Factors Related to Drop-outs by Borderline Patients

Treatment Contract and Therapeutic Alliance

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High patient drop-out rates have traditionally interfered with both treatment and study of patients with borderline personality disorder (BPD). The authors tested hypotheses that an adequate treatment contract, a positive therapeutic alliance, and the severity of illness would all correlate with continuation of treatment versus drop-out in a BPD cohort receiving psychodynamic psychotherapy. Therapists’ contributions to the contract and to the alliance correlated with the length of treatment. Patients’ impulsivity was negatively related to length of treatment. This study supports the view that the therapist’s technique plays a role in engaging the borderline patient to remain in treatment.


A high patient drop-out rate creates difficulties in any psychotherapy study. From the standpoint of design and statistical analysis, drop-outs interfere with the randomization procedure. The drop-out rate also raises questions about the generalizability of the treatment results obtained from those who remain in therapy. From a clinical standpoint, the patients who drop out are not profiting from the treatment, and the question remains as to how the treatment itself can be improved in order to reach these patients.

Patients with borderline personality disorder (BPD) are characterized by a particularly high drop-out rate. This is not surprising when one reviews the criteria for this Axis II disorder. The borderline patient is unstable in interpersonal relations, a phenomenon likely to be repeated with the therapist. She is angry and is labile in mood. She is prone to

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act on feelings rather than to explore them in the therapy, and she is likely to discharge them through impulsive action, whether it be in the form of sexual acting out, disturbed eating behavior, substance abuse, self-mutilating behavior, or suicidal actions.

[We use the feminine pronoun here in referring to the patient because the majority of borderline patients are women, and our research has been limited to female borderline patients.]

In addressing the drop-out problem in the borderline population, we chose to focus on the treatment contract, the therapeutic alliance, and the severity of the patient's borderline characteristics. Our interest in the treatment contract stems from our clinical experience that psychodynamic psychotherapy requires the early establishment of a frame that can contain the affective storms of the patient during treatment. Our attention to the therapeutic alliance is based on 1) its status as one of the few therapy variables that has been shown to correlate with outcome and 2) our awareness of the problems involved in conceptualizing and fostering therapeutic alliance in borderline patients, who often experience strong negative transference in therapy. We adopted Greenson's definition of therapeutic alliance: the ability to maintain contact with the reality of the therapeutic situation and to risk regression into fantasy.

With borderline patients, regression may be rapid; significant negative transference is likely early in the therapy, and there is the risk that regression will be accompanied by acting out. An effective alliance within the treatment frame established by the contract would encourage and contain the free expression of negative transference, which might otherwise emerge as acting out that could include ending the treatment. With the treatment frame in place, no matter how stormy the transference (and the countertransference), the patient and therapist would continue to communicate verbally within the structure of the therapy that had been established in the contract.

Skodol et al. compared the drop-out rates of borderline, other personality-disordered or neurotic, and schizophrenic patients treated in an outpatient clinic. The drop-out rate was highest for BPD patients. Sixty-seven percent of this diagnostic group dropped out within 3 months, whereas 58% of the other personality-disordered or neurotic group dropped out, and only 14% of the schizophrenic group terminated within the same time period.

Waldinger and Gunderson surveyed 11 clinicians who provided psychoanalytically oriented therapy to patients who fit criteria for either DSM-III BPD or borderline personality organization. Forty-six percent of these patients dropped out within the first 6 months of treatment.

Gunderson et al. reported on a prospective study of psychotherapy discontinuation among 60 BPD patients whose treatment began in a hospital setting. Patients were discharged from the hospital to continue psychotherapy as outpatients when clinically indicated. Of the entire sample, 43% had dropped out of psychotherapy within 6 months. Of those patients who entered outpatient treatment at some point during the 6 months, 66% had dropped out by the 6-month point.

Goldberg et al. carried out a controlled study of response to low-dose neuroleptic in a group of 50 outpatients with either BPD or schizotypal personality disorder. In their sample 42% of the patients on placebo and 54% of those on medication dropped out before the end of the 3-month study.

In contrast to the general trend of drop-out rates in studies of borderline patients, one must consider two recent studies. First, Linehan et al. reported on a study of parasuicidal borderline patients receiving cognitive-behavioral therapy in which 16% of 22 patients dropped out during the first year of treatment. Two of these patients dropped out during the initial 4 weeks of treatment (the induction phase), and the other two
dropped out later on in the treatment. One hypothesis concerning Linehan's lower drop-out rate is that it is related to a more overly supportive form of treatment that offers the patient more treatment contacts per week.

