# An Exploration of the Emotional Experiences of Therapists when Working with Individuals With Borderline Personality Disorder

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**Abbreviations**

| | |
|---|---|
| BPD | Borderline Personality Disorder |
| CAT | Cognitive Analytic Therapy |
| CBT | Cognitive Behavioural therapy |
| Consult | Consultation team |
| DBT | Dialectal Behaviour Therapy |
| EMDR | Eye Movement Desensitization and Reprocessing |
| GAF | Global Assessment of Functioning |
| HTA | Health Technology Assessment |
| MDD | Major Depressive Disorder |
| RCT | Randomised Control Trial |

## Introduction to the thesis

This thesis contains an overview of the emotions therapists experience when working with individuals with Borderline Personality Disorder (BPD). It contains a systematic review and empirical paper which will be prepared for publication and are presented in separate chapters.

Chapter one of this thesis describes a systematic review of the literature exploring therapists' emotions when working with individuals with BPD. The review utilised a systematic process to establish the quality of the included studies and the subsequent synthesis of their findings has taken this into consideration. The search process is described in detail to allow transparency and enable the search to be replicated. Of the 16 studies included in the review, 14 used quantitative methods and four were case studies. The review highlights the complexity of working with the client group and the variety of emotions therapists may feel. It also describes therapist and client characteristics which may influence the therapists' emotional experience. The review concludes that there is a need for further qualitative research into this area, to gain a greater understanding of therapists' emotional experiences.

Chapter two contains an empirical paper exploring the emotional experiences of therapists whilst implementing Dialectical Behaviour therapy (DBT), a psychological intervention designed for use with individuals with BPD which has demonstrated efficacy. The aim of this research was to establish therapists' emotions whilst implementing the therapy and explore the factors influencing them. To investigate this, Interpretative Phenomenological Analysis was used to analyse the data from interviews with nine DBT therapists. This revealed five themes which broadly described therapists' experiences whilst adapting to DBT, therapists feeling their emotions were contained by various aspects of the approach and the importance of support from others. When considering the literature from the systematic review and empirical paper, this study appears to be the first to use a

robust qualitative methodology to explore therapist emotions and therefore adds to the existing literature in this area.

It is important to contextualise the following research. The understanding of personality disorder is shifting from a categorical to a dimensional approach. Historically, personality disorder has been conceptualised by a categorical approach e.g. the presence or absence of criteria as listed within the Diagnostic and Statistical Manual-IV and DSM-5. The DSM-5 proposed that a dimensional model may be more appropriate than the categorical model it utilises currently. A dimensional approach explores the extent to which certain criteria are present and allows personality characteristics to be considered along a continuum (American Psychiatric Association, 2013). The next edition of the DSM is likely to include this conceptualisation of personality disorder and therefore future research may utilise different language regarding it. In the near future, there may be significant changes in the way personality disorder is conceptualised and our understanding of it. However, the following thesis utilises the current categorical conceptualisation of personality disorder, as to date this is the system still in use.

# The Emotions Therapists Experience when Working Therapeutically with Clients with Borderline Personality Disorder: A Systematic Review

Chapter 1: Systematic Review

Kayleigh Syrett

# Chapter 1. Systematic Review

## 1.1 Abstract

Despite reviews exploring the emotions experienced by emergency and nursing staff when working with individuals with Borderline Personality Disorder (BPD), to date there is no review summarising the experiences of therapists. Therefore, the aim of this review is to systematically review the available literature about the emotions therapists experience when working therapeutically with clients with BPD. Psycinfo, Scopus, Medline, Web of Knowledge and CINAHL were searched to identify relevant articles. The inclusion criteria for the search were; therapists or counsellors working with adult clients with BPD, utilising any therapy. The comparators were any other clients accessing therapy and the outcomes considered were emotions, reactions, attitudes and health outcomes. 16 papers were identified; 12 quantitative papers and four case studies. Therapists experience a wealth of strong emotions when working with clients with BPD. There were two client characteristics which influenced the emotions experienced by therapists, client burnout at the beginning of therapy and level of patient functioning. Therapist characteristics which may influence emotions were specialist training, primary discipline, experience, age, therapist expectations and the boundaries therapists set. In conclusion the author recommended that therapists are provided with sufficient support, such as supervision, to prevent strong emotions impacting upon the therapeutic relationship. Therapists may also benefit from accessing specialised training in BPD such as mindfulness, Dialectical Behaviour Therapy or Mentalisation Based Therapy. To date this area has not been researched using robust qualitative methodologies and the use of these would allow a greater understanding of the emotional experiences of therapists.

Key words: Systematic review, Borderline Personality Disorder, Therapist, emotions

## 1.2 Introduction

Borderline Personality Disorder (BPD) is a personality disorder which is estimated to affect one percent of the population in the United Kingdom (Coid, Yang, Tyrer, Roberts & Ulrich 2006). It is a diagnostic label which can cause controversy, as evidence has demonstrated that those with BPD can experience stigmatisation from professionals and themselves (Aviram, Brodsky & Stanley, 2006; Rüsch et al., 2006). To be diagnosed with BPD an individual must meet a minimum of five out of nine criteria, as described in the DSM-5 (American Psychiatric Association, 2013). These criteria describe a "pervasive pattern of instability of interpersonal relationships, self-image, affects and marked impulsivity" (American Psychiatric Association, 2013; p663). A large proportion of individuals with BPD present with high risk behaviours, such as suicide attempts or threats and para-suicidal behaviours like self-harm. Professionals working with this client group often report that progress is arduous and outcomes can be modest (Livesley, 2001). Individuals with BPD can be difficult to retain in therapy, may engage in therapy-interfering behaviours and their presentation may provoke emotional reactions in clinicians working with them (Linehan, 1993). Individuals with BPD tend to express heightened emotions and therefore, it may be expected that therapists working with them will also experience strong emotions. Individuals with BPD appear more likely to evoke negative counter-transference reactions than individuals with depression (Liebman & Burnette, 2013). There is a wealth of research evidencing the impact upon professionals of working with this high risk client group (Cleary, Siegfried, & Walter, 2002; Bland & Rossen, 2005). Professionals working with patients who are suicidal and self-harming experience higher stress levels (Loughrey, Jackson, Molla, & Wobbleton, 1997; Melchior, Bours, Schmitz, & Wittich,1997; Burnard, Edwards, Fothergill, Hannigan, & Coyle, 2000) and therapists voice trepidation and concern about working with this client group (Brody & Farber, 1996).

## 1.3 Summary of existing literature as a result of scoping searches

Despite the widespread view that working with clients who present with BPD characteristics is "difficult", there is no comprehensive review of the impact of working with this client group on the therapist. Reviews exist exploring the attitudes of nursing staff towards clients with BPD (Winship, 2010) and the attitudes of

emergency and psychiatric staff towards self-harm (Rees, Rapport, Thomas, John & Snooks, 2014; Saunders Hawton, Fortune, & Farrell, 2012). Despite the existence of literature about therapists' experiences when working with BPD, this has not been reviewed systematically and therefore there is the opportunity to explore and synthesise the research in this area. Therefore the research question for this literature review is: *What emotions do therapists experience when working therapeutically with clients with BPD?*

## 1.4 Methods

### 1.4.1 Search strategy

Thorough scoping searches were carried out to establish the availability of literature, to explore search terms and refine the research question. The key terms used for the review were decided upon as they returned a manageable number of results (rather than several thousand results) and produced the most relevant articles. The International Prospective register of Systematic reviews website (University of York, 2015) was checked to establish if there was a current review being undertaken in this area and there was not. A protocol was written for the systematic review and approved by both research supervisors. Then to begin the review Psycinfo, Scopus, Medline, Web of Knowledge and CINAHL were searched on the 25/01/2015, without defining a time period and using the key terms:

- Borderline Personality Disorder AND therapist

The returned articles from each database were exported to the reference management software package Refworks and exact duplicates deleted. The reference section of relevant articles were reviewed to identify additional relevant articles, identifying a further six articles.

### 1.4.2 Screening and selecting

*The titles and abstracts of the returned results were screened against the inclusion and exclusion criteria seen in Table 1 and studies which did not meet the inclusion criteria discounted. The criteria were decided upon by exploring the articles returned during the scoping exercises and using the Boland, Cherry and Dickson (2014) reference. Clients under 18 years old were excluded due to difficulties with applying the BPD diagnosis in this age group (Laurenssen, Hutsebaut, Feenstra, Van Busschbach, & Luyten, 2013) and also because age could act as a confounding variable. Only peer reviewed journals were included in the review. Dissertations were excluded because they may not have received the level of scrutiny of a peer reviewed journal. Once the criteria were applied 34 articles remained. The full articles were sourced and screened against the inclusion and exclusion criteria and 16 of these were considered relevant, retrieving 12 experimental studies and four case studies. It was not possible to access the full text for three of the articles due to the age of the papers. The reason for an article being discarded at this stage can be seen in Table 2. The search process and the number of articles returned at each stage of the process can be seen*

Figure 1. The included articles were screened against the inclusion and exclusion criteria by a second assessor to ensure they were appropriate for inclusion in the review.

