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Holding the treatment frame: borderline features, personality functioning, and psychotherapy dropout in a youth mental health service

Francesca De Salve,[1] Chiara Rossi,[2,3] Osmano Oasi,[1] Lara Malvini,[4] Maria Meliante,[4] Mauro Percudani,[4] Irene Messina[5]

[1]Department of Psychology, Università Cattolica del Sacro Cuore, Milan; [2]Department of Human Sciences, Guglielmo Marconi University, Rome; [3]Humane Technology Lab, Università Cattolica del Sacro Cuore, Milan; [4]Department of Mental Health and Addiction Services, Niguarda Hospital, Milan; [5]Department of Human and Social Sciences, Universitas Mercatorum, Rome, Italy

Abstract

Baseline personality pathology may shape both everyday functioning and engagement in psychotherapy. This study tested whether maladaptive personality trait domains and borderline symptom severity were associated with psychosocial functioning at intake and whether these variables were related to subsequent psychotherapy dropout within the same clinical pathway. Participants were 124 young adults (M age = 20.81, SD=2.30; 51.6% male and 48.4% female) assessed at intake in a youth mental health early intervention service in Milan, Italy (2024-2025). Measures included the Personality Inventory for the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (PID-5), the Borderline Symptom List-23 (BSL-23), and the Social and Occupational Functioning Assessment Scale (SOFAS). SOFAS was examined using stepwise multiple linear regression including PID-5 domains, BSL-23, sex, and age. Dropout was examined using Bayesian logistic regression and model comparison in the psychotherapy-only subsample (n=63; 13 dropouts, 20.6%). In the full sample, the final regression model retained only BSL-23, $F(1, 122)=5.57$, $p=.020$, $R^2=.04$, indicating that higher borderline symptom severity was associated with lower functioning ($B=-2.86$, $\beta=-.21$, 95% CI [−5.27, −0.46]). For dropout, inclusion evidence was strongest for disinhibition (Bayes factor for inclusion [BF_inclusion] = 3.36), followed by BSL-23 (2.39) and SOFAS (2.23), although model-averaged 95% credible intervals (CrIs) included zero for all predictors. Clinically, these findings suggest that disinhibition and borderline severity may be better understood as markers of relational intensity requiring a structured yet reflective therapeutic stance rather than as straightforward dropout risks.

Key words: disinhibition, borderline features, social and occupational functioning, dropout, psychotherapy.

Correspondence to: Francesca De Salve, Department of Psychology, Università Cattolica del Sacro Cuore, Largo Gemelli 1, 20123 Milan, Italy.
E-mail: francesca.desalve@unicatt.it

Introduction

Young adulthood is a developmental window marked by identity consolidation, expanding social roles, and increasing occupational demands (Lancini & Madeddu, 2014; Wood *et al.*, 2018). At the same time, it is a period of heightened vulnerability for the onset or escalation of psychopathology (Leebens *et al.*, 2017). Within youth-oriented mental health services, clinicians commonly encounter young people with clinically significant personality pathology – often expressed as maladaptive trait elevations and borderline features – that is closely intertwined with psychosocial impairment and may foreshadow poorer social adjustment and later anxiety and depression (Moran *et al.*, 2016).

Contemporary dimensional models of personality pathology conceptualize maladaptive traits as clinically meaningful individual differences that covary with dysfunction and disability; in clinical samples, pathological traits and personality disorders show robust links with psychosocial functioning impairment (Clark & Ro, 2014; Clark *et al.*, 2018). Consistent with this view, evidence from large outpatient youth cohorts indicates that borderline features – even when subthreshold for a categorical diagnosis – are associated with more severe clinical presentations and poorer social and occupational functioning (Thompson *et al.*, 2019). Moreover, in help-seeking young people with borderline personality disorder (BPD), greater borderline symptom burden predicts worse functioning and reduced quality of life, highlighting the functional costs of borderline psychopathology (Thompson *et al.*, 2020). These findings converge with broader work showing that social and occupational functioning is substantially impaired in individuals with BPD across the lifespan (Dhar *et al.*, 2023; Javaras *et al.*, 2017; Leichsenring *et al.*, 2024; Tomko *et al.*, 2014). Together, this literature supports the clinical premise that maladaptive traits (Langerbeck *et al.*, 2023; Xiao *et al.*, 2024) and borderline symptoms meaningfully impair psychosocial functioning and may shape engagement trajectories in psychotherapeutic treatment.

Beyond symptom reduction, an additional challenge for youth mental health services (Broadbear *et al.*, 2022; Shaikh *et al.*, 2017; Tate *et al.*, 2022; Zanarini *et al.*, 2004) concerns retention and continuity of care. Italy, like many countries, has faced

increasing pressure on community mental health systems, with large volumes of service users and substantial numbers of first contacts each year. National mental health reporting documents that, in 2023, specialized mental health services assisted 854,040 psychiatric service users and recorded 273,172 people entering contact for the first time during the year (Ministero della Salute, 2024). In this context, optimizing clinical resources is crucial yet difficult: service efficiency depends not only on appropriate assessment and case formulation, but also on minimizing preventable dropout and understanding which patient profiles are most likely to disengage prematurely.