Stevenson and Meares studied 48 borderline patients receiving a psychotherapy based on the concepts of self psychology. They report a 16% drop-out rate at the end of the 1-year study, with most of the patients who dropped out doing so during the first 3 months of treatment. However, their reported drop-out rate does not include 3 patients who were dropped from the study because of failure to keep three consecutive evaluation appointments or 11 patients who completed the evaluation and either did not agree to the terms of treatment or verbally accepted treatment and then dropped out. Including these patients leads to a drop-out rate of 35%.

In summary, some studies find that the drop-out rate for patients with BPD is twice the rate for those with neurotic and other personality disorders and four times the rate in patients with schizophrenia, with only 33% of the borderline patients remaining in treatment at the 3-month point. Other studies show that by the 6-month point, only 34% to 57% of BPD outpatients remain in treatment. Linehan's relatively small sample shows an encouraging 84% of patients continuing in treatment. Expanded studies of her treatment and its long-term impact should prove interesting. Stevenson and Meares also report a low drop-out rate, although their selection procedure screened out some of the subjects at highest risk for drop-out.

In studying the drop-out problem, our point of view is not to consider the BPD patient as an isolated individual who either remains in or prematurely ends treatment. Therapy is a process involving two participants, and the specific patient-therapist relationship is crucial. We studied aspects of both patient and therapist contributions to the interaction to determine 1) what characteristics of the early patient-therapist interaction correlate with the patient staying in treatment and 2) how the treatment approach can be modified to support treatment continuation. Our clinical understanding is that ultimately it is the interaction between a particular borderline patient, with her unique combination of pathology and assets, and a particular therapist and therapeutic technique at a specific point in the patient's treatment history that determines continuation or drop-out. We articulated three specific hypotheses for study:

1. An adequate treatment contract will correlate with continuation versus premature termination in psychodynamic psychotherapy with borderline patients.
2. A good therapeutic alliance will correlate with continuation versus premature termination in psychodynamic psychotherapy with borderline patients.
3. The severity of certain aspects of borderline pathology (one or more of the key criteria) is related to the likelihood of premature termination.

**Methods**

The data come from our study of the psychodynamic psychotherapy of borderline patients. We will give a brief summary of this study, which has been described in detail elsewhere.

**Subjects**

The subjects were 36 women between the ages of 18 and 45 with a DSM-III-R diagnosis of BPD as established by the Structured Clinical Interview for DSM-III-R (SCID). The sample was limited to female subjects to increase homogeneity and also because of the consistently higher representation of females in the BPD population. Subjects were recruited from the inpatient and outpatient units of the New York Hospital-Westchester Division and the community. Exclusion cri-
teria included ongoing substance abuse, an active major depressive illness at the time of evaluation for the study, bipolar illness, schizophrenia, schizoaffective illness, organic brain syndrome, and antisocial personality disorder. All patients gave informed consent before beginning in the study. Patients referred from inpatient units began treatment upon discharge.

The Treatment and the Therapists

The treatment was psychodynamic psychotherapy of borderline patients as presented in the project's manual. A total of 31 therapists treated the 36 patients in the study. Twenty-four of the therapists were trainees (psychiatry residents or psychology interns) with at least 1 year of psychotherapy experience before beginning the study. Seven of the therapists were members of the faculty. All therapists were trained by use of the project manual. The therapists in training completed a 12-session training seminar and received weekly supervision from the senior therapists.

Treatment consisted of two 45-minute psychotherapy sessions per week with no preset termination date. (Patients were asked to consider remaining in the study for 2 years.) The therapy sessions were taped and transcribed. Ratings of the treatment contract and therapeutic alliance were based on review of the tapes and transcripts.

We chose the contract-setting process and the therapeutic alliance as variables that were likely to correlate with whether a patient remains in therapy or drops out. The potential relevance of the treatment contract setting to the drop-out problem emerged from a review of the cases in the pilot phase of our psychotherapy research project. The cases where therapists did not adhere closely to the therapy manual with regard to the contract-setting phase tended to end in drop-out. We developed a rating scale (described below) for the contract-setting process in order to study our first hypothesis.

It seemed logical to investigate the correlation of the alliance to drop-out in this population. It also seemed that the therapeutic alliance could be understood as emerging from the treatment contract: the alliance is the putting into action of the model of therapy described in the contract. From a different perspective, the contract could be viewed as a sort of exoskeleton that serves to contain stormy transference and countertransference while the alliance is being formed.

In addition to the contract and the alliance, we chose to look at certain patient characteristics. Because the diagnosis of BPD encompasses a wide range of pathology, we looked at the level of severity of the individual symptoms that make up the BPD picture.

