project. This individual would ideally have significant local knowledge of relevant services, key personnel, and research and development procedures and support. Fortunately, having prepared for the potential difficulties in recruiting clients who had dropped out, the current study's design incorporated the use of several different data sources. By combining the use of pre-therapy questionnaires, a therapist focus group and individual client interviews, I was able to collect enough data to reach theoretical sufficiency (Dey, 1999), which is in keeping with the development of an initial explanatory theory in a previously unexplored area.

I also encountered several delays throughout the process, such as having to resubmit to both the original Salomons review panel, and the NHS ethics panel, which impacted significantly upon the time that was available to carry out the study. For example, it would

have been possible to spend more time on recruitment, and also conduct a more formal analysis of the pre-therapy questionnaire data, had more time been available. As such, it would have been beneficial for the applications for university and ethical approval to have taken place at an earlier stage. However, I am not sure how possible this would be given the time constraints of a doctoral research project.

It may perhaps be useful to also try and identify a service in which PD diagnoses are more explicitly given to and discussed with clients. This would allow clients to be asked directly about their diagnosis, what it meant for them, and how it may have impacted upon their ability to attend and remain in therapy, without the risk of exposing clients to a diagnosis that they had not formally received. It would also allow an exploration of whether or not the opportunity to discuss, understand, and if necessary contest their diagnosis with services was an important factor in their ongoing engagement with mental health services.

3. As a consequence of doing this study, would you do anything differently in regard to making clinical recommendations or changing clinical practice, and why?

Being placed on a waiting list was identified by participants as a frustrating experience, and it would seem beneficial that waiting lists were avoided wherever possible, and where not, there is clear and well-communicated provision of support while clients wait. One option could be a facilitated, open, drop-in supportive group for clients, perhaps where there was also an opportunity to find out more about the type of therapy they were waiting to receive. This could also allay fears about participating in therapeutic groups in the future, which can be a concern for clients with PD diagnoses (e.g. Hodgetts, Wright & Gough, 2007).

Both therapists and clients agreed on the importance of quickly building an open and trusting therapeutic relationship. This requires the therapist to be warm, supportive and encouraging, whilst also taking time to discuss with clients how the therapy will be

conducted, how it is expected to work, and any potential difficulties that may arise. This would give clients the opportunity to ask questions, share their expectations, and make their own decision about whether or not the therapy offered is right for them, as offering choice is an important factor in reducing dropout rates (Oldham, Kellet, Miles & Sheeran, 2012).

Given the potential for difficult attachment experiences to be evoked in the therapeutic relationship for clients with PD, it seems useful to raise this possibility at the start of therapy, and to allow for open discussion about this when it occurs. This may be particularly relevant in treatments where the therapeutic relationship is hypothesised to be a key mechanism for change, such as in psychodynamic therapies. At this early stage, it may also be possible to conduct a thorough assessment of important relationships in clients' lives, which may help in building a collaborative and shared longitudinal formulation of their difficulties, within the context of their lived experiences.

This study also emphasises the importance of good communication and consistency throughout the professional and personal support network for each client. This ensures that the work done in therapy is supported outside of therapy, and that a safety net is in place to support clients should therapy be unsuccessful. In order for this to happen, referrers need to be fully aware of the nature of treatments they refer their clients to, and psychological therapies services have a responsibility to help disseminate this knowledge. In addition, where clients are willing, supportive family members or friends could be nominated to attend initial appointments; to be made aware of some of the aspects of therapy that may be most challenging, and how they can best support the client.

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

The findings could be used to develop a measure of therapeutic alliance more specifically for people with PD, focussing on the areas of importance highlighted in the model. Following a pilot study to develop the questionnaire and carry out a factor analysis, a study could be set up to determine its association with clients' decisions to carry on with or dropout of therapy, perhaps using a regression model to determine its ability to predict dropout as a dichotomous outcome variable.

Given the hypothesised importance of helping clients to make sense of therapy endings, it would also be beneficial to conduct a study exploring the effect of offering post-therapy follow-up appointments, to both completers and clients who drop out. In the immediate term, the effect of this intervention upon distress could be recorded, but there is also potential to explore how it impacts upon clients' insight about their therapy experience and their perceptions of feeling supported by services.

I think that it would also be useful to conduct a further study exploring the factors that may contribute to the quality of a therapy ending, independently of whether or not the client completed or dropped out of therapy. In this case, I would aim to theoretically-sample clients who had experienced either 'good' or 'bad' endings, and then explore in depth the circumstances that led to the ending of their therapy, and how this may have compared with other therapeutic or interpersonal endings in the past. If there appears to be two conceptually-different groups, it may then be possible to compare them using a content analysis, based on elements found by the current study's model to be important. Studies such as these would offer the opportunity to test and refine the model produced in the current study, and to further contribute to the emerging literature about dropout from PD interventions.

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MAJOR RESEARCH PROJECT

JON CHATFIELD BA Hons MSc

SECTION D: APPENDICES

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2013

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Appendix A: Section A Literature Search Methodology

The electronic databases CINAHL with Full Text (EBSCO), ASSIA Applied Social Sciences Index and Abstracts, PsycINFO, Web of Knowledge, ScienceDirect (all journals), PubMed Central, MEDLINE, Cochrane Library and JSTOR were searched between 18.06.11 and 22.04.13 using the following terms:

Personality disorder AND attrition OR attend*, OR retention, OR drop out, OR dropout, OR engagement, OR disengag*, OR withdraw*, OR terminat*, OR leav*, OR quit*

These terms were searched with no time limitation, which yielded 278 unique articles. Abstracts were then scanned to identify quantitative studies that aimed to explore dropout from any psychosocial treatment for PD clients, and included contextual service factors, client's interpersonal style, or therapeutic relationship predictors. Where this was unclear, full texts were reviewed to assess the relevance of studies to the present review. Unpublished dissertations, manuscripts and congress abstracts were excluded, as were articles not available in English. Studies carried out in forensic settings were excluded, to maintain the focus of the current review on health settings, and to avoid including compulsory treatments. Articles where PD was a feature, but not the main presenting problem were also excluded.

This process identified nine relevant quantitative articles. Google Scholar was also used with the search terms above, and abstracts were similarly scanned for the first 300 most relevant results. This process identified five further relevant quantitative articles. Two existing relevant reviews were identified, and the studies contained in these reviews were additionally sourced where they had not been identified from the original search. This identified two additional articles, giving 16 in total.

Once this search was completed, another search combining the following key terms was conducted:

Personality disorder AND qualitative OR grounded theory OR IPA OR experience*, narrative* OR discourse OR perspective* OR interview* OR focus group* OR account*

This search initially yielded 25 articles, and abstracts were scanned initially with the aim of identifying articles that involved either talking to clients or therapists about dropout from PD interventions, or qualitatively compared therapy experiences of completers and dropouts. Relevant articles were reviewed in full, and a further search was carried out via Google Scholar with the same search terms, but ultimately only three articles were identified.

Appendix B: Personality Diagnostic Questionnaire-4th Edition Plus (PDQ-4+)

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Appendix C: Therapist Participant Information

Name	Gender	Job title	Years working with clients with PD
Rob	M	Psychoanalytic Psychotherapist	8
Bernadette	F	Psychoanalytic Psychotherapist	10+
Norma	F	Psychoanalytic Psychotherapist	10+
Carl	M	Psychoanalytic Psychotherapist	10
Neil	M	CBT Therapist	5
Olivia	F	Clinical Psychologist*	10

* practising psychodynamic psychotherapy

Appendix D: Client Participant Data

Name	Gender	Age at discharge	Time since therapy end (months)	Number of sessions attended¹	Type of therapy²	Dropout?
Sarah	F	21	27	32	Individual	Y
Cathy	F	40	26	Individual = 3 Group not known	Individual + Group	N + Y ³
Lisa	F	32	12	4	Individual	Y
Sally	F	23	26	2	Individual	Y
Miranda	F	54	16	1	Individual	Y
Clive	M	36	38	12	Individual	N

¹According to service data

²All clients had received psychodynamic interventions

³Client completed pre-group individual sessions, and then dropped out of group

Appendix E: Pre Therapy Client Questionnaire

This has been removed from the electronic copy

Appendix F: Therapist Focus Group Schedule

Introduction

Introduce self, title and aims of the project, aims of today. Consent to record focus group. Inform of confidentiality and anonymity of responses.