*Table 1. The inclusion and exclusion criteria applied to the article*

| | **Include** | **Exclude** |
|---|---|---|
| **Patient population** | Therapists/counsellors working with adult clients (>18 years old) with Borderline Personality Disorder | Emergency staff<br>Clients under 18 years old<br>Clients with other diagnoses |
| **Interventions** | Therapy (not specified) | Case management<br>Pharmocological interventions |
| **Comparators** | Other clients who access therapy<br>Other Personality Disorders | |
| **Outcomes** | Emotions, reactions, attitudes, health outcomes e.g. stress | |
| **Study design** | Randomised Control Trials, Quasi-experimental designs, Cohort study, case control, case studies. | |
| **Language** | English | Non-English |
| **Format** | Peer reviewed journal | Dissertations |

*Table 2: Reasons for articles being excluded*

| Reason reference excluded | Name |
|---|---|
| Does not discuss a BPD population or discusses another client population | Adelson (1995)<br>Holmqvist & Armelius (1996 & 2004)<br>Perry, Bond & Presniak (2013) |
| Describes transference and no countertransference | Bradley, Heim & Westen (2005) |
| Discusses very little about therapists' emotions or reactions | Carsky (2013)<br>Narud, Mykletun & Dahl (2005) |
| Description of theory no case material | Chessick (1993)<br>Mchenry (1994)<br>Newman (1999) |
| Unable to source full text due to age of article | Hoyt & Farrell (1984)<br>Kocmur & Zavasnik (1993)<br>Yeomans (1993) |
| Discusses alliance rather than therapist attitudes or emotions | Lingiardi, Filippucci & Baiocco (2005) |
| Not enough detail about the attitudes or emotions to use | Herschell, Lindhiem, Kogan, Celedonia & Stein (2014) |
| Clients are aged 15-24 (below age criteria) | Perseius, Kaver, Ekdahl, Asberg & Samuelsson (2007) |
| Not relevant when studied more closely | Ryle (1995)<br>Chatziandreou, Tsani, Lamnidis, Synodinou, & Vaslamatzis (2005) |
| Unclear whether a therapeutic intervention is being provided | Holmqvist (1998) |

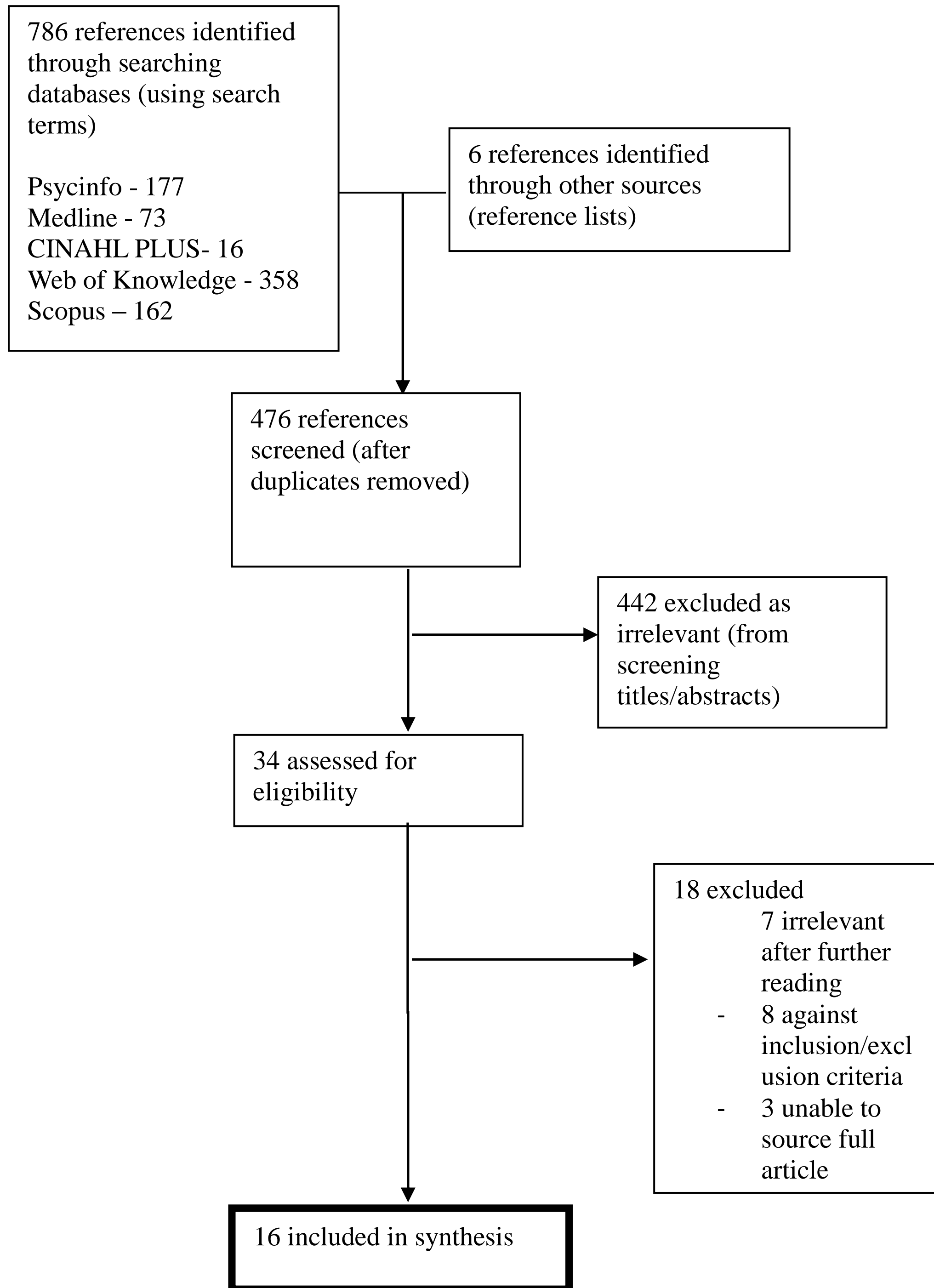


*Figure 1. PRISMA flowchart demonstrating the results returned at each stage of the process.*

### 1.4.3 Data extraction

A data extraction form was created to extract descriptive and analytic data such as outcomes. The data extraction form was piloted on two studies to ensure it extracted the correct data before being used for all the studies. The extracted data were then input into Table 3, Table 4 and Table 5 below.

*Table 3. Study characteristics table for the quantitative papers.*

| Author(s) | Study design | Intervention (therapy) | Study population | Type of therapist | Experience of therapist | Country | Comparators | Measures used | Method | Data analysis method |
|---|---|---|---|---|---|---|---|---|---|---|
| Betan et al.(2005) | Cross sectional | Psychodynamic<br><br>Eclectic<br><br>Cognitive behavioural therapy | Clients with a variety of Axis I and II disorders.<br><br>N=181 | N=181<br><br>Psychologist=141<br><br>Psychiatrist =40<br><br>106M 75F | > 3 years experience who perform ≥ 10 hours per week of direct patient care | USA | Clients with a variety of Axis I and II disorders. | Countertransference questionnaire<br><br>Clinical data form<br><br>DSM-IV | Asked therapists to consider a non-psychotic patient whom they had seen for a minimum of 8 sessions. | Factor structure of the countertransference questionnaire<br><br>Partial correlations |
| Bourke & Grenyer (2010) | Cross sectional | CBT<br><br>Interpersonal-dynamic therapy | N=40 BPD clients | N=20<br><br>3M 17F<br><br>Community healthcare | Doctoral level Psychologist=17<br>Masters level Psychologist=3<br><br>Range of experience= 2-14yrs<br>x̄ age= 34yrs | Australia | N=40 Clients with Major depressive disorder | Relationship Anecdotes Paradigm interview | Interviewed therapists Re four patients (2 BPD &2 MDD) | Core conflictual relationship theme-Liepzig/Ulm method<br><br>Multilevel modelling |
| Bourke & Grenyer (2013) | Cross sectional | CBT<br><br>Interpersonal dynamic | N=40 BPD clients<br><br>35F 5M<br><br>x̄ age= 32.75yrs | N=20<br><br>17F 3M<br><br>Community healthcare | Doctoral level Psychologists N=17<br><br>Masters level Psychologists N=3 | Australia | N=40 Major depressive disorder clients<br><br>26F 14M<br><br>x̄ age=41.1yrs | The Psychotherapy Relationship Questionnaire | Recorded interview Re 4 of their patients and then completed PRQ | Multilevel modelling<br><br>Content analysis |
| Brody & Farber (1996) | Cross sectional | Psychodynamic<br><br>Behavioural<br><br>CBT<br><br>Other | N=336 | x̄ age=42 | x̄ years of therapy experience=13.7<br><br>In Graduate school N=71<br>Interns N=39<br>Licensed practitioners N=218 | USA | Patients with Depression or Schizophrenia | Psychotherapist background information<br><br>Experience and Attitudes scale<br><br>Vignette rating scale | Questionnaires completed about emotional experiences in therapy and about vignettes. | ANOVAs<br><br>Paired t-tests<br><br>Univariate repeated measures ANOVA |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Colli et al.(2014) | Cross sectional | Psychodynamic<br><br>CBT | N=1<br><br>Variety of PDs<br><br>Age=<br>mid 30s to early 50s | N= 203<br><br>Psychologists 65%<br><br>Psychiatrists<br>35% | x̄ =10 years as a psychotherapist<br><br>SD = 3<br>Range = 3-7 years | Italy | Cluster A, B & C personality disorders | Therapist response Questionnaire<br><br>Shedler-Westen Assessment procedure-200 | Considered a client they are working with and then answered questionnaires | Partial correlations (two-tailed) |
| Liebman & Burnette (2013) | Cross-sectional RCT | DBT<br><br>Mindfulness<br><br>CBT<br><br>Psychotherapeutic<br><br>Education skills<br><br>Other | 1 BPD client aged 15 OR 25 years | N=560<br>147M 407F<br><br>Psychologist=257<br><br>Psychiatry=81<br><br>Psychotherapy/social work= 231 | 0-5yrs= 99<br><br>6-20yrs=209<br><br>20yrs+ = 249<br><br>No. of BPD clients worked with=<br>0-5=125<br>6-20= 197<br>20+ = 201 | USA | None | Choice of 7 diagnoses<br><br>Questionnaire created about countertransference | Read case vignettes describing a client with BPD, age and gender of client was changed. A diagnosis had to be applied. | Chi square tests<br><br>Logistic regression analysis<br><br>MANOVA |
| Linehan et al. (2000) | Cohort | DBT | N=70<br><br>Women with BPD<br><br>Aged 18-45 years | N=30<br><br>Psychotherapists in private practice | 10+ years of doing psychotherapy<br><br>Average No. of BPD clients seen=13<br><br>60% Doctoral degree<br><br>40% Masters degree | USA | None | Maslach Burnout Inventory<br><br>Questionnaire about clinical experience<br><br>Expectancies questionnaire | Asked therapists about their work with clients using questionnaires | Factor analysis<br><br>Scree plot<br><br>Regression analysis |
| McIntyre & Schwartz (1998) | Non-RCT | Behavioural<br>Cognitive<br>Psychodynamic<br>Systemic | Client with BPD | N=155<br>53M 102F | Range=3-27 yrs<br><br>x̄ =14.83 S.D=6.21 | USA | Clients with Major depressive disorder | Impact Message Inventory<br>Stress Appraisal Scale | Listened to interviews with a client either with BPD or MDD | ANOVA<br><br>Pearson-correlation coefficients |
| Miller et al (2010) | Cohort<br><br>Pilot study | DBT<br><br>Psychodynamic | Recently suicidal patients with BPD traits<br>Age=<br>18-25 | N=6<br>4F 2M | Therapists in training | USA | N/A | The Working Alliance Inventory-short form<br><br>Likert scale to rate session difficulty | Pre and post session saliva samples taken (to assess for stress response) | Linear mixed model/hierarchical linear model |