Instruments

Contract Rating Scale (CRS): The CRS was devised by Selzer, Yeomans, and Clarkin in order to rate reliably the contract-setting process in the dynamic treatment of BPD patients as defined by our therapy manual. From a research as well as a clinical point of view, the contract-setting period in dynamic treatment provides an excellent opportunity to gather data on the patient, the therapist, and the specific interaction between the two individuals. The contract setting is a time in the therapy when the therapist introduces standardized stimuli (the conditions of treatment, such as the description of therapist and patient responsibilities during the treatment) into the interaction, and the patient is given an opportunity to respond to these stimuli. At this point one can rate the patient’s response to the therapist's behavior as one would rate the response to a standardized test. To obtain further data on the dynamics of the therapeutic process, after rating the patient’s response we rated the therapist’s handling of the response; this latter rating provides a measure of the adequacy and skill with which the therapist pursues difficulties and resistance raised by the patient.
The unit of rating is the whole contract-setting phase of therapy (which usually consists of two or more sessions) as captured in transcribed sessions. Raters scored 12 items, each using a 5-point Likert scale. Each scale is anchored so that scores of 1 and 2 mean the process was clinically unsatisfactory, 3 means it was adequate, and 4 and 5 mean it was more thorough and complete. Raters were trained by use of a manual describing the individual anchor points (M. A. Selzer, J. C. Clarkin, and F. E. Yeomans: *The Contract Rating Scale* [1989], available on request). These 12 items are organized into four summary scales: 1) the therapist’s presentation of the conditions of treatment (statement of the treatment contract), 2) the patient’s response to these conditions, 3) the therapist’s handling of the patient’s response or resistance, and 4) the degree of consensus reached at between patient and therapist.

For data analysis, the therapist’s presentation of the contract and handling of the patient’s response are combined to give a single therapist score. The Therapist score, Patient score, and Consensus score combine to provide the Total Contract score for each case. Interrater reliability for these subscales of the CRS (intraclass correlation coefficient) was 0.74 for ratings of the Therapist score, 0.87 for ratings of the Patient score, and 0.92 with regard to the Consensus score.

**CALPAS-R:** Given the complexity of the concept of therapeutic alliance in the treatment of borderline patients as discussed above, we chose the CALPAS-R as the most appropriate alliance rating instrument (C. R. Marmar and L. Gaston: Manual of California Psychotherapy Alliance Scales [CALPAS], unpublished, 1989). Although there is good hypothetical understanding of the alliance with borderline patients, no instrument has been designed specifically for this population. The CALPAS is the best fit because its four dimensions address negative as well as positive responses from the patient. The “R” (external rater) version of the CALPAS involves a trained rater who uses an audiotape of a therapy session to rate 30 items on a 7-point scale. These items are then organized into the following four dimensions: 1) Patient Working Capacity (both positive contribution and negative contribution), 2) Patient Commitment, 3) Working Strategy Consensus, and 4) Therapist Understanding and Involvement (TUI). Our rater was trained by one of the authors of the CALPAS and then rated the contract-setting sessions.

**Severity of Illness Scale:** To explore our third hypothesis, we devised a 6-point Likert scale to measure the severity of each of the eight BPD criteria in Axis II. Each scale is anchored so that scores of 1 and 2 are subthreshold for the criterion, a score of 3 is the criterion as stated in DSM-III-R, and scores of 4 to 6 are more severe. Interrater agreement, evaluated by use of intraclass correlation coefficients, ranged from 0.99 to 0.89. Using these dimensional scores of the BPD criteria, we factor analyzed the 8 criteria with a large number of BPD patients (n = 76). Three factors emerged: 1) an Identity/Interpersonal factor composed of the criteria of identity diffusion, emptiness/boredom, fear of abandonment, and unstable relations criteria; 2) an Affective factor composed of the criteria of labile moods, anger, and suicidal and self-destructive behavior; and 3) an Impulsive Behavior factor composed of the impulsivity criterion alone. At the point of each subject’s entry into the study, a faculty psychologist rated her for severity of BPD criteria; these ratings were used to construct factor scores as well as an overall severity rating consisting of the sum of the eight criterion scores.

**RESULTS**

Drop-out Rate

To date, we have evaluated and begun outpatient treatment with 36 female BPD patients. Six patients (17%) ended treatment...
before or during the treatment contract-setting phase. By 3 months of treatment, 5 additional patients had dropped out, yielding a cumulative 31% drop-out rate at that time. By 6 months of treatment, 2 more patients had ended treatment prematurely, yielding a drop-out rate of 36% at that point.