Make clear that explicitly referring to people with diagnosis / clinical judgement of PD, unless specifically asked otherwise. Ask that any specific information that could identify an individual client is not shared.

Explanation that although focus is on psychoanalytic therapy for PD, other therapists invited to offer alternative perspectives and contrasting / varied experiences

“Any questions?”

(Start recording)

Conducting therapy with people with PD

Do you conduct therapy differently for people with PD compared to other clients? In what ways? Why? Has this changed over the years?

Beliefs about drop-out, and actions taken to prevent it

Why do people with PD drop out of therapy? Does the therapeutic relationship play a part? How? How about the clients' previous interpersonal experiences?

Do you ever make predictions about who might drop-out of therapy? What would an 'at risk of dropout' PD client look like? How about a 'likely completer'? What factors might you consider? Would you ever change your approach based on these factors?

Are there any warning signs for someone with PD dropping out of therapy? When these situations occur, do you do anything to try and prevent dropout? What works / doesn't work? Looking back, would you do anything differently with previous clients who dropped out?

Does the therapeutic model or approach impact upon the engagement and drop-out for people with PD? Where do each approach's strengths and limitations lie in this regard? Is there an 'ideal' cross-modality way to initially engage PD clients and build a relationship? What might that look like?

Is there anything else that you believe might be important, that we haven't yet discussed?

(End interview, stop recording)

Give thanks for participation; give opportunity to feedback on conduct of focus group; request contact details for those who wish to be kept informed about the study's findings; ask for consent to contact about potential further participation in study.

Appendix G: Original Client Interview Schedule

[NB – These represent a pool of potential questions that may be asked, but given the grounded theory methodology, specific questions and areas of enquiry will change depending on the emerging theory]

Briefing

- Reminders: confidentiality and anonymity; choice over which questions to answer; break(s) if needed
- Sign consent form (if not already done)
- “Any questions before we begin?”

If you think back to the time when you were just about to start psychotherapy at [REDACTED], what hopes and expectations for therapy did you have at that time?

- What were your first impressions of the therapy?
- Did these impressions change over time?

How was the relationship between you and your therapist?

- Did it remind you of any other relationships in your life?

What was your experience of other therapy clients while you were in therapy?
[Group clients only]

While you were in therapy, what do you think helped you to attend your sessions?

- Was there anything which made you want to avoid or skip sessions?

What were the circumstances that led to you leaving therapy?

- How did you feel about ending therapy?
- Did it remind you of other endings you have experienced in life?
- Did it remind you of the ending of any other relationships in your life?

How would you sum up your experience of therapy at [REDACTED]?

- What it was like?
- To what extent did it meet or not meet your expectations?
- To what extent do you sense it helped you or not?

If you were to have therapy again in the future, what would need to be different in order for you to be able to complete the treatment?

Is there anything else you would like to say about it that we have not covered but you feel might be relevant?

[Switch off recording]

[Debriefing]

The Research Project – A grounded theory approach to understand drop-out from psychotherapy for Personality Disorder

As part of a doctoral research project, I (Jon Chatfield, trainee clinical psychologist) will be carrying out interviews with clients to discuss their experiences of entering into, being in, and leaving therapy. I will be looking to select patients who may best assist the development of theories to better understand and treat clients diagnosed with a personality disorder. These clients will be chosen because their presentation or circumstances have been identified in the first two stages of the study as being a particular area for further study (for more information, see 'Procedure' below).

Clients who are selected will be contacted after they have stopped attending their treatment with the service, which could be either on completion or if they drop out, to be invited to an interview lasting approximately an hour (including briefing and debriefing), exploring their experiences of being in therapy in relation to early relationships and personality. I will expect to need to interview between 8 and 10 individuals in order to adequately address the research questions. I will only contact clients who have previously agreed that they can later be contacted. Further information about client participation is given below, followed by information about therapist participation I am seeking for a focus group.

Client Inclusion Criteria

This study will be utilising grounded theory methodology, an approach which aims to develop and refine theory as data collection and analysis are conducted alongside each other. As such, the inclusion criteria for this study are initially broad:

- Male or female client
- Diagnosed with or assessed as having one or more PD subtypes
- Accepted for psychodynamic psychotherapy (individual or group) provided by [REDACTED]

Client Exclusion Criteria

Any client that the service deems too high-risk to engage with a discussion of their experiences of therapy will be excluded from the initial pool of potential participants. We will be inviting you to identify any such clients at the start of the research, so that invitations to participate are not instigated.

Procedure

Stage 1 – Pre-therapy client questionnaires will be analysed to generate initial research hypotheses. This will include clients who failed to engage

initially or dropped out prematurely, as well as those completing their course of treatment.

Stage 2 – A focus group will be held to explore therapists' experiences of conducting therapy with people with PD. Although no confidential patient information will be discussed, this session will look to develop ideas and hypotheses about engagement to explore further in client interviews.

Stage 3 – Clients deemed most appropriate to test and refine these hypotheses will be selected to be contacted for interview. This process of selection, interview and analysis will then continue until the research questions have been addressed as fully as possible. Again, these clients may have failed to engage, dropped out or completed treatment.

The project will be supervised by Dr Sue Holttum, Senior Lecturer in Research at Salomons Campus, CCCU, and [REDACTED].

Ethics approval has been obtained from the National Research Ethics Service (NRES) ethics committee.

Therapist focus group

As mentioned above, stage 2 of the project proposes to invite therapists from [REDACTED] to a one-off focus group to discuss their experiences of treating people with personality disorder, and their beliefs about why some clients leave therapy prematurely while others do not.

It is intended that this focus group will be held at [REDACTED], will take around 60-90 minutes, and will be audio-recorded prior to being transcribed and anonymised for data analysis. Participation is entirely voluntary, and therapists are free to withdraw their consent at any time.

No confidential patient material should be shared during the focus group, so as to prevent individual cases being recognized.

Anonymous quotes from the focus group may be used in published reports of the findings of this research study.

In the event that it proves difficult to recruit previous clients to be interviewed for this study, there is also the possibility that a further therapist focus group may be conducted following the client interviews. Again, therapists' participation would be entirely voluntary, and giving consent to participate in the stage 2 focus group would not be taken as implied consent to participate in any later group.

Jon Chatfield
Trainee Clinical Psychologist

Appendix I: Therapist Consent Form

Research study: Understanding people's experiences of psychological therapy – relationships, attendance and withdrawal

As part of a doctoral research project, Jon Chatfield will be looking at pre-therapy questionnaire responses, as well as carrying out interviews with therapists and a number of clients to hear about their experiences of entering, being in, and leaving therapy (see information sheet for more details).

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Consent regarding accessing patients and their data

2. I agree that the researcher Jon Chatfield may use anonymous patients' responses from pre-therapy questionnaires to aid his research project.
3. I agree that he may approach previous patients of the service to invite them to take part in research interviews about their experiences of therapy. I have had the opportunity to exclude patients that I believe to be high-risk to re-engage

Consent to be take part in focus group

4. I understand that the therapist focus group(s) will take around 60-90 minutes, and agree to this being audio-recorded for research purposes.
5. I understand that my participation is entirely voluntary, and that I am free to withdraw at any time.
6. I understand that no confidential patient material should be shared during the focus group(s), so as to prevent individual cases being recognized.
7. I agree that anonymous quotes from the focus group(s) may be used in published reports of the findings of this research study.
8. I agree to take part in the above study.

Therapist Name (please print).....

Therapist Signature.....

Date.....

Appendix J: Client Invitation Letter

Research study: Understanding people's experiences of psychological therapy – relationships, attendance and withdrawal

Dear (Name),

We are writing to inform you of a research study which will be taking place between August 2012 and February 2013.

As part of a doctoral research project, Jon Chatfield will be looking at anonymous pre-therapy questionnaire responses of clients who have previously had therapy in the service. He will also be carrying out interviews with some clients to discuss their experiences of entering into, being in, and leaving therapy (see information sheet enclosed for more details).

