

ONTOGENY OF THE THERAPEUTIC ALLIANCE IN BORDERLINE PATIENTS

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The development of the therapeutic alliance is explored in a prospective study of 33 borderline personality disorder patients. Assessments of the alliance were made by both the patients and their therapists using the Penn Helping Alliance Questionnaire at six weeks, six months, and then annually for up to five years.

The major findings were: (1) The alliance was rated highly by both patients and therapists throughout treatment; (2) the alliance showed steady and significant improvement over time (and no significant deterioration at any point); (3) patients and therapists corresponded closely in their assessments; (4) therapists rated the alliance higher than did patients at three and four years; (5) therapist ratings of the alliance at six weeks was predictive of subsequent dropping out; but (6) early alliance scores were not strongly related to subsequent level of change. These results frame issues for future research in this area.

Prior research has established that patients with borderline personality disorder (BPD) frequently drop out of or are noncompliant with their treatments (Skodol, Buckley, & Charles, 1993; Waldinger & Gunderson, 1984; Gunderson et al., 1989; Yeomans et al., 1994; Stevenson & Meares, 1992). Such studies underscore the clinical problem of forming a treatment alliance with these patients. Indeed, the severity of the problems treaters encounter with these patients was the major incentive for defining the borderline disorder and for its inclusion in our diagnostic system. Current changes in psychiatric health care underscore the

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need to know more about what can realistically be expected in getting borderline patients to form an alliance with their proposed treatments.

A considerable body of research on the therapeutic alliance has shown that the failure of a patient and therapist to form an alliance is strongly associated with noncompliance (Eisenthal, Emery, Lazare, & Udin, 1979; Docherty & Fiester, 1985), premature termination (Fiester & Rudestam, 1975; Saltzman et al., 1976; Tracy, 1977; Najavits & Strupp, 1994), and poor outcome (Gomes-Schwartz, 1978; Morgan et al., 1982; O'Malley, Suh, & Strupp, 1983; Horowitz, Marmar, Weiss, & Marziali, 1984; Marziali, 1984; Marmar, Horowitz, Weiss, & Marziali, 1986; Horvath, Greenberg, & Pinsof, 1986; Alexander & Luborsky, 1986; Frank & Gunderson, 1990). Though these findings have been documented with many diagnostic types, few studies have examined the alliance in patients with BPD. Clarkin, Hurt, and Crilly (1987) found that the presence of a comorbid dramatic cluster personality disorder (i.e., borderline, antisocial, narcissistic, or histrionic) adversely affected the development of a therapeutic alliance for patients with affective, anxiety, and other Axis I disorders. The Menninger Treatment Intervention Project demonstrated an overall improvement in the alliance as assessed by independent raters from audiotaped transcripts for one BPD patient over the course of a long-term psychoanalytic therapy, but with considerable fluctuations from session-to-session (Gabbard et al., 1988). A microanalysis of individual single session recordings of 39 borderline patients indicated multiple shifts in the level of collaboration even within sessions (Allen, Gabbard, Newsom, & Coyne, 1990). The more recent macroanalysis on three long-term therapies shows that the level of alliance can fluctuate even after therapies are well advanced (Horwitz et al., 1996).

The present study is the first prospective assessment of the long-term course of the therapeutic alliance in a sample of borderline patients. In this study, we identify the natural course of the alliance, the ways in which therapist and patients agree and disagree in their ratings; patterns of change in subcomponents of the alliance; and whether early ratings of the alliance can be predictive of whether patients drop out of treatment or of the overall quality of their outcomes (most favorable change). Previous research on this sample has documented changes in their self-destructive behavior (Sabo, Gunderson, Najavits, Chauncey, & Kisiel, 1995), and other symptoms (Najavits & Gunderson, 1995). Because of limitations in the study design and data set, our goal is to utilize this unique data set to identify issues that will deserve more definitive future work.