| Rosenkrantz & Morrison (1992a) | Cross-sectional RCT | N/K | Clients with BPD | N=155 Members of the American Psychological association | N/K | USA | N/A | The Semantic Differential Personal Boundary Questionnaire<br><br>Depressive experience Questionnaire | Read vignettes of either a Rewarding or withdrawing client with BPD | ANOVA |
|---|---|---|---|---|---|---|---|---|---|---|
| Rosenkrantz & Morrison (1992b) | Cross-sectional RCT | N/A | Patients with BPD | N=158 Members of the American Psychological association | N/K | USA | None | The Semantic Differential forms<br><br>Background questionnaire | Vignettes of rewarding or withdrawing objects relations. Told to imagine working with client and complete questionnaire. | ANOVA |
| Rossberg et al. (2007) | Cohort study | Day treatment programme analytical & CBT group therapies | N=71 Cluster A, B & C clients | N=11<br>2M 9F<br>x̄ age=41 | N/K | Norway | Clients with cluster C Personality disorders | Feeling word checklist-58<br><br>SCID-II<br><br>Mini International neuropsychiatric interview | Asked to complete feeling word checklist about the last conversation they had with the patient | 2-tailed independent sample t tests<br><br>Levene's test for equality of variances<br><br>Pearson product moment coefficient |

*Table 4. The outcomes for the quantitative papers*

| Author | Outcomes |
|---|---|
| Betan et al.(2005) | Correlations for BPD = Special/overinvolved r=0.23. df =170, p=0.002 |
| Bourke & Grenyer (2010) | Effect of diagnosis = ROS=-1.29, SE=0.19, deviance =202.54, RSO=-1.04 SE=0.19, deviance =198.70, RSS=-1.41 SE=0.21, deviance =22.17 |
| Bourke & Grenyer (2013) | Positive working alliance -0.34 (0.14) p<0.05 deviance = 148.91 -0.34 (0.14), Therapist 0.14 (0.16), deviance= 148.18 Hostility- 0.75 (0.17) p<.05, deviance= 181.76, 0.76(0.17), deviance= 181.74 |
| Brody & Farber (1996) | Acknowledgment of liking patient F(2,620)=6.88, p<.001, Anger ($\bar{x}$ =3.56 SD=.77), Irritation($\bar{x}$ =3.58 SD=.72), Liking the BPD patient($\bar{x}$ = 2.41 SD=.67), Empathy($\bar{x}$ =2.82 SD=.71), Nurturance($\bar{x}$ =2.75 SD=.74), Think about patient($\bar{x}$ =2.90, SD=.76), Give advice($\bar{x}$ =2.93, SD=86), Run overtime($\bar{x}$ =2.57,SD=.73) |
| Colli et al.(2014) | Borderline partial correlations for: Criticised/mistreated=0.12, Helpless/inadequate=0.36 p≤0.001, Positive= -0.01, Parental/protective=-0.01, Overwhelmed/disorganised= 0.51 p≤0.001, Special/over-involved=0.22 p≤0.001, Sexualised=0.08, Disengaged=-0.11, Higher functioning= r=0.29, p≤0.001 |
| Liebman & Burnette (2013) | Empathy ( $\bar{x}$ =3.05 SD=0.53) Conduct problem ($\bar{x}$ =1.71 SD= 0.42) Distrust ($\bar{x}$ =2.79,SD=0.42) Dangerousness ($\bar{x}$ = 2.76 S.D=0.42)<br>Effect of diagnosis on clinician reactions= Wilks' $\lambda$ = .973, F(7,529) = 2.08, p<.05, Diagnosis of BPD given (impact on empathy)= F(1,537) =4.16, p<.05, M= 3.03 (.03). Empathy & Primary discipline= F(2, 389) = 4.7, p=.0, Empathy & special training= F(1,389) -12.29, p= .001<br>Chronicity & treated more clients= $r^2$ = -.12 F(1, 389) =7.02, p<.01, Chronicity & special training =F(1,389)= 5.31, p<.05<br>Discipline & impact on distrust=F(2, 389) = 3.40, p<.05 |
| Linehan et al. (2000) | Client severity & therapist emotional exhaustion = F change(3,16 )=.641,ns, total $R^2$ =.123<br>Client severity & therapist depersonalisation =Fchange (3,16)=.419, ns, total $R^2$=.087, Expectations & emotional exhaustion = Fchange(1,16)=5.711 p<.05, total $R^2$=.290, Pre-treatment client Emotional Exhaustion & therapist exhaustion after 4 months =r=.27,p=.07<br>Pre-treatment client depersonalisation & therapist depersonalisation after 4 months =r=.28,p=.06 |
| McIntyre & Schwartz (1998) | Dominance (F= 14.78 PR>F = .001 p<.05), Hostile (F=8.95 PR>F .001 p<,05) Difficulty (F= .13 PR>F =.72), Experience & feelings of client: Dominance r -.23 prob.>r =.05, Difficulty r-.08 prob>r =.49, Secondary appraisal=BPD ($\bar{x}$ =21.03, SD=6.34) MDD ($\bar{x}$ =19.23, SD=5.40) |
| Miller et al (2010) | AA levels pre & post treatment= F(1,21.75)=4.91, p=.038, CC levels pre & post treatment =F(1,27.86)=4.40, p=.45, Working alliance/C levels=b=-.004, p=.039 |
| Rosenkrantz & Morrison (1992a) | Self-evaluation & Introjective depression F(1,148)= 9.98, p<.01, Self-evaluation & boundary=F(1,148) = 4.52, p<.05, Anaclitic depression & object relations unit=F(1,148)= 12.70, p<.01, High anaclitic therapists & Withdrawing condition=F(1,148) = 5.50, p<.05, High boundary therapists & Patient A & B= F(1,74)= .80,ns, Patient B therapist, boundary & self-evaluations=F(1,73)=.23,ns, Anaclitic depression therapist & evaluation of patient=F(1, 148)= 3.85, P<.05, Introjective depression therapist & evaluation of patient F(1,148)= 5.38, p<.05, Boundary dimension & Object relations unit=F(1,148)= 4.75, p<.05, High boundary therapists' evaluation of patient A & B= F(1,74)=1.58,ns |
| Rosenkrantz & Morrison (1992b) | 1.Therapists' view of self: Rewarding objects relations unit=Positive evaluations F(1,153)=77.67, p<.01, Active F(1,153) =6.44, p<.01,Powerful F(1,153)=47.15, p<.01 2.Therapists' views of patient: Rewarding vs withdrawing F(1,154)= 37.72, p<.01, Active F(1,154) =10.90, p<.01, Objects relations, Patient & order F(1,154)=4.64, p<.03, Patient A, withdrawing presented first F(1,154)=28.28, p<.01 |
| Rossberg et al. (2007) | Start of treatment=Therapists confidence towards Cluster C (P=.029) End of treatment= Confident t=-2.24, p= .034, Rejected= t=2.88, p=.008, On guard= t=2.76, p=.010, Overwhelmed= t=2.28, p=.030, Inadequate= t=3.01, p=.005 Levene's= Rejected F= 8.537, p= .007, Inadequate F= 5.909, p=.022 |

*Table 5. Results of the data extraction exercise for the case studies.*

| Author(s) | Study type or design | Intervention (therapy) | Duration of therapy | Study population | Type of therapist | Experience of therapist | Country | Emotions reported |
|---|---|---|---|---|---|---|---|---|
| Bot (1997) | Case study | N/K | 6 months | A female client with BPD traits | Female Trainee Clinical Psychologist with interests in self-esteem and assertiveness | Trainee<br><br>3 years providing individual & group psychotherapy | Canada | Guilt, failure, uncomfortable, repulsion, anger, relief, responsibility. |
| Carsky & Yeomans (2012) | Case example | N/K | 2 years | A male client with previous suicide attempts | Male | Experienced therapist with a reputation for working with "very troublesome" patients. | USA | Responsibility, involved, concern, invested, anxiety, apologetic. |
| Poggi (1992) | Case study | Psychoanalytic | 3.5 weeks | A female client, aged 35 years admitted to an inpatient unit due to concerns Re her suicidal behaviour | Psychotherapist | N/K | USA | Anxiety, Special/grandiose/narcissistic anger, guilt, fear, disappointment, feeling out of control, helpless. |
| Wheelis & Gunderson (1998) | Case study | Psychodynamic psychotherapy | 1 year | A 35 year old female client with BPD admitted to a psychiatric inpatient unit due to suicidal thoughts and increase in alcohol abuse | Second year resident | N/K | USA | Challenged, anxiety, controlled, relief, fury, devalued, ridiculed. |

## 1.5 Quality assessment

The relevant papers used a variety of different methods to address their research questions. These included; cross-sectional, Randomised Control Trials (RCT), quasi-experimental designs, cohort studies and case studies. To decide upon an appropriate quality assessment tool the following resources were used; Boland et al. (2014), the Health Technology Assessment (HTA) report (Deeks et al., 2003) and the guidance from the Centre for Review and Dissemination (2009). Following this, tools by Downs and Black (1998) and Thomas (no date) were piloted for two of the papers to assess their appropriateness. The Downs and Black (1998) tool was then used to assess the 12 quantitative papers, this tool was considered both reliable and valid by the HTA and during the pilot process it thoroughly assessed the quality of the studies. Please see Table 6 below for the results of the quantitative quality assessment. To establish the reliability of the quality assessment, a second assessor conducted a quality assessment of two of the papers using the Downs and Black tool (1998) and any discrepancies were discussed.