Questionnaire responses will be made completely anonymous by the service prior to being made available to the researcher, to protect the identities of participants. It is hoped that this research will help therapists to improve the quality and effectiveness of their work for future clients.

If you are happy for your anonymous questionnaire responses to be used as part of this study, please let us know by completing and returning the slip below in the enclosed SAE within 4 weeks from the date of this letter.

If you are interested in potentially being invited to take part in an interview about your experience, in a location convenient to you, please provide us with some up to date details that Jon may contact you on to discuss this further. You do not have to inform us at [REDACTED] if you eventually do choose to participate.

Yours sincerely,

[REDACTED]

ENCL: Information about the research

Please return to: [REDACTED]

[REDACTED].

(Please delete as appropriate)

1. I **do** / **do not** give my consent for my anonymous questionnaire responses and therapy notes to be made available to Jon Chatfield for the research study described
2. I **do** / **do not** give my consent to be contacted again in the future regarding my further involvement in this research study (please provide details below)

Telephone:

Name:

Mobile:

Address:

Appendix K: Client Research Information

Research study: Understanding people's experiences of psychological therapy – relationships, attendance and withdrawal

Hello, my name is Jon Chatfield, and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in my doctorate research study taking place between July 2012 and February 2013. Before you decide it is important that you understand why the research is being done and what it would involve for you.

What is the purpose of this study?

This study is looking to better understand how people's past and current relationships may affect their attendance for psychological therapy. It is hoped that building upon current understanding in this area will help to improve people's experience of psychotherapy, and lead to better outcomes for clients. The project is being carried out with the support and consent of the [REDACTED].

Why have I been invited?

Potential participants have been selected from people who have attended psychotherapy provided by the [REDACTED]. As the study goes on, some people will be invited for interview. Others will be involved only through the answers they gave on questionnaires before starting therapy. This information will be anonymous – you will not be identified to me unless invited for interview at the second stage, and then only if you decide to take part in the interview. I will also be speaking to therapists about their experience of conducting therapy, but no personal client information or individual cases will be discussed.

Do I have to take part?

Taking part in the research is entirely voluntary and if you do choose to take part, you will be free to withdraw at any time without giving any reason. This would not affect the standard of care you currently receive now, or in the future.

What will happen to me if I take part?

In the first stage of the study, I will look at the questionnaires you completed at the start of therapy, to develop initial research questions and ideas. This data will be made completely anonymous prior to being made available to me.

Once you stop attending psychotherapy (if you haven't already done so), you may be invited for an interview lasting approximately 45-60 minutes, exploring your experiences of being in therapy and previous/current relationships. This could be after you finish your course of psychotherapy, or if for any reason you stop attending before it is completed. This interview will either be conducted at the [REDACTED], the [REDACTED], or via telephone, depending on your preference.

Your participation in the interviews would be confidential, and you do not have to inform anyone else that you are taking part. The only situation in which confidentiality cannot be

guaranteed is if I felt that you or someone else was at risk of serious harm. In this case I have a duty to share this information with relevant agencies.

These interviews will be audio-recorded, and then written up with any personal details removed. The recording will then be permanently deleted. If you find the interview process upsetting in any way, one-off follow-up sessions will be available from [REDACTED].

I will expect to need to interview between 8 and 10 people in order to adequately address the research questions, and any travel costs you incur will be reimbursed up to the value of £10.

All data collected will be completely anonymous, and will be held in accordance with trust data protection policies. No identifiable information will be included in any report or presentation of the findings.

Who is involved in the project?

- Jon Chatfield, Trainee Clinical Psychologist, Lead Researcher
- Dr Sue Holttum, Senior Lecturer in Research, Lead Supervisor
- [REDACTED], Psychotherapist, Secondary Supervisor

Jon and Sue are both based in the Department of Applied Psychology at Canterbury Christ Church University, and [REDACTED] is based in the [REDACTED], part of [REDACTED].

Canterbury Christ Church University is responsible for the organising and funding of the research.

What will happen to the results of the research study?

The intention will be for the study to be written up as a final report, and submitted to journals for publication. The results may also be presented as part of a conference presentation. These results may include quotes from individual participants, but any information presented will be made anonymous to prevent possible identification of individual participants.

Further information and contact details

If you would like to find out more about the study or have questions you would like answered, you can leave me a message on a 24-hour voicemail line at 01892 507673. Please say that the message is for Jon Chatfield and leave a contact number so that I can get back to you. Alternatively, I can be contacted via email on jon.chatfield@nhs.net.

You can find out more about being a participant in research via the Mental Health Research Network, by visiting their website at <http://www.mhrn.info/>

If for any reason you are unhappy with my conduct of the research, complaints can be made to the Research Director, Paul Camic, at the Department of Applied Psychology, Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent, TN3 0TG.

Appendix L: Client Interview Information

Doctorate research study: Understanding people's experiences of psychological therapy – relationships, attendance and withdrawal

Thank you for agreeing to be interviewed for the above study. What follows is some additional information to prepare you for the interview process.

How long will the interview last?

The interview will last 45-60 minutes, and you may ask to stop or take a break at any time. It may either be conducted at the [REDACTED], the [REDACTED], or via telephone, depending on your preference.

Is the interview likely to cover sensitive topics?

Some of the things covered in the interview could be of a sensitive nature, but you have the right to refuse any question you do not wish to answer, and the interview has been designed to minimise any risk of distress. I, (the interviewer), have experience of both conducting research interviews and working therapeutically. You may end the interview at any time.

If you feel distressed some time after having completed the interview, you are encouraged to speak to your GP or allocated mental health practitioner. The following services also offer counselling support phone lines:

The Samaritans	0845 790 9090	opening hours: 24 hours everyday
Saneline	0845 767 8000	opening hours: 6pm-11pm everyday

Should you wish to further discuss any distress experienced, one-off follow-up sessions are available from [REDACTED].

What will happen with the audio recording?

The recorded file will be transcribed (i.e. written up word for word), and made anonymous in the process, by removing any information that could identify you. The recording will be permanently erased following this process.

Are my responses confidential?

Your responses will remain completely confidential, and will only be presented or discussed elsewhere once they are made completely anonymous. The only exception to this would be if I felt that you or someone else was at risk of serious harm. In this case, I have a duty to share this information.

How can I find out about the results of the study?

If you wish to be informed about the results of the study, please provide me with an email or post address to be sent a summary of the findings once the study is completed.

Further information and contact details

If for any reason you are unhappy with the interview, complaints can be made to the Research Director, Paul Camic, at the Department of Applied Psychology, Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent, TN3 0TG.

Jon Chatfield, Trainee Clinical Psychologist

Appendix M: Interview Consent Form

Research study: Understanding people's experiences of psychological therapy – relationships, attendance and withdrawal

As part of a PhD research project, Jon Chatfield will be looking at pre-therapy questionnaire responses, as well as carrying out interviews with a number of clients to hear about their experiences of entering, being in, and leaving therapy (see information sheet for more details).

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Consent for use of questionnaire responses

2. I agree that the researcher Jon Chatfield may use my responses from previously completed questionnaires to aid his research project, and understand that my responses will be completely anonymous for this purpose.

Consent to be interviewed

3. I agree that once I stop attending my therapy sessions (whether or not I have completed therapy), I may be invited for interview by the researcher, Jon Chatfield.
4. If invited, I understand that my interview will take around 45-60 minutes, and agree to this being audio-recorded for research purposes.
5. I understand that my participation is entirely voluntary, and that I am free to withdraw at any time. I understand that my medical care or legal rights would not be affected if I choose to withdraw.
6. I understand that my responses are completely confidential, except if a situation arose in which the researcher had a duty to disclose (see information sheet).
7. I agree that anonymous quotes from my interview and questionnaire responses may be used in published reports of the findings of this research study.
8. I agree to take part in the above study.

Participant Name (please print).....

Participant Signature.....

Date.....

Appendix N: Questionnaire Review Example Memos

Below replicates some notes taken following a review of the 20 pre-therapy service questionnaires (one of the 21 consenting clients had not completed a questionnaire) on the 3rd December 2012. The questionnaires were scanned to look for themes emerging as possible differences between the dropout and completer groups, and a basic content analysis was conducted to formalise the analysis.