METHOD

SUBJECTS

The sample was comprised of consenting female patients who were culled from McLean Hospital's admission notes or referred by their clinicians with a presumptive diagnosis of BPD. Only patients who were to begin a new psychotherapy were recruited. Selection criteria included: (1) BPD diagnosis confirmed by a score above seven on the Diagnostic Interview for Borderlines (DIB; Gunderson, Kolb, & Austin, 1981); (2) age between 17 and 35; (3) beginning a new psychotherapy; (4) no lifetime diagnoses of schizophrenia, bipolar I, or an organic mental disorder; (5) not admitted for chemical dependency; and (6) IQ of 80 or above. A baseline sample of 33 patients completed these assessments

"critical" points of change (i.e., change from a score of 3 [probably not true] to a score of 4 [probably true]) could be found. To evaluate the overall pattern of change in the alliance, the mean ratings at baseline (i.e., six weeks) were compared to each successive time point using paired two-tailed *t*-tests. While multivariate tests would have been preferable to avoid inflation of the Type I error rate, missing data precluded their use. Separate analyses were conducted for the patterns of change in the patient and therapist ratings. In addition, alliance scores at six weeks for the 11 patients who had dropped out of therapy were compared by independent *t*-tests to the alliance scores from those who remained in their therapy. The 11 patients in our dropout group were those who had left therapy due to dissatisfaction with it (as reported previously; see Gunderson et al., 1989). Finally, we calculated the correlation (Pearson, two-tailed) between alliance scores at six weeks and patient outcomes at three years, controlling for the value of patient outcome variables at six weeks. Patient outcome measures were the DIB, SCL-90, SAS-SR, and the GAS.

RESULTS

As shown in Table 1, a correlation analysis comparing patient and therapist alliance scores revealed the correspondence was significant through two years (r 's = .63-.80, $p \leq .01$) but did not reach significance thereafter at three, four, or five years—perhaps because of poor statistical power. The therapists' HAQ ratings were generally higher than the patients', but when compared in paired *t*-tests the difference was only significant at three years ($t = -2.96$, $df = 11$, $p < .05$).

Table 2 shows how the HAQ ratings of the sample that was scored at each follow-up compared to that sample's baseline scores. As shown, the HAQ-T and HAQ-P ratings were uniformly higher than baseline at each time point studied, with significance at one, three and five years for the patient ratings; and six months, one, three, four and five years for the therapist ratings.

Examination of the changes on each of the nine component items of the HAQ revealed that therapists perceived a switch from "probably not true" to "probably true" only twice, both times during the interval between baseline (i.e., six weeks) and six months. These switches occurred in the therapists' baseline perception that their patients probably had not "Achieved New Understanding" and probably did not have the "Same Goals for Treatment" to perceiving that they probably did by six months. The "New Understanding" item was the only one where therapists consistently scored lower than patients through the first two years of therapy. The patients made a shift from generally

Table 1. Correlations Between Patient and Therapist Alliance at Each Time Point

Time	<i>r</i>	<i>df</i>
Baseline	.80**	28
6 months	.79**	27
1 year	.67*	15
2 years	.63*	16
3 years	0.33	11
4 years	0.63	8
5 years	0.06	8

Note. * $p < .01$. ** $p < .001$.

Table 2. Mean Helping Alliance (HAq) at Baseline Compared to Follow-Up

Time	Baseline		Follow-Up		<i>r</i> ²	<i>df</i>
	<i>M</i>	(<i>SD</i>)	<i>M</i>	(<i>SD</i>)		
Patient Ratings						
Baseline	3.75	(1.19)	4.02	(1.13)	1.82	22
6 Months	3.65	(1.10)	4.82	(.78)	3.28**	13
1 Year	4.24	(.73)	4.80	(.82)	1.91	16
2 Years	4.27	(.75)	4.70	(.63)	3.52**	13
3 Years	3.49	(1.17)	4.72	(.85)	1.91	12
4 Years	3.91	(1.17)	5.13	(.60)	2.41*	10
5 Years	3.94	(1.40)				
Therapist Ratings						
Baseline	3.90	(.89)	4.34	(.90)	3.07**	24
6 Months	3.93	(.85)	4.71	(.60)	2.87*	11
1 Year	4.34	(.57)	4.70	(.55)	2.02	12
2 Years	4.42	(.57)	4.84	(.42)	2.91*	9
3 Years	4.02	(.74)	5.01	(.51)	4.28**	10
4 Years	4.23	(.47)	5.12	(.52)	3.93**	8
5 Years	4.15	(.66)				

Note. *Paired sample t-test comparing baseline scores to follow-up scores. All *p* values are two-tailed. **p* < .05. ***p* < .01.

"probably not true" to "probably true" only once. That is, they moved from expecting that they probably will not "Solve Their Own Problems" at six months to expecting that they probably will be able to at one year. This was the only item that the patients uniformly scored lower than did the therapists throughout the five years of ratings.

Of particular interest was the item (i.e., "Joint Effort") that most directly assessed the psychoanalytic model of a working alliance, signifying whether the patient and therapist felt they worked together collaboratively. While both patients and therapists saw growth on the item during the course of the therapies, the growth was modest largely because both groups surprisingly felt it was probably true already at baseline (i.e., six weeks).