In psychotherapy research, dropout is typically defined as premature termination or unilateral ending of treatment (*i.e.*, discontinuation without mutual agreement and/or before the expected or therapeutically indicated endpoint) (Swift & Greenberg, 2012; Westmacott *et al.*, 2010). This construct should be distinguished from clinical discontinuation (or planned termination), in which treatment ends through a collaborative decision – often because treatment goals have been met or care is intentionally transitioned. Importantly, termination processes are heterogeneous: patients and therapists' perspectives frequently diverge regarding whether treatment ended "successfully", and unilateral terminators may leave therapy because of dissatisfaction, barriers, or a mismatch between expectations and the care received (Olivera *et al.*, 2017; Westmacott *et al.*, 2010).

Dropout is especially salient in the treatment of personality pathology. Reviews indicate that non-completion is common in interventions for personality disorders and is associated with poorer outcomes and increased service burden (McMurran *et al.*, 2010). In psychotherapy trials for BPD, dropout remains a persistent issue (Iliakis *et al.*, 2021), and meta-analytic evidence suggests that discontinuation risk is often highest early in treatment, highlighting the importance of early-phase engagement and retention strategies (Arntz *et al.*, 2023). Although psychological therapies for BPD show evidence of benefit, treatment effects, completion rates, and clinical outcomes remain variable across studies and treatment modalities (Cristea *et al.*, 2017; Crotty *et al.*, 2024; Rameckers *et al.*, 2021; Storebø *et al.*, 2020). Recent syntheses focusing specifically on psychotherapy dropout in personality disorders further emphasize the multifactorial nature of attrition and the need for service-based predictors that can inform prevention (De Freixo Ferreira *et al.*, 2023; De Salve *et al.*, 2025; Woodbridge *et al.*, 2022). However, relatively few studies have examined how dimensional indicators of personality pathology (*e.g.*, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition [DSM-5] maladaptive trait domains, borderline symptom severity) and baseline psychosocial functioning jointly relate to subsequent dropout in naturalistic youth mental health settings.

Against this background, identifying baseline factors linked to both psychosocial functioning and psychotherapy dropout is a pragmatic priority for youth services (Rossi *et al.*, 2025). Baseline functioning may influence not only clinical need but also the feasibility of regular attendance and the perceived necessity of remaining in care, whereas maladaptive traits and borderline symptoms may affect emotion regulation, interpersonal dynamics, and the capacity to tolerate the demands of psychotherapy. Yet it remains unclear whether, and how, these dispositional and clinical features combine to predict retention in routine youth mental health care.

The present preliminary study was designed to address this gap within a specialized youth mental health early intervention service in Milan, Italy. Although emerging adulthood is commonly conceptualized as extending from the late teens to the twenties, the present study focused on a younger subgroup within this developmental period, namely individuals aged 18-24 years, reflecting the target age range of the service from which the data were collected. Using a dimensional assessment framework, we focused on borderline symptom severity and maladaptive personality traits, namely negative affectivity, detachment, antagonism, disinhibition, and psychoticism, in relation to two clinically relevant outcomes: clinician-rated psychosocial functioning at baseline and treatment dropout. Specifically, we pursued two aims. First, we examined whether borderline symptoms and maladaptive personality trait domains were associated with baseline psychosocial functioning in a sample of help-seeking young adults. Second, we explored whether borderline symptoms, maladaptive personality trait domains, and baseline psychosocial functioning were associated with treatment dropout. Given the limited prior evidence in youth mental health early intervention settings, these analyses were primarily exploratory. However, we expected that a higher borderline symptom burden and higher disinhibition would be associated with increased dropout risk, whereas the role of baseline psychosocial functioning was considered an open question.

Clarifying these associations may help refine early assessment, support risk-informed engagement practices (Bordin, 1979; Tryon & Winograd, 2011), and guide targeted strategies (*e.g.*, explicit goal negotiation and shared definitions of "successful completion") to reduce preventable attrition among clinically complex young patients.

Materials and Methods

Participants and procedures

The sample comprised 124 participants (M=20.8 years, SD=2.1; 51.6% male and 48.4% female; years of education: M=12.70, SD=1.86) who spontaneously presented to the Youth Mental Health Early Intervention Service at Niguarda Hospital, Milan (Italy), for emotional, personality, or relational difficulties. Most received cognitive-behavioral therapy (80%), followed by psychodynamic (15%) and systemic approaches (5%), according to clinical indication and service organization. This naturalistic observational study was conducted in a community-based service for 18-25-year-old patients offering diagnostic assessment and evidence-based psychotherapies, with data drawn from routine baseline assessments and subsequent treatment records collected between December 2024 and May 2025. For the dropout analyses, we considered only the psychotherapy subsample (n=63). All patients in this subsample were observed over the same clinical observation window, from intake through the end of the data collection period, ensuring a comparable opportunity to initiate and discontinue psychotherapy across participants (Figure 1).

Exclusion criteria were i) an incomplete personality assessment and ii) a diagnosis of intellectual disability or autism, whereas inclusion criteria were i) being aged between 18 and 24 years; ii) being under care at the Youth Mental Health Early Intervention Service; and iii) having completed the standard routine assessment, including the test battery described in the *Measures* section. The study was approved by the Ethical Committee of Niguarda Hospital, Milan (protocol 305-19,052,021) and conducted in accordance with the 1964 Declaration of Helsinki and its later amendments (World Medical Association, 2013); informed consent was obtained during routine assessment from participants who chose to take part.