Observations:

Number	Dropout	Previous Therapy	Employment History	Self harm in last year
	Y	6m CBT aged [REDACTED]	baker [REDACTED]	Yes, more than once
	Y	counselling 'years ago', current psych MD	unemployed	No
	Y	2-3m counselling [REDACTED]	PT hospital technician assistant	Yes, once
	Y	In last year - 'wasn't ready for it'	one day per week farmhand	Yes, more than once
	Y	2 weeks counselling at GP, 'years ago'	unemployed since 1990s	Yes, more than once
	Y	counselling / outpatient Tx in past (no other details)	Yes (no other details)	Yes, more than once
	Y	none	warehouse [REDACTED], currently unemployed	No
	Y	6m counselling	not since 1999	No
	Y	counselling on two occasions	insurance administrator and supermarket worker	No
	Y	counselling in past, inpatient and outpatient treatment with ECT	data input assistant until retirement	Yes, once
	N	8 weeks CBT, 2 anger, [REDACTED], family therapy	PT volunteer in mental health	No
	N	6m psychody Tx, counselling 'most of adult life'	sacked public sector manager	No
	N	inpatient and outpatient in last year	off sick from local authority service manager position	Yes, more than once
	N	8 sessions counselling, 6 sessions with CP	PT personnel consultant	No ("I don't know how to answer this")
	N	8 sessions plus addit over years at [REDACTED]	finance manager	Yes, once
	N	CBT, just under a year long	worked at vets until [REDACTED] traffic accident	Yes, more than once
	N	counselling 18m, CBT 6m, CRT (cog remediation?)	volunteer, prev worked at [REDACTED] centre	No
	N	psychotherapy and CBT for 2 years, few weeks counselling	telecommunications network assessor	No
	N	3m counselling	work for driving company	Yes, more than once
	N	CBT in [REDACTED]	care centre agent, currently home business	Yes, more than once

- Completers wrote, on average, much more than dropouts – insight? Commitment? Invested?
- Completers appeared, on average, to have held more professional jobs, and had more therapy experience, but there seems to be little difference in recent self harm
- Completers seemed to have more specific goals for therapy, and more positive / hopeful expectations – hopelessness style in dropouts?

Questions raised:

- How important are people's expectations for therapy? What role does hope play? What about insight? Pre-therapy feelings towards service?
- Did starting therapy seem similar to other commitments, like work?
- How did previous experiences of therapy affect pre-therapy expectations?
- Did people think it was the 'right time' for therapy? Why / why not?

Appendix O: Example of Full Initial Coded Transcript

This has been removed from the electronic copy

Appendix P: Examples of theoretical memos

Information about mechanisms

Created On: 10/2/2013 7:30:18 PM

Created By: JC

Clients seemed to have little information about what to expect from therapy, or even what the goals were for therapy. Why would they keep coming back? Therapists could be seen to be withholding this information from clients, which prevents a collaborative approach to therapy. The process is also then experienced as persecutory, with clients not knowing what is expected of them.

Sally sees CBT as being better, offering something in addition (despite not having any personal experience of it), because 'counselling' seems like 'just talking', which would only be useful for people who haven't got anyone to talk to. Cathy similarly regretted not having CBT, seeing it as an expensive luxury that her GP could not afford. Sarah seemed not to know what was expected of her, but also explicitly unwilling to do it (whatever it was!)

Therapy as repeating relationships – re-traumatising?

Created On: 10/2/2013 3:22:55 PM

Created By: JC

Something personal about leaving for most participants that re-traumatizes them – reminds them of difficult relationships, repeating the same pattern – fails to offer an alternative narrative – same old story

Clive - father and feeling he would get a grilling, be criticised. Felt as if father and therapist were working together (despite him being deceased)

A sense that this kind of therapy encourages repeating patterns through providing a blank canvas, but if this can't be tolerated and dropout results, all it does is strengthen this attachment style. Should therapy for people with PD not make a special effort to ensure that this is not strongly evoked early on? Clients can blame themselves (Cathy, Sarah), which is insightful, but does suggest that therapists are not insightful about this, or not willing to acknowledge it. This perhaps might be experienced differently for completers, but not for Clive.

Interestingly, for those who don't seem to be re-experiencing anything when dropping out, they are the same people who said that the therapeutic relationship didn't remind them of anyone in their lives. This could perhaps be down to a lack of insight about their therapeutic experiences, or it could be that for these people interpersonal distress was less of an issue. However, whilst we might argue that this could be the case for Sally, it is less likely to be the case for Lisa?

Dropping out – good vs. bad

Created On: 10/2/2013 4:24:37 PM

Created By: JC

There's some suggestion that dropping out can be good - taking a little bit (knowledge, insight) at a time. However, how will cuts impact upon the ability to offer repeat relationships? If we are to model a family, can the child not withdraw and then return?

Dropping out without support built in may lead to feelings of abandonment, self harm/suicide, and worsening relationships to mental health services - repeating and strengthening early patterns?

Cathy: "I didn't really have any support at all. From anybody. I think that's one of my main problems with it."

Dropping out allowed Cathy to feel empowered to be autonomous, to recognise inner strength; and it was a similar experience for Lisa, who seemed to take control of her own recovery.

Attending therapy was a means to an end for Clive, and although he became unwell following therapy, he ultimately was able to access a diagnosis and medication, which he found beneficial.

Responsibility, cooperation and confrontation

Created On: 2/4/2013 6:02:50 PM

Created By: JC

For Sarah, she seems to place the blame on herself for her unwillingness to cooperate with the therapy. She even describes the therapist as nice, despite the long silences, and despite being asked questions about things that are already in her file - ambivalence? Perhaps not wanting to show displeasure for others?

She describes the relationships with her therapist and CPN as nice, lovely, but nonetheless not helpful, as either difficult things are avoided (and nothing gets resolved), or she is challenged, forced, coerced to attend and talk about things she doesn't want to, which makes her leave.

Her insistence that she doesn't want to be there in the first place also seems to put up a barrier - is it important for clients to both want therapy, and be willing to explore difficult, upsetting issues that they wouldn't normally discuss with friends, let alone a stranger? How do we resolve this?

Allocating blame for failure

Created On: 2/4/2013 7:26:34 PM

Created By: JC

There seems to be attempts made to make meaning for the failure, to try and work out why therapy didn't help, which varies a lot between individuals.

Clive seems to suggest the therapist was unhelpful, but that if he was medicated he may have been able to use it better.

Both Cathy and Sarah blame themselves, for their lack of ability and uncooperative nature respectively - they both describe good relationships with their therapists. For Cathy, this results in regret and guilt, while Sarah is more defiant.

Lisa is clear that the therapist was unhelpful, citing previous good counselling relationships as evidence for this. This leads her to blame the therapist rather than herself, or therapy more generally

These ideas were later developed in more detail:

Where does the blame for failure lie?

17th June 2013

Why is it that Lisa blames the therapist personally? Perhaps it's her previous experience of 'good' counselling? She really seems to think that the therapist shouldn't have been in her job, wasn't doing what she was supposed to do, and got it wrong.

Clive also seems to blame the therapist, but nonetheless completed and wanted more. He is also willing to accept that the difficulties in the relationship may have been due to a 'personality clash', and describes it feeling as though she were acting on instruction from his deceased father. Although he found her difficult to be with, he was able to open the 'can of worms' which was subsequently not contained due to the lack of sessions. He ultimately is unimpressed with the idea of therapy and would advise a friend that they'd be better off 'having a couple of sherbets' up the pub with him. Nonetheless, he also wonders if he would be able to use therapy better now that he was calmer on medication.

Cathy blames herself for being unable to persevere with group therapy, and said that the only thing that needed to change would be 'me'. Perhaps this is unsurprising given that her agoraphobia played a big part in her attendance and ultimate dropout. She is surprised by the lack of advice and interaction by the therapist, but found them 'nice' and was glad to be given free rein to talk about her problems. She feels that the kind of therapy, rather than the therapist themselves was the problem, and that money at the service level prevented her getting the CBT she needed.

Sarah is on guard from her therapist, and dislikes the 'tricks' and attempts to 'probe' into her, but ultimately forgives the therapist ("bless her") and describes her as 'nice', and acting under the instruction from someone else.