### 1.5.1 Quality assessment results for quantitative studies

When reporting the findings, only three of the studies reported the probability values. The remaining studies relied upon abbreviations such as $p<0.05$. It was also difficult to establish if the samples who agreed to take part in the studies were representative of the population, as demographic information of the sample was not compared to the wider population of therapists for nine out of the twelve studies. Half of the studies did not specify the validity or reliability of the outcome measures they used to measure emotions. One of the studies which claimed to randomly assign participants to conditions did not use a random method of allocation to do this i.e. they assigned every other participant to alternate conditions. However, the included studies had strengths in several important areas. All of the studies used appropriate statistical tests to investigate their research questions. All clearly defined the hypothesis, the outcomes to be measured and participant characteristics. The approached population appeared to be representative of the population and the findings were described clearly. Overall the quality of the included studies was satisfactory as they met criteria for these important areas. However, there appeared to be a disparity between the quality of the included studies

and therefore they were ranked to allow for greater emphasis on better quality studies. To do this, the results were first ranked by the number of criteria they achieved in the quality assessment in descending order. Then the studies were ranked by the number of criteria they were missing (ascending) and the number of not specified responses (ascending). The average rank was then calculated by adding the three ranks together and dividing by three. Table 7 demonstrates how the studies compare. The quality assessment exercise demonstrates that the following studies were of better quality; Miller et al. (2010), Liebman and Burnette (2013), Linehan, Cochran, Mar, Levensky and Comtois (2000), Rossberg, Kareurud, Pederson and Friis (2007), McIntyre and Schwartz (1998), Brody and Farber (1996) and Betan, Heim, Conklin and Westen (2005). It should be noted that the Miller et al. (2010) study was a pilot with a small sample size and therefore caution should be exercised in generalising these findings but the results of the quality assessment suggest that the methods used were robust.

*Table 6. The results of the quantitative quality assessment (Downs & Black, 1998)*

| | Reporting | | | | | | | | | External validity | | | Internal validity-bias | | | | | | | Internal validity- confounding (selection bias) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Author** | **Hypothesis** | **Outcomes to be measured defined** | **Participant characteristics** | **Intervention described** | **Confounding variables considered** | **Findings clearly described** | **Random variability described** | **Drop out explained** | **Probability values provided** | **Approached population representative** | **Sample representative** | **Facilities/location/settings representative** | **Subjects blind?** | **Researchers blind?** | **Data dredging occurred?** | **Adjustment for different follow up times?** | **Appropriate statistical tests used?** | **Reliable compliance with the intervention?** | **Outcome measures reliable and valid?** | **Different intervention groups or cases & controls recruited from same population?** | **Randomised to intervention groups?** | **Randomised assignment concealed from participant and researcher?** | **Adjustment for confounding variables?** | **Drop outs considered?** |
| Betan, Heim, Conklin &Westen (2005) | √ | √ | √ | n/a | √ | √ | √ | n/a | x | √ | √ | √ | n/a | n/a | √ | √ | √ | n/a | √ | n/a | n/a | n/a | √ | n/a |
| Brody & Farber (1996) | √ | √ | √ | √ | √ | √ | √ | n/a | x | √ | x | √ | √ | n/a | √ | n/a | √ | n/a | x | √ | x | x | √ | n/a |
| Bourke& Grenyer (2010) | √ | √ | √ | √ | √ | √ | √ | √ | x | ns | ns | x | n/a | n/a | √ | n/a | √ | n/a | √ | n/a | n/a | n/a | n/a | n/a |
| Bourke& Grenyer (2013) | √ | √ | √ | √ | √ | √ | √ | n/a | x | x | x | x | n/a | n/a | √ | n/a | √ | n/a | x | n/a | n/a | n/a | √ | n/a |
| Colli (2014) | √ | √ | √ | √ | √ | √ | √ | n/a | x | √ | x | x | n/a | n/a | √ | n/a | √ | x | x | x | n/a | x | √ | √ |

| | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Liebman & Burnette (2013) | √ | √ | √ | √ | √ | √ | √ | n/a | x | √ | x | x | √ | √ | √ | √ | √ | x | √ | √ | √ | x | √ | x |
| Linehan et al (2000) | √ | √ | √ | √ | √ | √ | √ | x | x | √ | x | x | n/a | n/a | √ | √ | √ | √ | x | n/a | n/a | n/a | √ | √ |
| McIntyre & Schwartz (1998) | √ | √ | √ | √ | √ | √ | √ | n/a | √ | √ | x | ns | √ | x | √ | n/a | √ | n/a | √ | √ | √ | x | √ | n/a |
| Miller et al (2010) | √ | √ | √ | √ | √ | √ | √ | n/a | √ | √ | √ | √ | n/a | n/a | √ | √ | √ | √ | √ | √ | n/a | n/a | √ | n/a |
| Rosenkrantz & Morrison (1992a) | √ | √ | x | √ | x | √ | √ | n/a | x | √ | ns | ns | √ | √ | √ | n/a | √ | n/a | x | √ | √ | x | x | n/a |
| Rosenkrantz & Morrison (1992b) | √ | √ | x | √ | x | √ | x | n/a | x | √ | x | x | √ | √ | √ | n/a | √ | n/a | x | √ | √ | x | x | n/a |
| Rossberg Kareurud Pederson & Friis (2007) | √ | √ | √ | √ | x | √ | √ | √ | √ | √ | √ | x | x | n/a | √ | √ | √ | n/a | √ | √ | n/a | n/a | x | √ |

*Table 7. The average rank for the quality assessment.*

| **Average rank** | | √ | **X** | **N/S** |
|---|---|---|---|---|
| 3.33 | Miller et al. (2010) | 18 | 0 | 0 |
| 4.66 | Liebman & Burnette (2013) | 17 | 6 | 0 |
| 5 | Linehan et al. (2000) | 14 | 5 | 0 |
| 5 | Rossberg et al. (2007) | 16 | 4 | 0 |
| 5.66 | McIntyre & Schwartz (1998) | 16 | 3 | 1 |
| 6 | Brody & Farber (1996) | 14 | 5 | 0 |
| 6 | Betan et al. (2005) | 14 | 0 | 0 |
| 7.33 | Rosenkrantz & Morrison (1992b) | 11 | 9 | 0 |
| 7.33 | Colli et al. (2000) | 12 | 7 | 0 |
| 8.66 | Bourke & Grenyer (2010) | 11 | 2 | 2 |
| 8.66 | Bourke & Grenyer (2013) | 10 | 5 | 0 |
| 9.66 | Rosenkrantz & Morrison (1992a) | 12 | 6 | 2 |

### 1.5.2 Quality assessment results for the case studies

To assess the quality of the four case studies included in the review, a check-list was created using questions from the critical appraisal skills programme check-list for case control studies, the check-list for qualitative research (CASP 2015) and a paper by Lee, Mishna and Brennenstuhl (2010) which describes factors that should be considered when critically evaluating case studies. The check-list was then piloted with two of the case studies before proceeding to appraise the remaining ones. Please see Table 8 below for the results of the quality assessment of the case studies.

The four studies described the following in detail; the subject (participant), the relationship between the subject and author and any ethical issues. They also used suitable methodology, included ample reflection, reflected the findings of other research (e.g. the quantitative studies) and were credible. The Poggi (1992) and Wheelis and Gunderson (1998) studies were of higher quality and included descriptive excerpts of the interactions with the subject, made attempts to triangulate data and gave more information about the provider, length of therapy and its content. They also described their constructs of BPD clearly and considered confounding variables.

*Table 8. The results of the case study quality assessment.*

| | External validity | | | | | | | | | Internal validity | | | | | | | | | Construct validity | | | Research design | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Author | Transferability or generalisability of findings1 | Subject described 1 | Dosage described 1 | Content described 1 | Context described 1 | Provider described 1 | Can the results be applied to the local population? 3 | Do the results of this study fit with other available evidence? 3 | How valuable is the research? 2 | Did the study address a clearly focussed aim? 3 | Credibility 1 | Triangulation used? 1 | Logic model? 1 | Several subjects? 1 | Multiple sources of data? 1 | Multiple time points for data collection 1 | Did the authors account for confounding variables? 3 | Was the recruitment strategy appropriate to the aims of the research? 2 | Are the constructs used clearly defined? 3 | Use of case study database 1 | Several subjects? 1 | Triangulation of data, theory or investigator 1 | Did the authors use objective measurements? 3 | Is a qualitative methodology appropriate? 2 | Has the relationship between researcher and participant been adequately considered? 2 | Have ethical issues been considered? 2 | Suitable reflection? 2 | Sufficient excerpts included? |
| Bot (1997) | | √ | x | 1 | x | √ | 1 | √ | 1 | √ | √ | x | x | x | x | x | 1 | ns | 1 | x | x | x | x | √ | √ | √ | √ | x |
| Carksy & Yeomans (2012) | | √ | 1 | √ | x | 1 | √ | √ | 1 | x | √ | x | x | x | x | x | x | ns | x | x | x | x | x | √ | √ | √ | √ | x |
| Poggi (1992) | | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | x | x | √ | √ | √ | ns | √ | x | x | √ | √ | √ | √ | √ | √ | √ |
| Wheelis & Gunderson (1998) | | √ | √ | √ | 1 | √ | √ | √ | √ | √ | √ | √ | x | x | √ | √ | √ | ns | √ | x | x | √ | x | √ | √ | √ | √ | √ |

Key

1. Lee et al. (2010)
2. CASP qualitative research checklist
3. CASP case control checklist

## 1.6 Summary of the quantitative results

As both quantitative and case studies were reviewed the decision was made to synthesise the literature separately, as suggested by Boland et al. (2014). Twelve quantitative papers were reviewed and their results synthesised in the narrative below. The results of the quality assessment were utilised to place greater emphasis on the studies of better quality.

### 1.6.1 The reactions of therapists when working with BPD clients compared to clients with other diagnoses

#### *1.6.1.1 The impact of diagnosis on empathy*

Clinicians who assigned a BPD diagnosis were less empathic than those who assigned other diagnoses (Liebman & Burnette, 2013). Brody and Farber (1996) found that BPD clients evoked the least amount of empathy when compared to patients with depression or schizophrenia. Bourke and Grenyer (2013) found that an empathic connection appeared to be more easily achieved with clients with Major depressive disorder (MDD) than BPD.

#### *1.6.1.2 Therapist expectations of therapy*

McIntyre and Schwartz (1998) found that therapists attributed higher scores for salience (caring and consequences), for clients with MDD rather than BPD, and hypothesised that therapists feel counselling MDD clients would be more beneficial and have greater potential for positive outcomes, than working with BPD clients. Bourke and Grenyer (2010) interviewed therapists about working with clients with BPD and MDD. They found that the therapists' wish for MDD patients was for therapy to provide support, and for BPD clients that therapy would assist them to become more independent. The therapists in the Liebman and

Burnette (2013) study were hopeful the BPD client would improve and that their difficulties were not due to a behavioural problem.