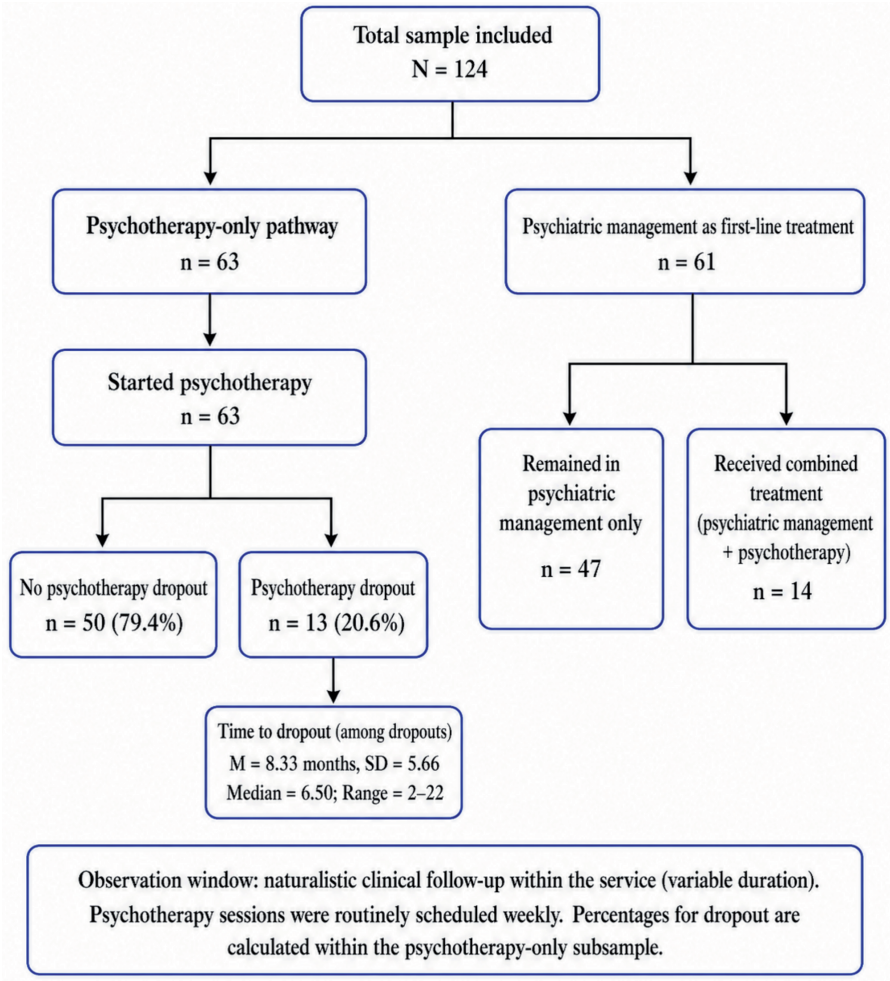

Figure 1. Participant flow and clinical pathway.

Measures

Socio-Demographic Questionnaire. The questionnaire collected information on age, gender, educational level, employment status, and other relevant socio-demographic variables.

Borderline Symptom List-23 (BSL-23; Bohus *et al.*, 2009). It is the short form of the *Borderline Symptom List-95* and consists of 23 items assessing the severity of borderline-specific symptoms over the preceding week. Items are rated on a 5-point Likert-type scale ranging from 0 (*not at all*) to 4 (*very strong*), and a total score is computed by averaging item responses, with higher scores indicating greater borderline symptom severity (ω=0.96).

Personality Inventory for DSM-5 (PID-5; Krueger *et al.*, 2012). It is a 220-item self-report measure designed to assess Criterion B pathological personality traits as outlined in Section III of the DSM-5. Items are rated on a 4-point Likert-type scale ranging from 0 (*very false* or *often false*) to 3 (*very true* or *often true*). The PID-5 assesses 25 lower-order trait facets, which are organized into five higher-order domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. McDonald's ω is greater than 0.90 for all PID-5 domain scales (Fossati *et al.*, 2013). Scores of the present study were analyzed following the indications of Krueger *et al.* (2012).

Social and Occupational Functioning Assessment Scale (SOFAS; Morosini *et al.*, 2000). It is a clinician-rated measure of current functioning that focuses specifically on social and occupational performance, independent from symptom severity. Scores range from 0 to 100, with higher scores indicating better functioning (*e.g.*, 91-100 = superior functioning in a wide range of activities; <30 = inability to function in almost all areas). In the present study, the SOFAS total score was used as an index of global psychosocial functioning.

Statistical analyses

After the implementation of descriptive statistics (see Tables 1 and 2), tests for skewness and kurtosis were conducted to assess the distribution characteristics of the data. The criteria outlined by Finney and DiStefano (2006) were applied, which indicate that skewness values exceeding ±2 and kurtosis values greater than ±7 suggest a non-normal distribution. The analysis confirmed that all variables fell within these acceptable thresholds. Specifically, skewness values ranged from −0.03 to 1.09, while kurtosis values ranged from −0.93 to 1.24, suggesting no substantial departures from normality.

In line with the study aims and the assessment battery described

above, we implemented two complementary models: i) a frequentist multiple linear regression to explain baseline psychosocial functioning (SOFAS) in the full sample (n=124), and ii) a Bayesian logistic regression to model psychotherapy dropout (yes/no). Of the 124 patients, 63 received psychotherapy as their first-line treatment; therefore, the Bayesian logistic regression was applied to this subsample. Psychotherapy sessions were routinely scheduled on a weekly basis within the service. For patients who dropped out of psychotherapy, we also extracted, where available, the number of months they remained in treatment before dropout as an approximate indicator of treatment exposure before discontinuation.