Appendix Q: Excerpts from Research Diary

21st January 2011 – Research fair

Having seen the list of potential projects, I'm definitely interested in exploring the gender differences in psychotherapy outcome in a service specialising in personality disorder. It seems that there's already a large amount of collected data at the service, which would be ideal for a quantitative study to explore some potential predictors of therapy outcomes. I've made contact with the external supervisor, but it seems like there's some competition from other trainees who are also interested in the area. It's a really tough process and can feel a bit like a beauty contest at times! Hopefully I'll be able to work something out, otherwise I'm a bit worried I'll end up stuck with something I'm not as personally interested in.

29th March 2011 – Researching the literature

Having met with David and Sue initially, I really wanted to explore David's interest in why men appear to be at a greater risk of dropping out from therapy, but it doesn't look from the research as if there's evidence of this across mental health diagnoses, or more specifically in PD research. There is evidence that they're less likely to seek help, but I'm not sure how that could be explored at the service. However, I have found research that suggests that clinicians may be more comfortable working with women with BPD rather than men, and that it may be more likely that men with BPD presentations are more likely to get diagnosed with ASPD and dealt with by the criminal justice system rather than the health service. I would like to develop some of these ideas further if possible, but it might mean that the sample is too small to be able to access a large enough amount of quantitative data.

2nd August 2011 – Refining the research questions

Having discussed the idea further with Sue and David, it's clear that Sue feels that a qualitative study would be more appropriate with this sample, and that the small numbers of males in the service make any exploration of the impact of gender upon dropout difficult. There's also some concern about the consistency with which the service has been collecting CORE and PDQ data over the years, which could mean that any quantitative study at this time might lack the power to find anything significant. Nonetheless, it was a good meeting between us all and everybody seemed to agree that using therapists' notes alongside client interviews would offer an excellent opportunity to qualitatively explore the circumstances surrounding dropout from therapy from both the client and therapist perspective. I've also begun to immerse myself in the literature more recently which has proven very helpful in developing identifying the gaps that could possibly be explored.

4th November 2011 – First Salomons review panel

I had my meeting with the review panel today and it was really tough! I must admit that it felt really difficult being grilled on so many aspects of the proposal, but it was really helpful in the sense that it had got me to focus on aspects of the project that need shoring up and a stronger rationale. Admittedly, at times it felt that they didn't really 'get' what the project was aiming to get at, but that also seems useful in that means I need to be able to more clearly communicate what I am trying to achieve. It has certainly made me reflect on why I specifically have chosen to use grounded theory – wanting to develop a novel theory based on multiple perspectives – and also why I have chosen to include all PD diagnoses rather than BPD in particular – aiming to represent an ecologically-valid 'real life' typical sample presenting to services, and having doubts about the robustness of the diagnosis both in general, and its subtypes.

27th January 2012 – Preparing for ethics application

Having met with both Sue and David in the last week, it's been a good opportunity to continue to flesh out the ethics application, which feels like it's getting there. It seems like we should be able to avoid me having to see any identifiable participant data prior to them having consented to this, which I think will be very important. I'm really glad to hear that an Assistant Psychologist will be starting at the service in March, and that she'll be able to assist me with the project. I think it will make a big difference having someone there on a daily basis, and she'll be able to help with recruitment, and access and anonymise data prior to it being made available to me. David also made some good suggestions to help with recruitment, such as approaching potential participants indirectly via contacts in the local Acute and Recovery teams, which are linked to the service. It also seems like we have good contingency plans in place in case any participants become distressed, with the service being able to offer single, follow-up appointments to anyone who feels they need it, with the potential for them to be re-referred to the service if necessary.

5th April 2012 – First ethics panel

It was very difficult at the ethics panel today, and they clearly had reservations both about using the opt-in method of participation and with the use of therapist's process notes. It's frustrating that this can be given the go-ahead by the lead therapist in the service and Salomons, but that a professional on the panel who does not conduct therapy themselves had the biggest reservations about it! Nonetheless, it's still helpful in the sense that I want to avoid any potential risk of causing distress to participants. However, it does raise a couple of questions: how will I be able to obtain enough data using an opt-in only method, and how do I make up for the lack of therapy notes?

14th June 2012 – Meeting with service user consultant

I had a really helpful meeting with [REDACTED] from SAGE today, who's given me some great advice about how to conduct the research, and in particular how to word the information and consent forms, and how to conduct the interview process in a way that will be non-invasive and reassuring for participants. I think it's really great that she is available to help to pilot the materials for the project, and to have someone be able to comment on the service user experience in research of this kind.

5th December 2012 – Focus group

I was really glad with how the focus group went today, it was a very interesting experience and I think I've collected a lot of high quality data. I was really struck by how thoughtful and knowledgeable the therapists were about how to work with clients with PD. There definitely seems to be a softening of the traditional psychodynamic approach in working with PD, but that it can still be very challenging to contain clients' distress at times. The therapists also highlighted the importance of working as part of a consistent and coherent team, and that clients need to be supported outside of the therapy in order to be able to tolerate it. I did wonder how much of this was being shared with the clients though, and whether or not clients' experiences will match the intentions of the therapists. I'll definitely now think about asking clients about the importance of external supports though, and how their expectations and previous experiences of therapy may have impacted upon the current therapy and their decision whether or not to continue.

11th February 2013 – Following first three interviews

I've been struck by several things in particular having conducted the first few interviews. Firstly, I was a little disappointed when I realised that (Clive) had actually completed his therapy, although I had intended to interview at least one completer as part of the study in keeping with GT and having a heterogeneous sample. However, it was really interesting how he had a negative experience nonetheless – he found the therapeutic frame persecutory, and it reminded him of his father, and he also felt powerless when it came to leave therapy – very interesting. (Cathy) offered another interesting perspective and a good contribution to the heterogeneous sample, having completed her individual sessions and dropped out of a psychodynamic group. She clearly felt a lot of guilt about leaving, but was able to feel empowered to do something for herself in future. Nonetheless, her symptoms re-emerged and she was also reminded of difficult interpersonal experiences from her past. (Sarah) was very interesting in that she clearly felt coerced into attending therapy, and as such unsurprisingly felt completely unwilling to use it. She also felt let down in a way that reminded her of her own mother, which was difficult for her to re-experience. They all seem to have felt out of control in one way or another in the process, and that they used different methods to try and reassert their control (with varying success).

16th June 2013 – Emerging model

I can't believe how long it's taking to develop and refine the model, I've used pages and pages to try and develop my understanding of what's happening in the data, and trying to represent it pictorially. It's really helped me to consider where the strongest relationships are between the various factors that have emerged in the data analysis to date. The memo writing is proving really useful to help me to crystallise exactly what I mean in each category, and how those interviewed have expressed those points.

15th July 2013 – Write-up

The write feels all-consuming at the moment, but I really think it's starting to take shape. The model is looking good, it seems to make sense, and going through using quotes to demonstrate the various categories is proving really helpful in helping me to refine my thinking and make adjustments where necessary. I've also gone back to the original questionnaires to check to see if the model fits with some of the things that clients were expressing prior to therapy.