#### *1.6.1.3 Impact on therapist behaviour*

Therapists referred to the need to maintain boundaries in the BPD group and supervision appeared to have a greater role with this population (Bourke & Grenyer, 2013). The importance of supervision may be explained by the finding that therapists working with BPD clients experience greater emotional distress compared to those working with MDD (Bourke & Grenyer, 2010). When working with BPD clients therapists were less likely to allow sessions to overrun, think about them when not at work or to provide advice when compared to the other patient populations (Brody & Farber, 1996).

#### *1.6.1.4 The working alliance/engagement with client*

Therapists reported that their working alliance was more positive with MDD clients than BPD clients (Bourke & Grenyer, 2013). The strength of the working alliance with BPD clients was shown to reduce the level of stress experienced by trainee therapists; the greater the strength of the alliance, the greater the reduction in therapists' cortisol levels (Miller et al., 2010). The BPD group were viewed as withdrawing from therapy, whilst the MDD group were viewed as actively attending. Therapists felt more confident when working with MDD clients and more tempted to withdraw from individuals with BPD (Bourke & Grenyer, 2010). Patients with BPD evoked the highest levels of anger, irritation and the least amount of liking, empathy and nurturance (Brody & Farber, 1996). They also elicited higher average ratings of dominance, hostility and difficulty (McIntyre & Schwartz, 1998; Bourke & Grenyer, 2013). Clinicians believed that BPD clients were not to be trusted and that they were dangerous to themselves and others (Liebman & Burnette, 2013). BPD patients were also least likely to evoke behavioural demonstrations of being liked by the therapist (Brody & Farber, 1996). Almost one third (32.5%) of responses regarding BPD clients were categorised as very negative, compared to just 5.5% of the MDD group (Bourke & Grenyer, 2010). Therapists' responses towards themselves were also more likely to be negative when treating BPD compared to MDD (80% versus 28.9%) (Bourke & Grenyer, 2010).

However, clinicians also demonstrated positive attitudes towards the BPD client, expressing they liked them and suggesting the client was capable of making friends (Liebman & Burnette, 2013). There were no significant differences between the amount of support the therapists reported they gave the two client groups during therapy (Bourke & Grenyer, 2010). Therapists were not less engaged or interested in working with BPD clients than clients with depression or schizophrenia and felt more positively challenged than when working with depressed clients (Brody & Farber, 1996).

##### *1.6.1.5 Conclusions about the findings comparing BPD with MDD or other Axis I disorders*

When considering the degree of empathy felt towards the client, therapists were either less empathic, or found it harder to be empathic, towards clients with BPD, than clients with MDD, depression or schizophrenia. Diagnosis impacted upon the therapists' expectations for therapy with their BPD client when compared to clients with MDD e.g. therapists felt counselling BPD clients would be less beneficial and had less potential for positive outcomes. Therapists wanted their intervention to help BPD clients be more independent rather than to provide support to them. Therapists experienced more emotional distress when working with a BPD population than when working with MDD and subsequently maintaining boundaries and receiving supervision were seen as more important. The findings from the studies suggest that therapists may feel more negatively towards clients with BPD than those with MDD in several ways. Therapists felt their working alliance was less positive, that BPD clients withdrew from therapy and therapists were also more tempted to withdraw from them. Therapists gave more negative responses and were less likely to demonstrate they liked BPD clients, expressing more anger, irritation, hostility and less liking, empathy and nurturance. Therapists felt the difficulty involved in working with BPD clients was greater and felt less confident about working with them. Therapists were also more negative about themselves when treating BPD clients. In conclusion, when comparing therapist responses to clients with a BPD diagnosis versus those with MDD or other Axis I disorders, the therapists appeared to experience more negative responses or emotions towards clients with BPD.

#### *1.6.1.6 Comparison between BPD and other Personality Disorders*

Three studies explored the reactions of therapists when working with BPD and other personality disorders. The following studies have "clustered" the personality disorders as they appear in the DSM-IV and DSM-5 e.g. cluster A, B and C. Cluster A personality disorders are; Paranoid, Schizoid or Schizotypal personality disorders. BPD is categorised within the cluster B personality disorders which include; BPD, Narcissistic, Histrionic, and Antisocial personality disorders. Cluster C personality disorders are; Avoidant, Dependent or Obsessive-Compulsive personality disorders.

Rossberg et al. (2007) explored therapist countertransference towards patients at the beginning and end of a day treatment programme. At the beginning of the programme, therapists reported feeling less confident towards patients with cluster A or B personality disorders, than those with cluster C. At the end of the programme, therapists felt less confident and more rejected, on guard, overwhelmed and inadequate towards the cluster A or B patients than cluster C patients. There was greater variance in the responses from therapists when reporting feeling rejected and inadequate in their interactions with patients with cluster A or B personality disorders. The authors attributed this finding to "splitting" within the therapists, which is the tendency for professionals working with a personality disorder client group to have strong opinions or feelings towards a client (Linehan, 1993).

Betan et al. (2005) found differences between the countertransference reactions for the various clusters. A significant association was found between the cluster A personality disorders and criticized/mistreated transference. There was an association between the cluster B patients and the therapist feeling disengaged and a negative correlation with positive countertransference. There were also positive associations with; helpless/inadequate, overwhelmed/disorganised and sexualised countertransference. The sexualised countertransference items in the countertransference questionnaire explored sexual feelings towards the patient or experiences of sexual tension. A significant association was found between the cluster C personality disorders and parental/protective transference. Colli, Tanzilli, Dimaggio and Lingiardi (2014) found associations for helpless/inadequate and overwhelmed/disorganised countertransference.

Helpless/inadequate countertransference is when the therapist experiences high levels of anxiety, tension and concern. They can feel incompetent or inadequate and afraid they are failing to help the BPD patient. Sometimes the therapist may feel a sense of responsibility and guilt when they see the client distressed or deteriorating. Overwhelmed/disorganised countertransference is the tendency for therapists to feel overwhelmed by strong emotions and intense needs. More so than with other patients, the therapist feels as though they have been "pulled into things" (Colli et al., 2014). By conducting a secondary analysis, Betan et al. (2005) found that BPD was associated with special/over involved countertransference. Special/over involved countertransference implies the therapist talks more about their BPD clients than other patients, viewing them as "special" and being willing to "go the extra mile" e.g. by ending sessions late. Again these findings were supported by Colli et al. (2014), who concluded that therapists experienced more mixed or negative emotional responses to patients with cluster B personality disorders than those with cluster A or C.

##### *1.6.1.7 Conclusions about the findings comparing BPD with other personality disorders*

Betan et al. (2005) completed a secondary analysis which concluded there was an association between clients with BPD and special/over-involved countertransference. This was the only quantitative study to highlight this, however this finding was supported by the case studies included in this review (the results of which will follow). The Betan et al. (2005) study was ranked seventh in the quality assessment but demonstrated that it was still of reasonable quality. Therefore it is possible to conclude that special/over-involved counter-transference may be associated with therapeutic work with clients with BPD.

Two of the studies comparing BPD with other personality disorders, only analysed their results at the 'cluster' level, which means that it is not possible to ascertain the reactions evoked by BPD specifically. Exploring therapist reactions at the 'cluster' level rather than exploring the specific personality disorders makes it difficult to make comparisons between therapists' reactions to BPD and other personality disorders. Therefore it is not possible to draw conclusions about any differences or similarities between the different personality disorders from these results. This means that whilst it may be possible to draw conclusions from

the findings comparing BPD with axis I disorders, this review has not found sufficient evidence to make conclusions from the findings comparing BPD with the other axis II disorders.

## 1.7 Patient characteristics which may influence the emotions therapists experience when working with BPD

### 1.7.1 Client burnout

Linehan et al. (2000) explored the concept of client burnout in therapeutic dyads. Burnout was conceptualised as "*emotional exhaustion, negative attitudes and depersonalisation of the other and decreases in effectiveness and personal accomplishment" (p330).* They hypothesised that as both client and therapist are actively involved in the "occupation" of therapy, thus both can experience burnout from the therapy process. The most accurate predictor of therapist burnout after four months was client burnout at the pre-treatment stage, suggesting that clients who feel burnt-out from work with a previous therapist may impact upon subsequent therapists.

### 1.7.2 Client difficulty

Client difficulty and severity of depression, anger or suicidal behaviours did not predict therapist burnout four months into therapy (Linehan et al., 2000). This finding is supported by McIntyre and Schwartz (1998) who found that countertransference did not differ with regard to perceived difficulty of the client.

### 1.7.3 Level of patient functioning

Higher patient psychological functioning was associated with more positive therapist reactions (Colli et al., 2014). A patient's improvement on the Global Assessment of Functioning (GAF) was positively correlated with therapist reactions of importance and feeling confident. Their improvement was negatively correlated with therapists feeling rejected, bored, on guard, overwhelmed and inadequate (Rossberg et al. 2007).

However in a study with a weaker methodology, Bourke and Grenyer (2010) found no significant effects for patient pre-treatment GAF scores and therapist reactions. Rosenkrantz and Morrison (1992b) found that therapists rated the client as more positive and themselves more positively, active and powerful when considering a higher functioning patient but not a lower functioning one. However, caution should be used when drawing conclusions from this study, as the results were subject to both condition and order effects and the quality assessment suggested the study was the poorest of the 12 quantitative studies.

## 1.8 Therapist characteristics which may influence countertransference

### 1.8.1 Specialist training in BPD

Clinicians with special training reacted with more empathy towards clients with BPD and thought the condition was less chronic than those without. Prior training in mindfulness, Eye Movement Desensitization and Reprocessing, trauma treatments and family systems was associated with lower perceptions of chronicity of the BPD characteristics (e.g. that the condition is unlikely to improve over time) and perceptions that the client was untrustworthy (Liebman & Burnette, 2013).

### 1.8.2 Primary discipline

Master's level therapists were more empathic than psychiatrists (Liebman & Burnette, 2013). Overall, Liebman and Burnette (2013) suggest that master's level therapists and psychologists had more positive reactions towards BPD clients and psychiatrists were more negative. However, psychologists and therapists viewed the client as less trustworthy than psychiatrists (Liebman & Burnette, 2013). The authors explained this finding by suggesting that psychologists and therapists are more likely to conceptualise a client's difficulties by considering their presenting problems, rather than using diagnosis as a psychiatrist would. Interestingly they suggest that by conceptualising BPD clients in this way, therapists and psychologists may focus more upon a client's “acting out behaviour”, resulting in a more distrustful attitude towards them.