Table 1. Descriptive characteristics of the full sample.

Variable	n (%)	M (SD)
Age	124	20.81 (2.30)
Years of education	124	12.70 (1.86)
Sex assigned at birth		
Female	64 (51.6)	
Male	60 (48.4)	
Diagnostic category		
Personality disorders	43 (34.7)	
Psychotic disorders	6 (4.8)	
Anxiety disorders	30 (24.2)	
Mood disorders	26 (21.0)	
Unspecified diagnosis	19 (15.3)	
Main study variables		
SOFAS	124	65.27 (13.54)
BSL-23	124	1.47 (0.99)
Negative Affectivity	124	1.37 (0.47)
Detachment	124	1.24 (0.50)
Antagonism	124	0.67 (0.52)
Disinhibition	124	1.26 (0.46)
Psychoticism	124	0.89 (0.60)

N, 124; SOFAS, Social and Occupational Functioning Assessment Scale; BSL-23, Borderline Symptom List-23.

Table 2. Descriptive characteristics of the psychotherapy-only subsample.

Variable	n (%)
Assigned sex birth	
Male	31 (49.2)
Female	32 (50.8)
Diagnostic macro-category	
Depression	12 (19.0)
Anxiety	12 (19.0)
Personality disorders	26 (41.3)
Psychosis	5 (7.9)
Unspecified diagnosis	8 (12.7)
Emergency access room, M (SD)	0.56 (0.96)
Range	0-4
Hospitalizations, M (SD)	0.41 (0.84)
Dropout from psychotherapy	
No	50 (79.4)
Yes	13 (20.6)
Treatment type	
Psychodynamic psychotherapy	3 (4.7)
Systemic psychotherapy	1 (1.59)
Cognitive-behavioral therapy	59 (93.7)
Months of treatment before dropout, M (SD)	8.33 (5.66)
Median	6.50
Range	2-22

N, 63. Percentages are calculated within the psychotherapy-only subsample. Emergency room accesses and hospitalizations refer to the number of events recorded for each patient. Psychotherapy sessions were routinely scheduled on a weekly basis within the service.

Primary predictors were borderline symptom severity (BSL-23) and maladaptive personality traits (PID-5 domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, Psychoticism). Age and sex assigned at birth were included as demographic covariates in the linear regression model predicting psychosocial functioning. Years of education and psychotherapy approach were reported descriptively but were not included as covariates in the final regression models in order to preserve model parsimony, given the modest sample size and, for the dropout analysis, the limited number of events. Continuous predictors were mean-centered; for secondary presentation of effects, standardized coefficients are reported where appropriate. Complete-case analyses were performed after applying the study's exclusion criteria and inspecting data completeness for the included variables.

For psychosocial functioning, we fitted a multiple linear regression with SOFAS as the dependent variable and BSL-23 *plus* the PID-5 domains as candidate predictors, with age and sex assigned at birth entered as demographic covariates. To obtain a parsimonious specification in view of the modest sample size, we used a stepwise selection procedure including BSL-23, PID-5 domains, age, and sex. Because stepwise selection may capitalize on sample-specific associations, the retained model was interpreted cautiously and was not considered evidence of the clinical superiority of retained predictors over those excluded from the final model. Model assumptions (linearity, homoscedasticity, normality of residuals) were checked *via* residual plots and quantile-quantile (Q-Q) plots; multicollinearity was examined with variance inflation factors (VIF), with VIF>5 flagged for scrutiny. When heteroskedasticity was indicated, heteroskedasticity-consistent robust standard errors were reported. Unstandardized coefficients (B), SEs, *t*-tests, two-sided p-values (α=.05), 95% CIs, and adjusted R^2 are presented. Where informative, standardized beta (β) coefficients are also provided.

For dropout from psychotherapy, due to the small number of events and the risk of small-sample bias, we estimated a Bayesian logistic regression using JASP 0.18.3 with the default prior settings for logistic models. All candidate predictors were assigned equal prior inclusion probabilities of .50, indicating no prior preference for including one predictor over another. No custom informative priors were specified by the authors. The model included BSL-23, the PID-5 domains, and baseline SOFAS as candidate predictors. Additional demographic and treatment covariates were not included in the dropout model to avoid overfitting, given the limited number of dropout events in the psychotherapy-only subsample. Posterior summaries are reported as posterior means, SDs, and 95% credible intervals (CrIs). Evidence for predictor inclusion was quantified using Bayes factors (BFs) for inclusion and posterior inclusion probabilities.

Results

A multiple linear regression analysis was conducted to examine whether pathological personality traits (Negative Affectivity, Detachment, Antagonism, Disinhibition, Psychoticism), borderline symptoms (BSL-23), sex, and age predicted baseline psychosocial functioning (SOFAS) in the total sample (n=124). Correlations

among the variables are reported in Table 3. Using an exploratory stepwise procedure, only borderline symptom severity was retained in the final model and explained a small but significant proportion of variance in SOFAS scores, F(1, 122)=5.57, p=.020, R^2=.04, adjusted R^2=.04. Higher BSL-23 scores were associated with lower psychosocial functioning, B=−2.86, SE=1.21, β=−.21, 95% CI [−5.27, −0.46]. None of the other predictors (maladaptive personality traits, sex, or age) significantly improved the model once BSL-23 was included.