Appendix R: Audit Trail of Model

Corresponding quote	Example initial / focussed code	Subcategory	Category	Context
<p>“So, erm, one of the reasons that I sought therapy was because obviously, I wanted to get better, and, I knew it was, I had a very unhealthy lifestyle” (Client - Cathy)</p> <p>“Someone suddenly being able to see further ahead in their lives and realising, ‘This has got to change’” (Therapist - Norma)</p>	<p>Wanting therapy to help lead a healthier lifestyle</p> <p>Recognising need to change life</p>	Recognising need	Seeking therapy	Pre-therapy
<p>“To be honest with you I was hoping that the therapy would say: ‘Do this, do that, and you’ll be cured’” (Client - Cathy)</p> <p>“Just for it to help, really, to help me to cope with my problems and, um, dunno, fix me.” (Client - Sally)</p>	<p>Wanting directions to a cure</p> <p>Wanting to cope better, be ‘fixed’</p>	Hope		
<p>“She just said she thinks I need counselling, some sort of counselling so I said ok and went on the waiting list.” (Client - Lisa)</p>	<p>Taking GP’s advice about counselling</p>	External demands		
<p>“I’m thinking of a few people that I saw here, one notably really, who, erm, would drop out of everything but would then be extremely demanding to have a service[...],and also the very passively aggressive people, who come along, erm, but they don’t really ever engage. They’re going to stick in, but they’re not going to be able to, or willing to do any work on themselves (Therapist - Norma)</p>	<p>Those who attend but do not fully engage</p>	Motivation		
<p>“I didn’t really have any [hopes or expectations], if I was honest, I was kind of pushed into it by my CPN [...] people telling me I had to go. That’s why I went.” (Client - Sarah)</p>	<p>Lack of expectations as felt coerced to attend</p>	Compliance		
<p>“The waiting is the worst part [...] Because it’s, you go to your GP because you need that help, and then they’ll turn round and say to you “Right, we’ll refer you”, but then it could be six months. But then you think, in that six months space of time, how much worse is somebody gonna be?” (Client - Sally)</p> <p>“You’re gonna be put on a list, but we don’t know how long it’s gonna be. Minimum six months, could be more.’ And the thing is, when you get referred for counselling, you want it now. If you’re feeling that desperate...” (Client - Miranda)</p>	<p>Experiencing waiting list as withholding of timely support</p> <p>Uncertainty about when therapy will be available, imminent need</p>	Waiting list		
<p>“I didn’t even know what it was about, I thought it was the textbook, laying on the couch and let’s talk about thoughts and feelings” (Client - Sarah)</p>	<p>Relying on popular understandings of therapy</p>	Knowledge of therapy	Expectations of therapy	
<p>“I’ve been through some counselling psychotherapy before, nothing’s really helped in the past so I wasn’t really expecting, erm, a great deal out of it.” (Clive)</p>	<p>Low expectations due to past therapy experiences</p>	Experiences of therapy		
<p>“It just wasn’t what I was expecting but obviously I had no experience of knowing what to expect and I wasn’t given any. There was no leaflet sent out...” (Client - Miranda)</p>	<p>Having limited expectations due to lack of information</p>	Information vacuum		

<p>"You've [interviewer] said more in a couple of seconds! Do you know what I mean? I just felt, you know, totally overpaid and underworked." (Client - Lisa)</p>	<p>Therapist did not make an effort to talk</p>	<p>Effort</p>	<p>Perception of therapist</p>	<p>Therapy</p>
<p>"I said, 'You know, one of the things I hate is the first 10 minutes,' and she sort of said [...] 'It gives you time to adjust to your surroundings.' And I, I thought, 'Well, it's just a room' you know, with pictures on the wall" (Client - Clive)</p> <p>"Explain to them exactly what you're aiming to do. I think that promotes a sort of engagement at that level, which hopefully will help hold you when you get into the more emotional work." (Therapist - Rob)</p>	<p>Therapist gave a confusing explanation</p> <p>Explaining the approach to engage and prepare clients</p>	<p>Openness</p>		
<p>"I found it very, sort of, cold. There was no real warmth [...] It wasn't a warm environment." (Client - Clive)</p> <p>"They tend to come with a fairly sort of, an expectation of something quite hostile, quite paranoid position they might be coming from unless you demonstrate that you're friendly" (Therapist - Rob)</p>	<p>Environment lacked emotional warmth</p> <p>Needing to show 'friendliness' to overcome negative expectations</p>	<p>Empathy</p>		
<p>"So, I was following her, and she never said a word to me all the way to her room, no chit chat, nothing. She didn't address me by name once during the consultation and it was almost as if she was just sitting there" (Client - Miranda)</p> <p>"I think I was probably more active with people who already come with that diagnosis because the whole process of engagement is so difficult." (Therapist - Bernadette)</p>	<p>Therapist was impersonal, like I was not there</p> <p>Being more active to engage</p>	<p>Interest</p>		
<p>"I mean, because they're supposed to make you feel comfortable and things so that you do get things off your chest and I felt really uncomfortable." (Client - Lisa)</p> <p>"It was just not comfortable. Not comfortable at all." (Client - Miranda)</p> <p>"It's about, you know, our relationship rather than also what they may bring or their history, and not to make any comments around, what has happened to them before, unless they bring it in. But it's just to keep it very slowly going in the now, and connected to us in a way." (Therapist - Olivia)</p>	<p>Therapist failed to make me comfortable</p> <p>Therapist made me uncomfortable</p> <p>Focussing on the relationship</p>	<p>Comfort</p>	<p>Therapy processes</p>	
<p>"I didn't like it, I didn't like someone trying to probe into me, 'cause I didn't want to be there anyway and have someone trying to probe in and talk about stuff that I didn't want to talk about." (Client - Sarah)</p>	<p>Avoiding therapist's attempts to open me up</p>	<p>Willingness to explore</p>		
<p>"Like I said there was a couple of times when, erm, I suppose the penny dropped, erm . So, you know, I can't sit here and say it's all bad, you know?" (Client - Clive)</p>	<p>Achieving some understanding through therapy</p>	<p>Insight</p>		
<p>"In the end I thought 'No, this [group therapy] isn't working'. So I stopped going." (Client - Cathy)</p>	<p>Leaving ineffective therapy</p>	<p>Perceived effectiveness</p>		
<p>"And I went out feeling very distressed" (Client - Miranda)</p>	<p>Leaving session distressed</p>	<p>Distress</p>		

“Paradoxically, symptoms might go up if you are getting anywhere meaningful.” (Therapist - Norma)	Making meaning, progress as potentially distressing			
“Sometimes, and this is one thing from mentalization I have found helpful, is, erm, apologising to people helps (lots of agreement from others), which kind of takes the wind out of people’s sails. It’s a very, even if you haven’t done anything wrong, it’s a quite helpful connection.” (Therapist - Carl)	Apologizing to reduce emotional intensity	Attempts to contain		
“Because I was on a waiting list for about six months and I thought I’ve at least got to give it a really good go, you know?” (Client - Lisa)	Value through effort already expended	Perception of value	Considering continuation	
“I probably felt like I could have done going more but it was just more the fact that you was only allocated so many sessions and your time’s up.” (Client - Clive)	Lacking control over therapy ending	Perceived control		
“I felt I had to go to get to the, the next stage. I felt very much like if I didn’t turn up they’d be like, “Well we’re offering you the help, and you’re turning it down,” (Client - Clive)	Attending to progress through the system	External influences		
“Erm, d’you know I actually felt guilty. I did feel guilty. ‘Cos I know that they go through years and years of training, and I was lucky to be offered it in the first place. And I felt immense guilt really, about not going back [to group therapy].” (Client - Cathy)	Feeling guilty about leaving therapy	Guilt		Beliefs about therapy failure
"I should have stuck with it really, I really should. I think I only went about four times. And I do wish I’d stuck with it." (Client - Cathy)	Regret at not carrying on	Regret		
"It wasn't that it wasn't helping me; it would have helped if I'd have cooperated but I just didn't" (Client - Sarah)	Blaming self for therapy failure	Self blame		
“I think it made me realise that all the problems were in my head. And that it’s me that’s got to deal with it at the end of the day. There’s no-one out there that can wave a magic wand and make me better. It’s got to come from me.” (Client - Cathy)	Feeling responsible for own problems, relying less on others	Autonomy		
“I think it just made me more, I dunno, to me, that was like, well, ‘Right, I’ve tried that, that’s not helping, they’re not going to help me. What can I do for myself?’” (Client - Sally)	Taking responsibility in absence of help from others			
"Apart from not having to go there every week, no. I felt a bit let down, by it." (Client - Clive)	Feeling let down by therapy	Disappointed		
Interviewer: "But do you feel you learnt anything about... having been through that experience, that you learnt about yourself, or about therapy or your life or..." P: "No, if I'm honest." (Client - Sarah)	Absence of therapy learning experience			
“I was pissed off, to be honest with you, I thought I’d get some sort of switching off, something out of it...” (Client - Lisa)	Anger at lack of relief offered	Anger		
"Because the woman, the counsellor I had, because she said, “Oh, I don't think you're ready for it.” I mean, when are you supposed to be ready for counselling? What a thing to say. You know? I can't understand that at all. I mean, if you were ready for counselling you wouldn't need counselling, would you? That's what it says to me, that." (Client - Lisa)	Confusion, disagreement with therapist about who should have therapy	Confusion		