### 1.8.3 Experience of therapist

The findings with regard to therapist experience and its impact on their emotions are mixed. McIntyre and Schwartz (1998) found the more experienced the therapist, the lower their perceptions of feeling dominated by the client and of the client's difficulty. However, studies with a weaker methodology by Bourke and Grenyer (2010 & 2013) found no significant association between therapists' years of experience and their reactions when working with either BPD clients or MDD clients. Clinicians who had treated more BPD clients thought the condition was less chronic and had more positive reactions towards them (Liebman & Burnette, 2013). A pilot study by Miller et al. (2010) explored the physiological stress responses of trainee therapists when working with clients who were recently suicidal. Physiological data suggested that trainee therapists experienced physiological stress in anticipation of sessions and that these levels reduced once the session was over. However, it should be noted that even pre-session levels were within a normative range, as compared to unpublished ranges described by the company that provided the equipment used for measurement.

### 1.8.4 Age of therapist

Older clinicians viewed the BPD client as less of a conduct problem and as more ill than younger clinicians. Older clinicians were more negative about clients with BPD, the explanation given for this was that older clinicians may not have had specialised training as recently or as often as their younger colleagues (Liebman & Burnette, 2013).

### 1.8.5 Therapist expectations about the outcome of therapy

A therapist's level of emotional exhaustion four months into therapy was positively related to their pre-treatment expectations of how much they thought the client would improve as a result of treatment (Linehan et al., 2000). Those with higher expectations were more likely to experience burnout. Two explanations were offered for this; firstly, that higher expectations may lead to more therapeutic work, which in turn leads to exhaustion. Secondly, therapists with higher expectations were more likely to be disappointed with the progress of BPD clients, leading to demoralisation and emotional exhaustion. In their conclusions Linehan

et al. (2000) explain that in their clinical experience, therapists with little experience of treating BPD clients need training and supervision to ensure their expectations for change are realistic. McIntyre and Schwartz (1998) found that countertransference did not differ between BPD and MDD clients with regards to secondary appraisal e.g. pre-treatment evaluations of one's skill to cope with the client and perceived success in coping with the stress that may be involved in working with them.

### 1.8.6 Gender of therapist

No gender differences were found between the countertransference reactions of male or female therapists (McIntyre & Schwartz, 1998).

### 1.8.7 Anaclitic & Introjective depressive tendencies

Rosenkrantz and Morrison (1992a) suggested that unresolved depressive feelings in therapists may facilitate countertransference reactions to a BPD client's enactments. They defined two types of depressive feelings: anaclitic and introjective. Anaclytic depression is related to loss of autonomy, feeling lonely and helpless, wanting to be close to others and fear of abandonment. Introjective depression relates to feeling guilty and empty, tending to assume blame and feel critical towards self and ambivalence towards self and others. There were two client conditions: the first was characterised by the client enacting a *Rewarding* object relations pattern e.g. the client holds an image of a “good” self and an idealised giving other. The second was a client enacting a *Withdrawing* object relations pattern e.g. the client holds an image of a “bad” self and a bad punitive other. Therapists with higher levels of anaclitic depressive issues evaluated patients and themselves less positively in the Withdrawing condition. Therapists with higher scores on introjective depression evaluated self and clients more positively irrespective of transference condition. These findings are surprising given that introjective depressive tendencies are suggestive of self-criticism. Rosenkrantz and Morrison (1992a) acknowledge that this finding suggests further research is required to understand the meaning of a high introjective score in this population.

### 1.8.8 The boundaries therapists set

The boundaries therapists put in place may impact how they feel about BPD clients. Therapists with high boundaries are those who attempt to create highly structured interactions with clients, by implementing boundaries in space and time and establishing clear rules (Rosenkrantz & Morrison, 1992a). Therapists with high boundaries rated clients who enacted a withdrawing object relations pattern as more positive and also themselves (Rosenkrantz & Morrison, 1992a).

### 1.8.9 Therapist's theoretical orientation

The studies included therapists from a variety of theoretical backgrounds e.g. CBT, Psychodynamic therapy, Dialectical Behaviour Therapy (DBT) etc. The therapists' theoretical orientations did not influence the emotions they reported (Betan et al. 2005; Colli et al. 2014; Bourke & Grenyer, 2013). This finding is surprising, as some therapies, such as psychodynamic, are more likely to explore the therapist's emotions due to the importance of attending to transference and counter-transference. Therefore, it may be expected that in some therapies, therapists may have a greater understanding of the emotions involved in working with BPD clients and therefore for some difference to be seen in the emotional reactions reported. However, the results of this review have not supported this.

## 1.9 Summary of the case study results

The four case studies described in this review did not utilise a specific methodology, instead they were written narratives or descriptions about a therapeutic intervention. These were reviewed and the main emotions experienced by the therapists are described below.

### 1.9.1 Anxiety at maintaining boundaries

All the case studies describe the therapist struggling to maintain or enforce boundaries with their BPD client. The Poggi (1992) case study highlights the therapist's concern that the client is “fragile”, and their anxiety that attempts to enforce boundaries will trigger the client to harm themselves. The therapist in this case study, Dr R increased his availability until he had almost daily contact with his client, either by telephone or in session. Examples of potential boundary crossings given in the studies are: clients not being “billed” if they were having financial difficulties, clients being late for sessions or cancelling them, clients telephoning frequently or late at night, agreeing to see a client after office hours, and in one case study the therapist left voicemail messages on the client’s phone during breaks from therapy (Carsky & Yeomans, 2012). Bot (1997) expressed concern that by enforcing the boundary she would fail to meet her client Tina's needs and would offend Tina who would react angrily. This case study highlighted how BPD clients can push boundaries and how therapists can find it difficult to enforce them due to concerns about the client's response. Wheelis and Gunderson (1998) describe how they felt pressure to offer their client an evening appointment, as they were concerned they would “lose her” if she had not been offered an appointment outside of the working day. Dr Wheelis explains this “bending over backwards” to accommodate Ms A's needs, reassures Ms A of her specialness and her ability to control the therapy.

### 1.9.2 The therapist feeling controlled or out of control

The case study by Poggi (1992) describes both Dr R and Poggi feeling they were “out of control” in therapy with Ms M. When Dr R was unable to reduce the session frequency due to Ms M's threats to attempt suicide, he reported feeling “out of control” and questioned whether he or anyone else could treat Ms M. Poggi

describes how when they confronted Ms M about her continued contact with her regular therapist, she felt "out of control" in therapy and surprised by the strength of her anger. Dr Wheelis (Wheelis & Gunderson, 1998) also describes an occasion when they felt controlled by their client. They report an impasse reached in therapy when Ms A complained of feeling something she refused to discuss, whilst saying she thought she needed to go back into hospital. Dr Wheelis describes feeling manipulated by Ms A and unsure "how far Ms A would go" to make Dr Wheelis act. Dr Wheelis describes feeling anxious about Ms A's safety at several points during the intervention. She describes a weekend when she received numerous calls from Ms A complaining of feeling suicidal and then she was late for her next appointment. Dr Wheelis' nerves were "frayed" and she experienced a mix of relief and fury when Ms A did eventually arrive for her appointment. Dr Wheelis felt anger that Ms A was indifferent to her therapist's fears for her safety, making her feel devalued and ridiculed.

### 1.9.3 Feeling liked or special

The Poggi (1992) study demonstrates the seductiveness of working with this client group, which many of the other studies have not described. It demonstrates how working with BPD clients can lead therapists to feel "special" and become over-involved in the client's care because of a belief that this will meet the client's needs, as in the case of Dr R having daily contact with Ms M. The case study describes how Ms M idealised her long-term therapist Dr R, insisted on being his favourite patient and resented him spending time with other patients and his family. Poggi (1992) describes how during sessions with Ms M they felt as though they were "at their best", feeling they understood her and Ms M was looking forward to attending. When Poggi (1992) became aware that despite Ms M's admission and therapy with Poggi, Ms M continued to see Dr R six times a week, Poggi describes feeling furious. They describe how they had been experiencing an "omnipotent ego state" and feeling "fused" with the patient. Ms M's interactions had transmitted a feeling of "specialness" that led Poggi to feel grandiose and omnipotent. They describe how fear of Ms M attempting suicide and their guilt at feeling unable to meet her needs, activated narcissistic defences within them and created a fantasy of "unity" with the patient. Dr Wheelis (Wheelis & Gunderson, 1998) explains their client told her she liked her at the beginning of therapy, and she expresses caution about listening to comments

such as these from BPD clients, explaining that Ms A would like her to feel needed and special.

### 1.9.4 Good versus bad therapist

Several of the case studies refer to the therapist feeling 'good' or 'bad' and this split between the judgement of their abilities into all good or all bad appears typical of work with BPD clients, who often experience people as either good or bad objects (Klein, 1946). In the Carksy and Yeomans' (2012) case study, Mr A accused Dr N of being unprofessional for not answering his phone late at night, despite the agreement that he would not be available. However, Dr N's response was to feel apologetic and confused that the patient failed to acknowledge the commitment he had given to him. At the beginning of therapy, Dr N had established that his "commitment" was to provide Mr A with the best possible treatment he was capable of. However, Mr A interpreted this to mean that the therapist would do whatever it took to make him feel better. During therapy, Dr N lost sight of his own view of commitment and therefore began to agree with Mr A's criticism that he was a "bad therapist", as he was not doing whatever it took to help his patient (by the patient's standards). Carsky and Yeomans (2012) conclude that intense guilt appears to be a common countertransference reaction in therapists working with BPD clients, feeling they have failed to understand, help or even care for patients at times. This case study helps to highlight clients' expectations about their needs being met through therapy and how these may not always be realistic or similar to the expectations of the therapist working with them. Dr N was anxious about how Mr A would respond to his behaviour and this can perpetuate therapists feeling they need to be a "good therapist", to not make mistakes or respond in ways the client will not like. Bot (1997) also acknowledges the pressure therapists can feel to be good. She explained they were uncomfortable that their client's tears did not evoke compassion and at times she found them repulsive. At these feelings Bot experienced guilt, as she felt a "good therapist" should not feel repulsed by a client.