To examine whether baseline pathological personality trait domains and borderline symptom severity were associated with psychotherapy dropout, we estimated a Bayesian logistic regression (Table 4) in the psychotherapy-only subsample, including baseline psychosocial functioning (SOFAS) as an additional candidate predictor (n=63; 13 dropouts, 20.6%). Given the limited number of dropout events, demographic and treatment covariates were not included in this model to avoid overfitting. Descriptive characteristics of the psychotherapy-only subsample are reported in Table 2. Among patients who dropped out, the mean time in treatment before dropout was 8.33 months (SD=5.66; median = 6.50; range = 2-22). Psychotherapy sessions were routinely scheduled on a weekly basis within the service; however, session-by-session attendance data were not available in the routine clinical database.

Model comparison indicated that the model including all seven predictors (Negative Affectivity, Detachment, Antagonism, Disinhibition, Psychoticism, BSL-23, and SOFAS) had the highest posterior model probability, P(M|data) = .251, with a Bayesian R^2 of .212. This value was used as a descriptive index of model fit, while substantive interpretation relied on posterior model probabilities, BFs, posterior inclusion probabilities, and CrIs. The null model was less supported (P(M|data) = .066; BF_{10}=0.263 relative to the best model), indicating that the full model received approximately 3.80 times more support than the null model. Posterior inclusion evidence was strongest for Disinhibition (BF_inclusion = 3.36; P(inclusion|data) = .771), followed by borderline symptom severity (BSL-23; BF_inclusion = 2.39; P(inclusion|data) = .705) and SOFAS (BF_inclusion = 2.23; P(inclusion|data) = .691).

Model-averaged posterior summaries suggested that Disinhibition (b=−0.98, SD=1.04, 95% CrI [−3.31, 0.45]), BSL-23 (b=−0.20, SD=0.28, 95% CrI [−0.82, 0.24]), and SOFAS (b=0.01, SD=0.02, 95% CrI [−0.02, 0.06]) were associated with small changes in the log-odds of psychotherapy dropout. Expressed as odds ratios (ORs), these effects corresponded to OR=0.38 for Disinhibition, OR=0.82 for BSL-23, and OR=1.01 for SOFAS. However, the corresponding CrIs were wide and included OR=1, indicating substantial uncertainty. Evidence for the remaining trait domains was weak to anecdotal (BF_inclusion range = 1.28-1.74; P(inclusion|data) range = .561-.635).

Overall, the models indicated that greater borderline symptom severity was associated with poorer psychosocial functioning, while disinhibition, borderline symptom severity, and baseline functioning showed the strongest, although still uncertain, evidence of association with psychotherapy dropout. However, all 95% CrIs included zero on the log-odds scale, indicating substantial uncertainty regarding the direction and magnitude of these effects; these findings should therefore be interpreted as tentative trends rather than robust results.

Discussion

The present preliminary study examined whether baseline maladaptive personality traits and borderline symptom severity were

Table 3. Correlations among main study variables in the full sample.

Variable	1	2	3	4	5	6	7
1. SOFAS	—						
2. Negative Affectivity	−.07	—					
3. Detachment	−18*	.68**	—				
4. Antagonism	−.09	.37**	.14	—			
5. Disinhibition	−.15	.68**	.51**	.56**	—		
6. Psychoticism	−.21*	.64**	.51**	.43**	.62**	—	
7. BSL-23	−.21*	.45**	.49**	.12	.51**	.46**	—

N, 124; SOFAS, Social and Occupational Functioning Assessment Scale; BSL-23, Borderline Symptom List-23; *p<.05; **p<.01.

Table 4. Bayesian logistic regression predicting psychotherapy dropout in the psychotherapy-only subsample.

Predictor	b	SD	95% CrI for b	OR	95% CrI for OR	BF_inclusion	P (inclusion|data)
Negative Affectivity	0.06	0.66	[−1.16, 1.76]	1.06	[0.31, 5.81]	1.28	.561
Detachment	0.21	0.57	[−0.93, 1.53]	1.24	[0.40, 4.63]	1.43	.589
Antagonism	0.30	0.58	[−0.64, 1.66]	1.35	[0.53, 5.26]	1.74	.635
Disinhibition	−0.98	1.04	[−3.31, 0.45]	0.38	[0.04, 1.57]	3.36	.771
Psychoticism	−0.20	0.55	[−1.54, 0.69]	0.82	[0.22, 1.99]	1.46	.593
BSL-23	−0.20	0.28	[−0.82, 0.24]	0.82	[0.44, 1.27]	2.39	.705
SOFAS	0.01	0.02	[−0.02, 0.06]	1.01	[0.99, 1.06]	2.23	.691

N, 63; b, posterior mean on the log-odds scale; SD, posterior standard deviation; CrI, credible interval; OR, odds ratio; BF_inclusion, Bayes Factor for inclusion; BSL-23, Borderline Symptom List-23; SOFAS, Social and Occupational Functioning Assessment Scale. Odds ratios and their credible intervals were obtained by exponentiating the posterior means and 95% credible interval limits.

associated with psychosocial functioning and whether baseline maladaptive personality traits, borderline symptom severity, and psychosocial functioning were related to subsequent psychotherapy dropout. Findings indicated that higher borderline symptom severity was associated with poorer psychosocial functioning. In addition, Bayesian model comparison suggested that dispositional and clinical variables may contribute to the understanding of psychotherapy dropout, with comparatively stronger evidence for disinhibition, borderline symptom severity, and baseline social-occupational functioning. However, because the CrIs for the individual dropout predictors included zero, these findings should be interpreted as preliminary and hypothesis-generating rather than as definitive evidence of independent predictors of dropout.