<p>"Well, in some ways I was quite pleased it had finished, because I hated, sort of, going there." (Client - Clive)</p> <p>"I was kind of glad if that makes sense, 'cause I was... Like I said I didn't wanna be there." (Client - Sarah)</p>	<p>Relief at avoidance of distressing therapy</p> <p>Gladness at no longer being required to attend</p>		Relief
<p>"If anything it brought a lot of issues to the top and then it was like we were finished and I was like, well, I've got all this emotion or can of worms, you know, and I was just being put to the side." (Clive)</p>	<p>Therapy as exposing vulnerabilities, which ending fails to contain</p>	Exposed	Level of distress
<p>"I just went back to being a hermit, basically." (Client - Cathy)</p> <p>"I'd go in, be quite positive, and 'I'm really gonna give this a go' and then I'd come out and my mum was like 'your attitude's really changed' within the sort of hour or so than I was in there. She was like 'you seem worse every time you go there'." (Client - Sally)</p>	<p>Leaving therapy causing resurgence in problems, complete retreat</p> <p>Therapy made me feel worse, took away my optimism</p>	Worsening symptoms	
<p>"So now I've got my daughter so I have to get up and I have to get on with the day and I have to put those bad feelings away to bring her up and make sure she's happy." (Client - Sarah)</p>	<p>Sacrificing self for child, burying bad feelings</p>	Avoidance	Ongoing recovery
<p>"I'm not putting anything really helpful down to the therapy. Apart from the fact, like I say, because it didn't work that's then forced me to change things really." (Client - Sally)</p>	<p>Failure of therapy forced me to make changes</p>	Making positive changes	
<p>"So once I'd sort of, found out what it was, and I could sort of read up on, that helped me. Because I could think 'Yeah that. I do do that'" (Client - Clive)</p>	<p>Better recognising and understanding own problems through research</p>	Understanding condition	
<p>I used to let things get me down and that would make things worse. I would sit and I'd be thinking and that's when I used to get really bad. So I think in forcing myself to not be like that, so I'd sit there and think 'Well I'm not doing that,' and then I'd think, 'No, I don't wanna do that so I'm gonna make myself go and do that', and I think after doing that a few times it sort of built my confidence up to try different things and try new things (Client - Sally)</p>	<p>Adopting a more hopeful attitude, focussing on positive coping</p>	Shifting attitudes	
<p>"I was sort of given was a list of telephone numbers. If I actually needed to talk to someone there and then, you know. But apart from that it was very much, I felt very much hung out to dry." (Client - Clive)</p> <p>"I didn't really have any support at all. From anybody. I think that's one of my main problems with it [leaving group therapy]." (Client - Cathy)</p> <p>"You could, I think I still can now, they always say to you 'If you get any problems, there's these numbers and you can come back and speak to us any time that you need to'. And I think that's quite helpful." (Client - Sally)</p>	<p>Feeling abandoned at end of therapy, little support</p> <p>Lack of support when leaving in distress, isolating</p> <p>Comfort from just having knowledge that support exists if needed</p>	Support	

<p>“Well, um, it left me feeling very, very negative that, for getting so far, that somebody else in the medical field could make me feel so little, um, and obviously, if it hadn't been for Dr X [psychiatrist] pulling me up...” (Client - Miranda)</p>	<p>Importance of support from psychiatrist following dropout</p>			
<p>“There was one particular occasion when, when my children were very small, and I was in an abusive relationship, and they went to live with their dad. And that impacted me greatly [...] But erm, yeah, that caused a lot of guilt as well [as leaving therapy]. (Client - Cathy)</p> <p>“Interviewer: And did that, sort of, that ending, did it remind you of other things that have happened in your life before?</p> <p>Sarah: Yeah, I suppose it did a bit, actually, yeah.</p> <p>I: Is there anything in particular?</p> <p>S: Um, my relationship with my so-called mother and things, just like, comments that she'd be there for me and stuff and she really didn't. She's too hooked up on drugs and alcohol so... yeah, I suppose it did, really, yeah.” (Client - Sarah)</p>	<p>Leaving therapy reminiscent of guilt when left children</p> <p>Therapy ending reminiscent of mother breaking promises to care</p>		<p>Repeating previous experiences</p>	
<p>“There's a kind of, a weight of people pushing stuff into you all the time.” (Therapist - Carl)</p> <p>“I was thinking about how hard it can be, to be really working with somebody and be the bad one, you know, be the useless one” (Therapist - Norma)</p>	<p>Feeling emotional burden from clients</p> <p>Being made to feel useless</p>	<p>Therapist distress</p>	<p>Managing complexity</p>	<p>Therapist</p>
<p>Some quite borderline people use a process of benign splitting I think where they actually identify different people they're working with to hold different parts of their personality. So sometimes you're the good person and the CPN is the bad, erm, person, and someone else is the useless person, and sometimes it switches around. (Therapist - Carl)</p>	<p>Splitting the team</p>	<p>Team distress</p>		
<p>I think the actual approach is less important than that sense of working together. (Therapist - Rob)</p> <p>“I wonder whether sometimes, that the way that you sort of position yourself, you know, working something separate or something part of the team can have positive or negative kind of impacts, particularly with that client group where, perhaps, the team's kind of, that hated thing, and you're just another one of those lot.” (Therapist - Neil)</p>	<p>Importance of consistent team working over modality</p> <p>Taking advantage of splitting to build relationships with clients</p>	<p>Team working</p>		
<p>“It also demands that the professionals erm, have good supervision really because [...] you might need to be able to be helped to think about what's going on between you” (Therapist - Norma)</p> <p>“Part of what's important I think is people who've had therapy of their own is sort of, hugely helpful in supporting, and developing that resilience and sense of working together.” (Therapist - Rob)</p>	<p>Making sense through supervision</p> <p>Personal therapy helping team consultation and working</p>	<p>Support</p>		
<p>“It's the big worry about cuts, and it's the big worry about training, and lack of supervision that really you are talking about people who've never really had an opportunity to be contained in a way that's safe and allows them to develop” (Therapist - Norma)</p>	<p>Impact of cuts on ability of team to contain</p>	<p>Resources</p>		

<p>“One of the features of the kind of patients we’re talking about is they often come with a massive diagnostic stuff trailing behind them, in a way, the unclear picture is part of the picture. And sometimes you don’t know until you try, you don’t know until you start, predictability of the work in some of the patients we have is actually very poor.” (Therapist - Carl)</p>	<p>Struggling to predict dropout in complex clients</p>	<p>Difficulty predicting dropout</p>	<p>Attempts to predict dropout</p>
<p>“I think BPD are much more difficult to hold [...] the chances of them suddenly dropping out, very near the beginning are much higher in BPD, that’s my experience.” (Therapist - Rob)</p> <p>“I do think there’s something about people sometimes, enthusiastically wanting to tell their story, erm, and then it reaching a point where telling the story just isn’t enough, you know. It’s quite clear that this is not enough.” (Therapist - Norma)</p> <p>"I think if they’d dropped out lots of times in the past, then this would be a clear warning sign, that would be important to take up with them." (Therapist - Rob)</p> <p>"I often think of a warning sign as people who are quite placatory, and tell you what a good job you’re doing, and how wonderful it is." (Therapist - Carl)</p>	<p>Identifying risk of early dropout in BPD</p> <p>Risk of superficial story-telling</p> <p>History of dropout presenting risk</p> <p>Placatory clients as warning sign</p>	<p>Identified risk factors</p>	

Appendix S: Respondent Validation

Thank you for agreeing to answer these additional questions. Please bear in mind that the final model represents the experiences of a large number of participants, and as such will not match each *individual's unique experience perfectly*. However, it is hoped that the model should incorporate the majority of experiences across the entire model.

1. Do you feel that the final model incorporates your own experiences of being in, and leaving therapy? How does it do this successfully / unsuccessfully?