Contract Rating and CALPAS

We examined the relationship of the CRS ratings to the CALPAS ratings and the relationship of each to treatment drop-out/remainer status. We transcribed sessions from the first 20 patients in the study for whom we had data for contract and alliance ratings. Two patients who dropped out of treatment prior to the contract-setting process were not included because of lack of data. Our 20 subjects, therefore, come from the first 22 patients enrolled in the study. Our initial pilot work with these instruments suggested that a sample size of 20 would be sufficient to detect relationships between the treatment contract, the alliance, and staying in treatment. Ten of these first 20 subjects ended treatment as drop-outs, and the other 10 continued to termination. There were no significant correlations between the two instruments, but two correlations approached significance. Using the Pearson correlation, the negative Patient Working Capacity score on the CALPAS and the Patient Contribution score on the CRS showed a correlation of -0.39, \( P = 0.088, n = 20 \). (All statistical tests were two-tailed.) The correlation between the CALPAS Patient Commitment score and the Patient Contribution score on the CRS was 0.42 (\( P = 0.069 \)). In terms of content, these associations are quite plausible.

To explore the relation between therapeutic alliance, treatment contract, and the drop-out phenomenon, we chose to study the relation between the two treatment variables and the length of time a patient stayed in therapy rather than the dichotomous drop-out/remainer status of the patient. The reason for this choice is that looking only at the drop-out/remainer status results in a loss of data because a patient who dropped out after the 5th therapy session would be considered equal to a patient who dropped out after the 80th session. Clearly, though, the latter patient would have had a different experience of treatment than the former and would have had more chance to benefit to some degree from the treatment. The number of sessions a patient stayed in treatment ranged from 5 to 455 in our sample. These correlations are summarized in Table 1.

Two correlations between the CRS data and the length of treatment were significant. The correlation between the therapist’s contribution to the contract and the number of sessions was 0.64 (\( P = 0.002 \)). The correlation between the Total Contract score and the number of sessions was 0.55 (\( P = 0.013 \)). The correlation between Patient Contribution to the contract and number of sessions was not significant (\( r = 0.04, P = 0.86 \)); nor was the

### TABLE 1. Correlations of scores with length of treatment of borderline patients

<table>
<thead>
<tr>
<th>Instrument/Item</th>
<th>( r )</th>
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<tbody>
<tr>
<td>Contract Rating Scale</td>
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<tr>
<td>Therapist contribution to contract</td>
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</tr>
<tr>
<td>Total contract score</td>
<td>0.55*</td>
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<tr>
<td>Patient contribution to contract</td>
<td>0.04</td>
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<td>Consensus score</td>
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<tr>
<td>CALPAS</td>
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<tr>
<td>Therapist understanding and involvement</td>
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<td>Patient working capacity—negative</td>
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<tr>
<td>Patient working capacity—positive</td>
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<td>Patient commitment</td>
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<tr>
<td>Working strategy consensus</td>
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<tr>
<td>Severity of Illness Scale</td>
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<tr>
<td>Impulsivity factor</td>
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<tr>
<td>Identity/interpersonal factor</td>
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<tr>
<td>Affective factor</td>
<td>0.19</td>
</tr>
<tr>
<td>Total severity of illness</td>
<td>0.11</td>
</tr>
</tbody>
</table>

\* \( P < 0.05 \).

\** \( P < 0.01 \).

\( \text{Note: } n = 20 \text{ for all except impulsivity, where } n = 18 \). CALPAS = California Psychotherapy Alliance Scales.
correlation between the Contract Consensus score and the number of sessions ($r = 0.37$, $P = 0.11$).

We found a significant correlation between the CALPAS Therapist Understanding and Involvement subscale scores and the number of sessions a patient stayed in treatment ($r = 0.48$, $P = 0.032$). The other subscales of the CALPAS did not show significant correlations with the number of sessions (see Table 1).

Given these correlations, we carried out a regression analysis to further explore the relationship between the Therapist Contract score, the CALPAS TUI, and length of treatment. Length of treatment was entered as the dependent variable, with Therapist Contract score and TUI on the CALPAS entered simultaneously as predictors. The two predictors accounted for a significant proportion of the variance in length of treatment (adjusted $R^2 = 0.47$, $P < 0.002$). Inspection of the beta weights for the predictors showed that the Therapist Contract score made a significant independent contribution to length of treatment, above and beyond the TUI ($\beta = 0.56$, $P < 0.005$). The beta for TUI approached significance ($\beta = 0.34$, $P < 0.063$).