The association between borderline symptom severity and poorer psychosocial functioning aligns with previous literature documenting the functional burden of borderline personality pathology (for a systematic review, see Dhar *et al.*, 2023). Notably, in our study, the inclusion of additional maladaptive personality traits did not improve the predictive model, suggesting that borderline symptom severity may capture a clinically salient dimension of impairment in this population. This finding is consistent with previous evidence showing that adults with BPD often present marked functional impairment even after adjustment for demographic variables such as age and sex (Javaras *et al.*, 2017). Importantly, the present study extends this line of evidence to a sample of young adults receiving care in a specialized early intervention service, suggesting that the link between borderline symptom severity and functional (Clark *et al*., 2018; Tomko *et al*., 2014) impairment may already be evident early in the clinical trajectory.

This result is also clinically coherent with qualitative findings showing that individuals with BPD often report difficulties in organizing daily activities, maintaining agency, and sustaining role functioning (Falklöf & Haglund, 2010). In this sense, borderline symptom severity may represent not only a cluster of affective and interpersonal symptoms but also a marker of broader difficulties in translating personal goals and social expectations into stable day-to-day functioning. At the same time, the cross-sectional nature of this part of the analysis prevents conclusions about directionality. Poorer functioning may be a consequence of borderline symptom severity, but functional impairment may also contribute to the persistence or exacerbation of borderline features over time.

Regarding psychotherapy engagement, Bayesian model comparison indicated that the model including all candidate predictors performed better than the null model. Within this model, disinhibition, borderline symptom severity, and baseline social-occupational functioning showed comparatively stronger evidence of inclusion. These findings suggest that psychotherapy dropout may be better understood as a clinically complex phenomenon involving both dispositional and functional dimensions rather than as the consequence of a single patient characteristic. This interpretation is consistent with previous reviews showing that treatment response, non-response, and dropout in BPD psychotherapy are influenced by multiple patient, treatment, and process-related factors (Barnicot *et al.*, 2012; De Freixo Ferreira *et al*., 2023; Rameckers *et al*., 2021; Woodbridge *et al.*, 2022). Nevertheless, the uncertainty around individual parameter estimates indicates that these results should be interpreted cautiously and require replication in larger samples.

From a diagnostic perspective, disinhibition is conceptualized in the DSM-5 Alternative Model for Personality Disorders (AMPD; APA, 2013) as a maladaptive trait domain reflecting reduced capacity to inhibit immediate impulses, limited deliberation and planning, and a tendency toward behavior guided by internal states and situational cues rather than longer-term goals (APA, 2013). Clinically, these features may be expressed through inconsistent follow-through, difficulty tolerating delay and frustration, and a tendency toward action rather than reflection.

Disinhibition is also directly relevant to the AMPD characterization of BPD. In the DSM-5 AMPD, the borderline profile requires impairment in personality functioning (Criterion A) alongside a specific constellation of maladaptive traits (Criterion B) spanning primarily Negative Affectivity, such as emotional lability, anxiousness, separation insecurity, and depressivity, and facets reflecting Disinhibition and Antagonism, such as impulsivity, risk-taking, and hostility (APA, 2013). Thus, disinhibition is diagnostically meaningful, but it should be understood as part of a broader configuration of affective, relational, and self-regulatory difficulties rather than as an isolated trait dimension (Widiger & McCabe, 2020). This is also consistent with findings showing that negative affectivity and disinhibition may interact with interpersonal vulnerabilities in pathways to suicidal behavior among individuals with BPD (Allen *et al*., 2022).

Previous studies have often linked disinhibition or related externalizing features to poorer treatment engagement and premature discontinuation (De Salve *et al.*, 2025; Rodriguez-Seijas *et al.*, 2020). In the present study, however, the estimated association between disinhibition and dropout was negative. Although this result should be interpreted with caution, given the uncertainty of the estimate, it raises an interesting clinical possibility. In a specialized early intervention service, more overt disinhibited features may elicit closer clinical monitoring, more structured risk-management strategies, and more intensive efforts to maintain contact with the patient. In this context, higher disinhibition may not necessarily translate into greater dropout risk; rather, it may activate clinical responses that help sustain treatment engagement. This interpretation remains speculative, as the study did not directly assess service intensity, therapist responses, or treatment-process variables, but it offers a clinically plausible explanation for a finding that differs from the expected direction.

A similar consideration may apply to borderline symptom severity. Patients with higher borderline symptom severity typically present with affective instability, interpersonal sensitivity, impulsivity, identity disturbance, and heightened vulnerability to crisis states. These features are often associated with greater use of emergency and mental health services, self-harm and suicidal behaviors, and complex patterns of comorbidity (Ansell *et al.*, 2007; Broadbear *et al*., 2022; Ellison *et al.*, 2018; Grecucci *et al.*, 2022; Grecucci *et al.*, 2023; Leichsenring *et al*., 2024; Shaikh *et al*., 2017; Swan *et al.*, 2025; Tate *et al*., 2022; Yi *et al.*, 2025; Zanarini *et al*., 2004). In naturalistic services, higher borderline symptom severity may therefore function as a signal of clinical complexity and may lead clinicians to provide more intensive follow-up, clearer treatment structures, or greater efforts to maintain engagement. At the same time, the same clinical features may also increase the risk of instability in the treatment relationship and premature discontinuation. Thus, borderline severity may have a dual clinical meaning: it may increase vulnerability to treatment disruption while also mobilizing greater clinical attention and containment.