2. Is there anything important related to leaving therapy that you feel is not represented in the model?

3. Is there anything in the model that seems as if it does not make good sense at all, or may even be completely wrong?

Please return your answers in the stamp-addressed envelope to the following address:

██████████, Canterbury Christ Church University, Runcie Court, David Salomons Estate,
Broomhill Road, Tunbridge Wells, TN3 0TF

Or via email to: ██████████

Appendix T: NHS Ethics Approval Letter

This has been removed from the electronic copy

Appendix U: Summary Report for Ethics Panel, R&D and Therapists

Note: A summary report was also sent to clients who had asked to be informed about the results of the study, with references to PD removed for ethical reasons

Summary Report: July 2013

Project

Understanding premature termination from psychoanalytic psychotherapy for Personality Disorder (PD) – a grounded theory (GT) approach

Rationale

Whilst existing research has aimed to identify static and historical sociodemographic and clinical predictors of dropout from psychotherapy for PD, recent reviews of the literature have suggested that an exploration of factors relating to the therapeutic relationship and subjective client experiences may prove more useful. The current research was carried out in order to attempt to generate a theory to understand why some clients with PD drop out from outpatient psychotherapy, based on client and therapist experiences.

Methodology

A total of 21 clients with PD diagnoses who had previously attended psychotherapy at the [REDACTED] hypotheses, which were then explored further by carrying out a focus group with six current and previous therapists at the service, and then six individual interviews were carried out with previous clients. Data were collected and analysed using a Grounded Theory approach.

Findings

The final model is displayed below:

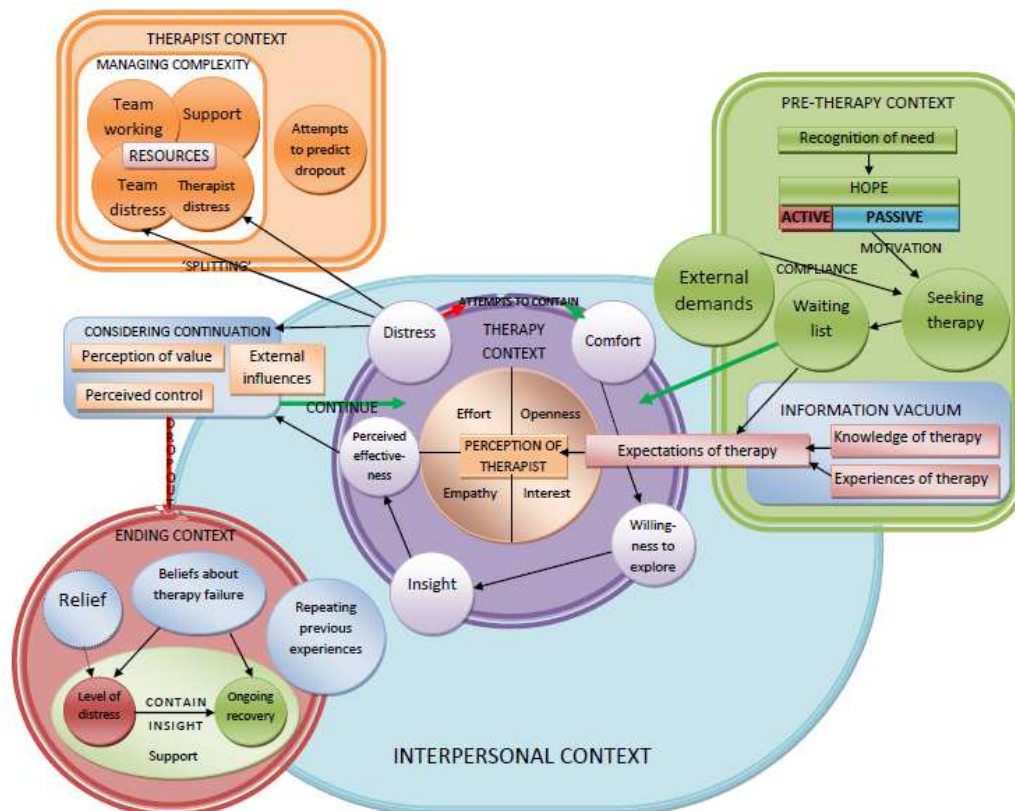


Figure 1. Final GT model of client and therapist experiences of therapy for PD

There were several different stages or 'contexts' to clients' and therapists' experiences of therapy, which will be discussed briefly below:

Pre-therapy context

Clients often came to therapy when they *recognised a need* to seek help, and this could facilitate motivation and hope for change. However, some clients felt coerced or pressured to seek therapy by other professionals, friends or family members.

Clients experienced being on a *waiting list* as particularly unhelpful, as it meant that their current needs were not being met.

Expectations for therapy were often limited based on not being given enough *information* about the therapy, or having little *experience of therapy*. This meant clients often had to fill in the gaps about how they thought they may be treated based on their previous relationships, which therapists identified could result in them expecting something unhelpful or critical.

Therapy context

Clients identified that they wanted therapists to be *interested, open, empathic* and *effortful* in therapy sessions, which was echoed in the intentions of therapists working with this client group. However, clients often did not feel that these needs were met, which could lead them to feel uncared for, criticised, confused and upset. Clients particularly struggled with therapeutic silences and inaction on the part of therapists.

Clients frequently expressed feelings of *distress* in therapy sessions, and therapists reported making *attempts to contain* this at a manageable level. Clients identified feelings of *comfort* in the relationship as important to be *willing to explore* difficult issues. This could help them to develop *insight* into their difficulties, which was a factor in determining the *effectiveness* of the therapy.

Considering continuation

When considering whether or not to return to their next therapy session, clients took into account the *perceived value* of the therapy, based on its perceived effectiveness and the distress it caused them. They also considered how much *control* they felt they had over their decision, and may also have been influenced by *external factors*, such as the opinions of others, or other competing responsibilities or life events.

Ending context

Some clients expressed *relief* initially at ending therapy, but depending on their *beliefs about the ending*, including where to allocate blame, a wide variety of emotions could be experienced such as guilt, anger, disappointment and regret, which could cause *distress*. However, with time, some clients were able to develop feelings of autonomy and empowerment, and were able to engage with an *ongoing recovery* process. The level of social and professional *support* seemed very important in this regard. Some clients reported that therapy endings *repeated previous experiences* of endings, which could feel rejecting or disempowering.

Therapist Context

Therapists often found dropout from therapy *difficult to predict*, and were concerned about the impact of financial and clinical pressures on the *resources* available to them, which may impact on their ability to *manage complex and challenging PD clients* in the future. These resources were needed to contain both *team* and individual *therapist distress*, through obtaining *support* from colleagues through supervision and consultation, and through consistent *team working*, which if done effectively could be analogous to a family around the client.

However, clients related their therapy experiences as being very separate from any other care they received, and several felt isolated from services when their therapy came to an end.

Implications for practice

The emerging model suggested the importance of preparing clients with PD with information about suggested therapies, including a rationale, and how the therapy is supposed to work. Given the likelihood for difficult past relationships to be evoked in the relationship with the therapist, it was suggested that this was discussed and prepared for early in therapy.

Therapists were also encouraged to adapt a warmer, more active and empathic therapeutic stance with clients with PD than may otherwise normally be used, which appeared to be in line with how they reported now currently working with this client group.

The importance of ensuring that clients had good support outside of the therapy was also emphasised, with a need to work closely with referrers about the treatment provided, and to update care co-ordinators about clients' progress. Family members and carers could also be encouraged to be more engaged in the therapy process, considering the importance of these relationships in helping clients to tolerate often difficult therapy sessions.

The model also indicated that clients need to be given support to make sense of their therapy ending, particularly for those who drop out, as they are unlikely to have been able to address this in therapy. This may require follow-up appointments with either another professional in the team, or by a professional with an ongoing relationship with the client, such as a GP or psychiatrist. This would also allow clients' ongoing care to be planned and managed, to avoid gaps in service provision.

Finally, the pressures under which clinical services are currently operated were highlighted, with a need to maintain sufficient support and supervision for teams and individual clinicians managing complex and challenging clients with PD diagnoses.

Appendix V: Journal Submission Guidelines

Instructions for Authors

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form.

Submissions

All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at <http://mc.manuscriptcentral.com/cjmh>. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords

Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association, and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18, 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management*. London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G. Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London: Lawrence Erlbaum.

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of

the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Accepted papers

If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

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