**Discussion**

The drop-out problem is understandable with borderline patients, whose pathology would logically lead to difficulties in collaboration, flight from exploratory work, and defenses against change. In order to further understand the drop-out process and treatment factors that may influence it, we examined the contract-setting process, the therapeutic alliance, and the severity of patient characteristics in the dynamic treatment of BPD patients as described in our treatment manual. We formulated a rating scale for the contract-setting process in order to see if our therapists set the contract as taught. We used a rating scale of therapeutic alliance to explore the role of that related variable in the drop-out process.

Our 31% drop-out rate at 3 months compares favorably with the 67% rate reported by Skodol et al. in their outpatient study and the 48% rate reported by Goldberg et al. in their outpatient medication study. Our 36% dropout rate at 6 months is lower than Waldinger and Gunderson's 46% of outpatients in psychoanalytically oriented therapy and Gunderson and co-workers' 43% of an inpatient and outpatient sample.

Linehan et al. and Stevenson and Meares both report a 16% drop-out rate at 1 year. These studies merit further consideration. Stevenson and Meares excluded subjects we would have counted as drop-outs (e.g., those who did not accept the conditions of treatment after the evaluation period). Applying our criteria to their sample, the drop-out rate would have been 35%, with most drop-outs occurring during the first 3 months of treatment. Our similar experience...
that most of the drop-outs left treatment during the first 3 months suggests that this is a critical period for forming a treatment alliance and should be studied in more detail.

A factor in the results of Linehan et al. may be the holding environment provided by weekly 2½-hour group therapy sessions. In our study we have not to date distinguished patients who might benefit from a supportive psychodynamic therapy versus an expressive dynamic therapy. Nor have we included in our treatment, which focuses on fostering independence through internal character change, the assistance of a social worker or case manager whose help may be indicated for some patients to structure their lives and deal with external stresses.

Comparing the correlations between therapeutic alliance and length of treatment with those between contract-setting scores and length of treatment, we begin to see convergent data that the therapist’s technique and skills have a role in determining whether or not the borderline patient remains in this therapy. Our regression analysis including both the Therapist Contract score and CALPAS TUI as predictors of length of treatment suggests that the therapist’s skill in discussing the treatment contract is an important variable, independent of the therapist’s score on the alliance instrument, in determining how long the patient will remain in treatment. Nevertheless, because regression analysis on a small sample is fraught with hazards, the present results can only be considered suggestive. Future work will focus on providing improved teaching and immediate feedback to therapists about their setting of the treatment contract. This might alter our drop-out rate and the length of time our patients remain in treatment.

The patient’s level of impulsivity was the only patient variable we measured that showed a correlation with the length of treatment. This negative correlation is not surprising: dropping out of therapy is a frequent manifestation of the impulsivity that is characteristic of many borderline patients. The interesting finding of a negative correlation between the patient’s level of impulsivity and the Therapist’s Contract score fits with our clinical impression that therapists tend to work less skillfully when faced with the threat of impulsive acting out. This correlation is one of the reasons we emphasize the need for a contract-based structure in the therapy to contain the patient’s impulsivity and allow the therapist to maintain the ability to think clearly and work effectively without becoming caught up in the onslaught of the patient’s pathology.

Our data, although tentative because of the small N, suggest a direction that is helpful in our manualization of a treatment. It appears that the therapist’s technique and skills play a significant role in engaging the borderline patient in treatment and beginning a therapeutic alliance. One could argue that the correlations of Therapist Contract score and the CALPAS TUI with the length of treatment are reflections of an overall association between the general skill of the therapist and length of treatment and that this factor is more important than the contract or the alliance. We plan to study this hypothesis in future work by applying to our data an instrument measuring a broad range of therapeutic skills.

The next stage of our work will be to explicate the specific interventions of the therapist who achieves a contract-based alliance with the BPD patient and to explore other therapist variables, such as level experience. What does the therapist with a high contract score and CALPAS-R TUI rating actually do? How does he or she identify and work with the inevitable resistance encountered?

In summary, the borderline patient, although yearning for contact, resists the treatment in numerous ways, starting with the contract setting. Whether in silence, through reaction to various requirements of the therapy, or by controlling and/or attacking the treatment, the patient is likely to alternate between overly dependent pleas and hostile
attack and devaluation. The therapist's use of the contract-setting phase to both delineate a structure and assess the dynamics of the patient's response to that structure plays a critical role in keeping the psychodynamic work on track throughout the treatment. Future research will provide data on this therapeutic function of the treatment contract and its relation to the development of the therapeutic alliance.

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References