The positive association between baseline psychosocial functioning and dropout also deserves consideration. Although this estimate should not be interpreted as definitive, it suggests that better

functioning at intake does not necessarily protect against premature discontinuation. Several explanations are plausible. First, patients with relatively better baseline functioning may experience faster subjective improvement and therefore discontinue treatment earlier, even when the ending is not formally agreed upon. Second, higher functioning may be associated with greater external role demands, such as work, study, or family responsibilities, which may compete with regular attendance. Third, patients with more preserved functioning may have greater autonomy and more alternative resources, potentially lowering the threshold for disengaging or seeking help elsewhere when treatment feels frustrating, insufficiently useful, or emotionally demanding. This interpretation is consistent with the idea that dropout does not always reflect greater clinical severity; in some cases, it may also reflect ambivalence, competing life demands, or a mismatch between perceived needs and the treatment frame. First-person accounts of disengagement from mental health services similarly suggest that leaving treatment may reflect heterogeneous combinations of perceived mismatch, autonomy needs, dissatisfaction, and contextual barriers rather than severity alone (Katz *et al*., 2022).

Taken together, the dropout findings suggest that treatment discontinuation in this population is likely to be shaped by the interplay between patient characteristics, clinical severity, functional resources, and the organization of care. The present study did not directly assess therapeutic alliance, rupture-repair processes, therapist responses, mentalization, countertransference, or the subjective meaning of dropout. Nevertheless, they provide a useful clinical framework for interpreting why dispositional and clinical variables may not operate in a linear way. Prior research has shown that dropout is frequently associated with process-level difficulties, including alliance ruptures, unresolved misunderstandings, and failures to negotiate goals and tasks within the therapeutic relationship (De Salve *et al.*, 2024; De Salve *et al.*, 2025; Difronzo *et al.*, 2025; Notaerts *et al.*, 2025; O'Keeffe *et al.*, 2020; Sharf *et al.*, 2010; Von Below, 2020). Consistently, qualitative evidence on patients' experiences of non-mutual psychotherapy termination indicates that treatment endings may be linked not only to patients' clinical characteristics, but also to relational dynamics, therapist behaviors, mismatches between therapy and patients' needs, perceived readiness to end, and economic or structural factors (Antichi *et al.*, 2025). In light of this literature, traits such as disinhibition or borderline symptom severity may be best understood as factors that shape the relational and organizational context of treatment rather than as direct and sufficient causes of dropout.

Qualitative process studies are particularly informative in this regard. Difronzo *et al.* (2025), for example, found that adolescents who dropped out of short-term psychoanalytic psychotherapy often showed a fragile alliance in the sessions preceding termination, with unresolved ruptures and a growing mismatch between patients' disengagement and therapists' attempts to explore their difficulties. Similarly, Von Below (2020) described a process in which young adults experienced not being understood, limited meta-communication about goals and tasks, and pseudo-mentalizing dynamics that progressively weakened collaboration. Although these processes were not measured in the present study, they help contextualize why dropout may emerge from the interaction between patient vulnerabilities and treatment processes. Future studies should therefore combine baseline clinical assessment with repeated measures of alliance, rupture-repair, mentalization, and session-by-session attendance to clarify how these processes contribute to premature termination.

Clinical implications

Clinically, the present pattern invites a shift from viewing disinhibition or borderline severity as straightforward "dropout risks" toward conceptualizing them as signals of relational intensity that require an appropriately structured, reflective, and responsive therapeutic stance. This perspective is consistent with guideline-oriented and review-based recommendations emphasizing structured, coherent, and specialized psychological treatments for BPD, while also recognizing that treatment selection and implementation should be adapted to clinical context and patient needs (Azzam *et al*., 2024; Leichsenring *et al*., 2024; Simonsen *et al*., 2019; Storebø *et al*., 2020). From a psychodynamic perspective, disinhibition and borderline features can evoke strong countertransference reactions – urgency to rescue, frustration, helplessness, anger, excessive control, or disengagement – especially when sessions are marked by crisis, inconsistency, or perceived manipulation (Eubanks *et al.*, 2018). Such reactions are not merely therapist "noise"; they may constitute clinically meaningful data about the patient's interpersonal world and typical relational pulls. At the same time, unrecognized countertransference can contribute to enactments – tightening the frame punitively, over-accommodating to avoid conflict, colluding with avoidance, or responding with emotional withdrawal – that amplify rupture and increase the likelihood of premature termination (Oasi *et al.*, 2024).

Accordingly, one implication is that retention in these cases may benefit from interventions that explicitly support the therapist's capacity for mentalization and reflective functioning under pressure, including regular supervision/consultation, structured risk-management practices that do not eclipse curiosity, and a shared team frame that reduces the therapist's sense of being alone with clinical risk. In-session, maintaining a stance that is both boundary and emotionally attuned – naming shifts in affect, tracking relational meanings, and treating impulses to act (in patient and therapist) as material for joint reflection – may help transform potential dropout moments into opportunities for rupture repair (O'Keeffe *et al.*, 2020). Historically, psychodynamic treatments for BPD have also emphasized the need for a coherent treatment frame and systematic attention to behavioral change and relational dynamics (Clarkin *et al.*, 2001).