### 1.9.5 Feeling responsible or over-involved

Poggi (1992) explains that Dr R's attempts to maintain therapeutic boundaries triggered Ms M's anger and threats of suicide. Due to the threats, Dr R increased his availability and frequency of sessions and decided it

would not be possible to reduce this as, Ms M would attempt suicide. Poggi, the other therapist in this case study, explained that Ms M's expressions of hopelessness intensified towards the end of sessions, triggering concern that she may attempt suicide should they leave her. Poggi describes how fear of Ms M attempting suicide and their guilt at feeling unable to meet her needs, created a fantasy of "unity" with the patient. This study highlights how a client's expression of suicidal thoughts can lead the therapist to respond in ways that may be described as over-involved, which may be an attempt to reduce anxiety the therapist is feeling as a result of feeling responsible for the client's safety. In her case study, Bot describes a relief when she discovered a diagnosis (BPD) that could explain the problems she was experiencing with her client Tina and take "the responsibility off myself". Bot's relief at Tina having a diagnosis is important, as she speaks of feeling less responsible because she was able to attribute her difficulties in working with Tina to Tina. This suggests that previously she may have felt responsibility for the difficulties in their relationship.

### 1.9.6 Conclusions from the case studies

The findings from the case studies suggest there were several themes which captured therapists' experiences when working with clients with BPD. All the case studies described the therapist experiencing difficulties with maintaining or enforcing boundaries with their BPD client. Therapists gave examples of where they had crossed boundaries and suggested they had been anxious about enforcing these, due to concerns about their client's response e.g. that they would respond with anger or by harming themselves. Two case studies described the therapist feeling anxious and angry as a result of feeling controlled by their client due to expressions of suicidal thoughts or intent e.g. when a client alluded to being at risk of hurting themselves but did not provide further details. Two of the case studies mention feeling 'special' during therapy with a BPD client and describe how the client can idealise their therapist, leading them to feel as though they are crucial for the client receiving what they need. The studies describe how this can be seductive to the therapist leading to them feeling grandiose or omnipotent. In contrast to therapists feeling special, three of the case studies describe instances of the therapist feeling a 'bad' therapist. Therapists experienced anxiety about wanting to meet their clients' needs and felt guilty when they perceived they had failed to do so. Two therapists described feeling responsible for their clients' safety and the difficulties within the therapeutic

relationship. Feeling responsible led therapists to respond in ways that could be viewed as being 'over-involved' e.g. by extending session times or frequency. A case study describes one intervention and therefore it is not possible to generalise the findings. However, case studies are valuable in providing an in-depth insight into a phenomenon and therefore provide important information about the experience of therapists whilst undertaking therapy with an individual with BPD.

## 1.10 Discussion

Despite the widespread notion that BPD clients are "difficult" to work with therapeutically and the anecdotal evidence that may exist, a review had not been conducted to assess the emotions of therapists whilst working with clients with BPD. Reviews exist exploring the experiences of other professional groups e.g. nurses, but not therapists. The 16 identified studies answered the review question and highlighted the complexity of the emotions therapists experience when working with individuals with BPD. By reviewing the literature it was also possible to consider the patient and therapist characteristics which may influence therapist emotions. The results of the review are congruent with the findings from research with other professional groups and demonstrate that working with BPD clients is complex and a variety of emotions are elicited.

The included studies had several strengths. The studies used different methods to assess therapist emotions; some ask therapists about clients they are working with, some ask therapists to imagine working with a client described in a vignette or to listen to a recording of a session. Studies which directly assessed therapists' feelings towards their current clients obviously have more validity than studies which asked therapists to consider fictional clients. Twelve of the sixteen studies asked therapists about their responses to actual clients. Therefore, the majority of the studies included in this review explore therapists' reactions in the context of work with a real life client. The quality assessment specified the studies which were conducted more robustly, allowing greater emphasis to be placed upon their results and more faith in the conclusions drawn. Overall the quality of the research was comparatively high.

Several limitations were identified in the research in this area. The Rossberg et al. (2007), Betan et al. (2005) and Colli et al. (2014) studies categorised clients into “clusters” as described in the DSM-IV. The difficulty with research that categorises its participants in this way is that it is not possible to ascertain the reactions evoked by the specific personality disorders. As a BPD diagnosis is made by assessing the presence of five out of nine criteria, it means that clients with BPD can be a heterogeneous sample, as potentially there are 254 different presentations of the nine criteria used to diagnose it (Paris, 2007). Combining clients with personality disorders into 'clusters' is likely to further the heterogeneity of the sample and impact on the ability to draw conclusions about the populations studied.

The studies highlight some of the difficulties that exist in exploring therapists’ emotions. A difficulty of using measures to assess emotions is that it can cause superficiality in the data e.g. reporting that therapists experience hostility towards BPD clients. These superficial labels do not describe the complexity of the therapist's emotional experiences whilst working therapeutically. The case studies included in this review add depth to the quantitative research, but further information is required to capture the experiences of therapists more fully. Due to the complexity of therapy with BPD clients it may be difficult for therapists to untangle their emotions from their client's. In the psychodynamic literature the concept of projective identification suggests that the client transfers emotions they may be finding difficult on to the therapist (Klein, 1946). This means that during clinical practice it can be difficult to ascertain what the therapist is feeling and what they are feeling as a result of projective identification from the client. This may make investigating therapists’ emotions difficult.

The studies may also be subject to several types of bias. Therapists may experience pressure to respond in a socially desirable way. A desire to appear professional may impact upon their ability to report reactions they may deem negative or shameful, such as sexualised feelings towards a client (Najavits, 2000). The studies may also be subject to a self-selection bias, as some therapists may be more inclined to engage with research studies than others. Some therapists may feel intimidated about taking part in research that explores their feelings due to concerns they may appear unprofessional or that they are not coping (Najavits, 2000).

Therefore the therapists who choose to engage with research may be those who feel confident in their abilities or feel emotionally robust.

A strength of this review is that the quality of the studies was assessed systematically. The quality assessment process was cross checked by a second assessor utilising the quality assessment tools to consider two articles. A thorough research protocol was developed prior to conducting the review, and the inclusion and exclusion criteria were developed during the scoping searches by reviewing the returned literature. It could be argued that the search terms used for the review were simplistic, acting as a limitation of the review. However, due to the extent of the literature on BPD, it was difficult to conduct a search that returned a manageable number of results. Therefore this review balanced the need to return a manageable number of results with the risk that relevant articles could be missed. To reduce this risk, the reference lists of relevant articles were cross checked, identifying the small number of relevant articles that may have been missed by these terms. Thorough scoping searches were conducted prior to the review and these terms returned the most relevant articles to ensure the review question could be answered. The included articles were screened against the inclusion and exclusion criteria by a second assessor. This ensured that the included articles were relevant, however it does not account for the articles which were excluded at an earlier point. A more thorough approach to this would have been for the second assessor to compare the 34 articles which were assessed for eligibility. A further limitation of the review is that none of the studies was conducted in the United Kingdom. The healthcare system in the United Kingdom may differ in several ways from the mental healthcare received in the countries where the research was conducted, which may impact upon the ability to generalise the findings to the National Health Service (NHS). Some of the studies referred to payment or boundaries being tested with regards to the therapist receiving payment from the client and this is obviously not applicable to a healthcare system which is free and publicly funded. It is interesting that to date research has not been conducted in this area in the United Kingdom. Further research conducted within the NHS could shed light on the experiences of therapists within the United Kingdom.

### 1.10.1 Conclusions

From the results of this review it is possible to conclude that therapists experience a wealth of strong emotions when working with BPD clients, such as; empathy, stress, less confidence, anger, irritation, liking, nurturance, dominance, hostility, distrust, interest, positively challenged, rejected, on guard, inadequate, disengaged, helpless, overwhelmed, disorganised, anxiety, tension, concern, responsible, guilt, feeling special, feeling controlled or out of control, relief, fury, devalued, ridiculed, over-involved, apologetic and confused. When clients with BPD were compared to clients with MDD, therapists reported feeling; less empathy, less positive about outcomes, less confident, more anger, more irritated and less nurturance. Generally the responses were less positive, however therapists reported feeling more positively challenged and no less engaged or interested in BPD clients than MDD clients. There are certain client and therapist characteristics which may influence the therapist's emotions. In this client group, only two client characteristics influenced the emotions experienced by therapists; client burnout at the beginning of therapy and level of patient functioning. Therapist characteristics which may influence the emotions experienced are: specialist training, primary discipline, experience, age, therapist expectations and the boundaries therapists set.

The results of this review may be of interest to therapists working with clients with BPD. The literature suggests that therapist orientation does not impact on the reactions they experience and so therapists from all theoretical backgrounds could be interested in the findings. The findings may be particularly pertinent for therapists whose characteristics are described within the review as influencing the emotions they may experience. Therefore these results may be of interest to psychiatrists, trainee therapists, older clinicians and those with higher expectations for therapy. The findings of this review have implications for the professional practice of therapists working with clients with BPD. Clients with BPD are likely to experience interpersonal sensitivity and there is evidence they may be more sensitive than controls in identifying the emotional expressions of others (Lynch et al. 2006). This review has highlighted that therapists experience strong emotions towards clients with BPD. Therefore it is important to ensure that therapists have sufficient support when working with clients, so that they continue to express positive regard, contain the emotions

they are feeling and prevent them reacting to these in unhelpful ways. Should a client be aware of a therapist's feelings, this could impact upon the therapeutic relationship and have implications for the outcomes of psychological therapies (Lambert & Barley, 2001). To counteract this it is important that support systems are in place, such as regular supervision. Therapists may also be interested in the finding that those who have received specialised training appear to be more empathic and more optimistic about the reduction of the BPD characteristics over time. This may suggest that therapists benefit from specialised training in BPD such as mindfulness, DBT or mentalisation based therapy, and that therapists should seek this training when working with clients with BPD.

The quantitative research highlights the emotions experienced by therapists and the case studies add more depth to this data. However, to date this area has not been researched using robust qualitative methodologies. The use of a qualitative methodology to explore this area would allow a greater depth of understanding about the emotional experiences of therapists during therapy. By utilising a recognised methodology such as Thematic analysis or Interpretative Phenomenological Analysis it would add additional credibility to the research in this area.