Differences between the 11 patients who dropped out due to dissatisfaction with therapy and the 23 who remained in therapy were examined by comparing their HAq-P and HAq-T scores at six weeks. The patients who remained in therapy scored significantly higher on the HAq-T ratings ($t = 2.24$, $df = 12.8$, $p = .048$, two tailed), and showed a trend on the HAq-P ratings ($t = 1.71$, $df = 17.8$, $p = .072$, two tailed) compared to the patients who dropped out. We also evaluated effect sizes for these comparisons, with a finding of $d = .82$ for the HAq-T and $d = .63$ for the HAq-P (a large and medium effect size, respectively; Cohen, 1977).

Therapists' HAq scores at six weeks correlated with outcome scores at three years on the SAS-SR ($r = -.98$, $n = 2$, $p < .01$). No other statistically significant correlations were found between either the HAq-P or the HAq-T ratings at baseline (i.e., six weeks) and our other three indices of outcome (i.e., the DIB, SCL-90, and GAS).

DISCUSSION

The problems of conducting a long-term unfunded study requiring the collaboration of a volatile patient sample are evident in this report. Missing data led to

use of very basic statistics, and multiple comparisons increased the Type 1 error rate, thus precluding us from doing some of the analyses and reaching as many firm conclusions as we had hoped. On the other hand, the data acquired is for the most part the first of its kind and it allows tentative conclusions that should greatly inform future research in this area.

The high ratings of the alliance found from the start were unexpected. Though normative data from other types of patients are not available, we would expect that alliance ratings in a BPD sample would be comparatively low. Of note is the observation that the Menninger study, using another version of the Penn Helping Alliance scale also found relatively high baseline ratings (Horwitz et al., 1996). Our data then showed a modest but steady growth in the alliance over a long period of follow-up. We believe this gradual increase reflects a generic attachment process which is an essential aspect of a long-term therapy, but whose slow rate may be more specific to borderline patients who are likely to enter treatment with basic failures to have previously achieved secure attachments (Paris & Zweig-Frank, 1993; Gunderson, 1996). This slow, steady improvement contrasts with the major fluctuations in alliance ratings, including very low scores, found even during advanced stages of the long-term therapies of the three borderline patients followed in the Menninger Treatment study (Horwitz et al., 1996). This difference may be explained by the fact that the two studies used different rating methodologies. In the Menninger study the alliance ratings were done on individual therapy sessions by independent ("neutral") research raters off of audiotaped transcriptions. Our alliance ratings, in contrast, were synthetic overview judgments made by knowledgeable but highly invested, perhaps optimistic, raters. Despite their lack of neutrality, the fact that the correlations between our patient and therapist alliance assessments were consistent and strong provides consensual validation for their judgments being of phenomena perceptible to both during treatment. We expect that neutral observers who were asked to develop synthetic ratings based on many sessions would reach similar conclusions.

The generally higher ratings of the alliance by the therapists than by the borderline patients poses an interesting question. Does this reflect therapist optimism or patient pessimism? The finding that therapists' baseline ratings of the alliance could distinguish which patients subsequently dropped out from those who remained, whereas patients' ratings did not, suggests that the therapists' ratings have the greater predictive validity. This suggests that the therapists have a more realistic appreciation of positive processes in the therapies (such as growth in trust, disclosure, or dependency) than the patients are able to recognize or acknowledge. The examination of items shows that the borderline patients were particularly hesitant to endorse the belief that they would solve their problems. This is probably a result of the implication on this item that to answer otherwise might imply they may not be in need of therapy. Revealing such hopeful signs could engender fears and thus they are safer not acknowledging such perceptions to themselves or others. It is also notable that therapists appeared slower to perceive these patients as having achieved new understanding (i.e., "insight"). Presumably this is because therapists are both more attentive and discriminating in their perception of insight learning than are borderline patients.

Previous work has documented that a high percent of BPD patients drop out of therapy before six months (Skodol et al., 1983; Waldinger & Gunderson, 1984; Gunderson et al., 1989; Stevenson & Meares, 1992; Yeomans et al., 1994).