Finally, the finding that better baseline functioning predicted higher dropout suggests that clinicians should not assume that higher functioning equates to lower dropout risk. For these patients, early dropout may reflect ambivalence about dependence, sensitivity to perceived inefficacy, or a preference for self-reliance – dynamics that can be explored explicitly. Discussing expectations, negotiating goals, and collaboratively defining what would count as "successful completion" may be particularly important to distinguish adaptive early termination from avoidant disengagement and to reduce preventable attrition (Bordin, 1979; Swift *et al.*, 2012; Tryon & Winograd, 2011).

Limitations

Several limitations should be acknowledged when interpreting the present findings. First, the sample size – particularly within the psychotherapy-only subsample – was modest, which limited statistical power and increased uncertainty in estimates related to dropout predictors. This also constrained our ability to examine potential interactions, including the moderating effects of treatment modality. Relatedly, the use of a stepwise selection procedure in the linear regression model should be considered an additional limitation. Although this approach was used to obtain a parsimonious

exploratory model in the context of a modest sample size, stepwise regression is data-driven and may capitalize on sample-specific associations. Therefore, the retention of BSL-23 in the final model should not be interpreted as evidence of its clinical superiority over the other personality pathology indicators. Rather, it indicates that borderline symptom severity provided the most parsimonious contribution to the prediction of psychosocial functioning in this specific sample. Future studies with larger samples should test theory-driven models and validate these associations using cross-validation or independent replication samples.

Second, participants were recruited from a highly specialized early intervention service for personality disorders – the Youth Mental Health Early Intervention Service at Niguarda Hospital (Milan, Italy) – which may limit the generalizability of the findings to broader or less specialized clinical settings. All therapists have specific expertise in this area, and cognitive-behavioral therapy therapists also practice dialectical behavior therapy. This high level of specialization may have influenced the observed pattern of associations. Moreover, although the sample reflects the clinical complexity typically encountered in early intervention services, it was diagnostically heterogeneous. The present analyses did not control for diagnostic category or psychiatric comorbidity, and this should be considered when interpreting the associations between personality pathology, psychosocial functioning, and psychotherapy dropout. It is possible that some of the observed effects were partly influenced by unmeasured differences in clinical presentation across diagnostic groups.

A related limitation concerns the absence of information on several potentially relevant clinical confounders. The routine clinical database did not include systematic data on psychopharmacological treatment, acute symptom severity at intake, suicidality or self-harm risk, substance use, illness duration, or previous psychological and psychiatric treatments. Consequently, we could not determine whether these factors contributed to psychotherapy allocation, treatment engagement, dropout, or psychosocial functioning. This is particularly relevant because medication use, acute clinical instability, prior treatment exposure, and comorbid substance use may all influence both treatment pathways and clinical outcomes in naturalistic settings. The findings should therefore be interpreted as preliminary and descriptive of associations observed in a real-world clinical service, rather than as evidence of independent effects after full adjustment for clinical confounding. Future studies should include more comprehensive clinical characterization and adjust for diagnosis, comorbidity, medication status, suicidality, substance use, and previous treatment history.

Third, the study relied on self-report measures, which may be subject to response biases, limited insight, or transient affective states, and may not fully capture the multidimensional nature of borderline symptomatology and social or occupational functioning.

A further limitation concerns the granularity of treatment exposure data. Although psychotherapy sessions were routinely scheduled on a weekly basis and we were able to report the duration of treatment before dropout for most patients who discontinued psychotherapy, session-by-session attendance data were not available in the routine clinical database. Therefore, we could not determine the exact number of sessions attended by each patient, the exact time between intake and the actual start of psychotherapy, or the exact number of sessions completed before dropout. Future studies should collect session-by-session data to provide a more precise analysis of treatment engagement and premature discontinuation.

Finally, dropout was operationalized as unplanned treatment discontinuation without differentiation of underlying motivations, restricting inferences regarding the psychological and contextual mechanisms contributing to attrition. Future research employing larger, multisite samples and multimethod assessment is warranted to elucidate how dispositional and clinical factors shape psychosocial functioning and treatment completion.

Conclusions

Taken together, these preliminary findings suggest that, in help-seeking young adults attending a specialized early intervention service, borderline symptom burden is a more proximal and robust correlate of psychosocial functioning than broader maladaptive trait domains, age, or sex. In contrast, baseline predictors of psychotherapy dropout appeared less consistent and should be interpreted as tentative: disinhibition, borderline symptom severity, and higher baseline functioning showed signals of association with discontinuation, but with considerable uncertainty and small effect sizes. Clinically, the pattern supports a shift away from viewing disinhibition and borderline severity as straightforward dropout "risk markers" toward conceptualizing them as indicators of relational intensity that require structured, reflective, and well-supported therapeutic responses. At the same time, the observation that better functioning was linked to higher dropout underscores the need not to assume that higher baseline resources protect against premature termination and to attend carefully to ambivalence, role demands, and expectations in this subgroup.

Within the constraints of a modest sample size and a highly specialized service context, the study highlights both the promise and the limits of relying on baseline individual-difference variables to anticipate treatment trajectories.

Future research in larger, more heterogeneous youth samples, integrating dimensional personality assessment with process-level measures of the therapeutic relationship and rupture-repair dynamics, will be crucial to clarify when and how personality pathology and functioning contribute to engagement, continuity of care, and long-term outcomes.

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