Regrettably, many of the patients who entered this study (and whose dropping out we have previously documented, Gunderson et al., 1989) did not give us the alliance data which could add strength and generalizability to our findings. Nevertheless, our comparison of six-week HAq-T alliance scores for the 11 who left therapy dissatisfied versus the 13 who remained in therapy suggests that therapists could learn to judge whether the alliance at six weeks is good enough to predict which borderline patients will remain in treatment. This finding is consistent with prior work with schizophrenic subjects (Frank & Gunderson, 1990). It strengthens our clinical impression (Gunderson, Sabo, & Najavits, 1993) that borderline patients who fail to identify an overall positive relationship to a new therapist with hopefulness about the therapy even at six weeks should be considered cause for concerned attention—not as an expectable course—and often consultation should be sought. Our data suggests that some changes in the patient alliance, i.e., feeling that therapy is helping or believing that they will solve their problems should show progression over the first year. We would also say that therapists should observe a progression in the alliance with respect to patients having achieved new understanding of themselves during the first year. Here, too, the absence of such progression may be cause for consultation.

The correlation of six-week alliance ratings with three-year outcomes yielded meager results. Higher therapist ratings were associated with significantly more improvement on the SAS social relations scale. Other therapist and patient six-week alliance rating were only weakly (i.e., insignificantly) related to our outcome measures at three years. These results are provocative but inconclusive. We expect that larger samples and more specific outcome assessments would yield stronger and more conclusive associations.

The formation of a good alliance may represent a "marker" for a whole host of variables that we did not study (differential motivation on the patients' or therapists' part, prognostic subtypes of BPD, more effective forms of early therapeutic intervention, etc.). Previous research has already shown that formation of a good alliance is associated with specific therapists' attitudes and skills (Luborsky et al., 1985; Najavits & Strupp, 1994). We believe that variance in the therapists' attitudes and skills or, perhaps, in their "personal match" may be particularly important to the engagement of very difficult patients such as those in this study. In future research on BPD samples, relating the alliance to facets of therapy such as the therapists' use of specific forms of early intervention may improve our understanding of how to encourage and sustain the alliance. This understanding will obviously be useful for psychotherapists but it will also have important implications for nursing staffs, pharmacotherapists, and others who wish to help these patients.

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Zusammenfassung

Die Entwicklung der therapeutischen Allianz wurde in einer prospektiven Studie bei 33 Patienten mit Borderline-Persönlichkeitsstörungen überprüft. Die Einschätzungen der Allianz wurden sowohl von den Patienten als auch von ihren Therapeuten mit Hilfe des Penn Helping Alliance Fragbogens nach sechs Wochen, sechs Monaten und dann jährlich über den Zeitraum von fünf Jahren vorgenommen.

Die Ergebnisse der Studie sind: 1) Die Allianz wurde sowohl von den Patienten als auch von den Therapeuten über die gesamte Behandlung hinweg hoch eingeschätzt; 2) Die Allianz verbesserte sich stetig und signifikant innerhalb des Behandlungszeitraums und wies keine signifikante Verschlechterung an irgendeiner Stelle des Prozesses auf; 3) Patienten und Therapeuten stimmten in ihren Einschätzungen weitgehend überein; 4) Therapeuten schätzten die Allianz im dritten und vierten Jahr höher ein als die Patienten; 5) Die Einschätzung der therapeutischen Allianz nach sechs Wochen durch den Therapeuten kann spätere Therapieabbrüche vorhersagen, aber 6) die frühen Allianzwerte waren nicht sehr ausgeprägt bezogen auf spätere Veränderungswerte. Die Ergebnisse stecken den Rahmen für zukünftige Studien in diesem Bereich ab.

Résumé

Le développement de l'alliance thérapeutique est exploré dans une étude prospective sur 33 patients avec trouble de la personnalité borderline. Des évaluations de l'alliance ont été faites par les patients et leur thérapeute à l'aide du Questionnaire Penn Helping Alliance, à six semaines, six mois et ensuite annuellement pendant cinq ans.

Les découvertes majeures ont été: 1) L'alliance a été évaluée "forte" à la fois par les patients et les thérapeutes pendant le traitement; 2) L'alliance a montré une amélioration stable et significative à travers le temps (et à aucun moment il n'y a eu de détérioration significative); 3) Les évaluations des patients et des thérapeutes correspondaient fortement; 4) Les thérapeutes ont évalués l'alliance plus forte que l'ont fait les patients après trois et quatre ans; 5) Les évaluations de l'alliance par les thérapeutes étaient prédictives d'un subséquent désistement; mais 6) Les scores de l'alliance précoce n'étaient pas fortement liés à un subséquent niveau de changement. Ces résultats forment des points intéressants de discussion pour de futures recherches dans ce domaine.

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