## References

Adelson, M.J. (1995). Clinical supervision of therapists with difficult-to-treat patients, *Bulletin of the Menninger Clinic, 59* (1), 32-52.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (Fifth ed.). Arlington, VA: American Psychiatric Publishing.

Aviram, R.B., Brodsky, B.S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications, *Harvard Review of Psychiatry, 14*(5), 249–256.

Betan, E., Heim, A.K., Conklin, C.Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation, *American Journal of Psychiatry, 162(5)*, 890-898.

Bland, A.K., & Rossen, E.K. (2005). Clinical supervision of nurses working with patients with borderline personality disorder, *Issues in Mental Health Nursing, 26,* 507-517.

Boland, A., Cherry, M.G., & Dickson, R. (2014). *Doing a systematic review: A student's guide.* SAGE publications: London.

Bot, S. (1997). Overcoming my model of goodness as a psychotherapist: Setting boundaries - the case of Tina, *Women & Therapy, 20(1)*, 127-130.

Bourke, M.E., & Grenyer, B.F.S. (2010). Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis. *Psychotherapy Research, 20*(6), 680-691.

Bourke, M.E., & Grenyer, B.F.S. (2013). Therapists' accounts of psychotherapy process associated with treating patients with borderline personality disorder. *Journal of Personality Disorders, 27(6)*, 735-745.

Bradley, R., Heim, A.K, & Westen, D. (2005). Transference patterns in the psychotherapy of personality disorders: empirical investigation, *British Journal of Psychiatry,* 186, 342-349.

Brody, E.M. & Farber, B.A. (1996). The effect of therapist experience and patient diagnosis on countertransference. *Psychotherapy, 33*, 372-380.

Burnard, P., Edwards, D., Fothergill, A., Hannigan, B., & Coyle, D. (2000). Community health nurses in wales: Self-report stressors and coping strategies. *Journal of Psychiatric and Mental Health Nursing*, 7, 523-528.

Carsky, M. (2013). Supportive psychoanalytic therapy for personality disorders, *Psychoytherapy, 50*(3), 443-448.

Carsky, M., & Yeomans, F. (2012). Overwhelming patients and overwhelmed therapists. *Psychodynamic Psychiatry, 40(1),* 75-90.

CASP (2015). Critical Appraisal skills Program: Making sense of evidence. Retrieved in March 2015 from: www.casp-uk.net/

Centre for Reviews and Dissemination (2009). Systematic reviews: CRD's guidance for undertaking reviews in Healthcare. Retrieved in January 2015 from:www.york.ac.uk/inst/crd/SysRev/!SSL!/WebHelp/SysRev3.htm

Chatziandreou, M., Tsani, H., Lamnidis, N., Synodinou, C., & Vaslamatzis, G. (2005). Psychoanalytic Psychotherapy for Severely Disturbed Borderline Patients: Observations on the supervision group of psychotherapists, *The American Journal of Psychoanalysis*, *65* (2), 135-147.

Chessick, R.D. (1993).The outpatient psychotherapy of the borderline patient, *American Journal of Psychotherapy, 47* (2), 206-227.

Cleary, M., Siegfried, M., & Walter, G. (2002). Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder. *International Journal of Mental Health Nursing,* 11(3), 186–191.

Coid, J., Yang, M., Tyrer, P., Roberts, A. & Ulrich,S. (2006). Prevalence and correlates of personality disorder in great britain, *The British Journal of Psychiatry, 188*(5), 423-431.

Colli, A., Tanzilli, A., Dimaggio, G., & Lingiardi, V. (2014). Patient personality and therapist response: An empirical investigation. *The American Journal of Psychiatry, 171*(1), 102-108.

Deeks, J., Dinnes, J., D'Amico, R., Sowden, A., Sakarovitch, C., Song, F., Petticrew, M., Altman, D.G., International Stroke Trial Intervention Group and European Carotid Surgery Trial Collaborative Group (2003). Evaluating non-randomised intervention studies. *Health Technology Assessment, 7(27)*, 1-173.

Downs, S.H. & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality of both randomised and non-randomised studies of healthcare interventions. *Journal of Epidemiology and Community Health, 52*, 337-84.

Herschell, A. D., Lindhiem, O. J., Kogan, J. N., Celedonia, K. L., & Stein, B. D. (2014). Evaluation of an implementation initiative for embedding dialectical behavior therapy in community settings. *Evaluation and Program Planning, 43*, 55-63.

Holmqvist, R. (1998). The influence of patient diagnosis and self-image on clinicians' feelings, *Journal of Nervous and Mental Disease, 186,* 455-461.

Holmqvist, R., & Armelius, K. (1996). Sources of therapists' countertransference feelings. *Psychotherapy Research, 6*(2), 70-78.

Holmqvist, R., & Armelius, K. (2004). Associations between psychiatric patients' self-image, staff feelings towards them, and treatment outcome, *Psychiatry research, 128* (1), 89-102.

Hoyt, M. F., & Farrell, D. (1984). Countertransference difficulties in a time-limited psychotherapy. *International Journal of Psychoanalytic Psychotherapy, 10*, 191-203.

Klein, M. (1946). Envy and Gratitude and Other Works 1946-1963 (The Writings of Melanie Klein, Volume 3). Chippenham: Contemporary classics.

Kocmur, M., & Zavasnik, A. (1993). Problems with borderline patients in a crisis intervention unit: A case history. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 14*(2), 71-75.

Lambert, M.J. & Barley, D.E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome, *Psychotherapy: Theory, Research, Practice, Training, 38(4)*, 357-361.

Laurenssen, E.M.P., Hutsebaut, J., Feenstra, D.J., Van Busschbach, J.J., & Luyten, P. (2013). Diagnosis of personality disorders in adolescents: A study among psychologists. *Child and Adolescent Psychiatry and Mental Health, 7*(1), http://www.capmh.com/content/7/1/3

Lee, E., Mishna, F., & Brennenstuhl, S. (2010). How to critically evaluate case studies in social work. *Research on social work practice, 20(6),* 682-689.

Liebman, R. E., & Burnette, M. (2013). It's not you, it's me: An examination of clinician- and client-level influences on countertransference toward borderline personality disorder. *American Journal of Orthopsychiatry, 83*(1), 115-125.

Linehan, M., M. (1993). *Cognitive behavioural treatment of borderline personality disorder*. London: Guildford press.

Linehan, M. M., Cochran, B. N., Mar, C. M., Levensky, E. R., & Comtois, K. A. (2000). Therapeutic burnout among borderline personality disordered clients and their therapists: Development and evaluation of two adaptations of the maslach burnout inventory. *Cognitive and Behavioral Practice, 7*(3), 329-337.

Lingiardi,V., Filippucci, L., & Baiocco, R. (2005). Therapeutic alliance evaluation in personality disorders psychotherapy, *Psychotherapy Research, 15* (1-2), 45-53.

Livesley, J. (2001). *Handbook of personality disorders: Theory, research and treatment.* London; The Guildford press.

Loughrey, L., Jackson, J., Molla, P., & Wobbleton, J. (1997). Patient self-mutilation: When nursing becomes a nightmare. *Journal of Psychosocial Nursing and Mental Health Services*, *35*(4), 30–34.

Lynch, T.R., Rosenthal, M.Z., Kosson, D.S., Cheavens, J.S., Lejuez, C.W., & Blair, R.J. (2006). Heightened sensitivity to facial expressions of emotion in borderline personality disorder, *Emotion, 6,* 647–655.

Mchenry,S.S. (1994). When the therapist needs therapy: Characterological countertransference issues and failures in the treatment of the borderline personality-disorder. *Psychotherapy, 31* (4), 557-570.

McIntyre, S. M., & Schwartz, R. C. (1998). Therapists' differential countertransference reactions toward clients with major depression or borderline personality disorder. *Journal of Clinical Psychology, 54*(7), 923-931.

Melchior, M. E.W., Bours, G. J.J., Schmitz, P., & Wittich, Y. (1997). Burnout in psychiatric nursing: A meta-analysis of related variables. *Journal of Psychiatric and Mental Health Nursing*, 4, 193-201.

Miller, G. D., Iverson, K. M., Kemmelmeier, M., MacLane, C., Pistorello, J., Fruzzetti, A. E., et al. (2010). A pilot study of psychotherapist trainees' alpha-amylase and cortisol levels during treatment of recently suicidal clients with borderline traits. *Professional Psychology: Research and Practice, 41*(3), 228-235.

Najavits, L.M. (2000). Researching therapist emotions and countertransference, *Cognitive and Behavioural practice, 7,* 322-328.

Narud,K., Mykletun,A., & Dahl,A.A. (2005). Therapists' handling of patients with cluster B personality disorders in individual psychotherapy, *Comprehensive psychiatry, 46* (3), 186-191.

Newman, C.F. (1999). The case of Anna: addressing three special problems in treatment, Cognitive and Behavioral Practice, 6(1), 84-91.

Paris, J. (2007). Why psychiatrists are reluctant to diagnose borderline personality disorder, *Psychiatry, 4*(1), 35-39.

Perry,J., Bond,M., & Presniak, M.D. (2013). Alliance, reactions to treatment, and counter-transference in the process of recovery from suicidal phenomena in long-term dynamic psychotherapy, Psychotherapy research, 23(5), 592-605

Perseius,K.I., Kåver, A., Ekdahl,S., Åsberg, M., & Samuelsson,M. (2007). Stress and burnout in psychiatric professionals when starting to use dialectical behavioural therapy in the work with young self-harming women showing borderline personality symptoms, *Journal of Psychiatric and Mental Health Nursing, 14* (7), 635-643.

Poggi, R. G. (1992). Short-term hospitalization: An aspect of the psychoanalytic treatment of character disturbance. *Bulletin of the Menninger Clinic, 56*(1), 95-112.

Rees, N., Rapport, F., Thomas, G., John, A. & Snooks, H. (2014). Review: Perceptions of paramedic and emergency care workers of those who self-harm: A systematic review of the quantitative literature, *Journal of Psychosomatic research, 77(6)*, 449-456.

Rosenkrantz, J., & Morrison, T. L. (1992a). Psychotherapist personality characteristics and the perception of self and patients in the treatment of borderline personality disorder. *Journal of Clinical Psychology, 48*(4), 544-553.

Rosenkrantz, J. & Morrison, T.L. (1992b). Psychotherapist perceptions of self and patients in the treatment of borderline personality disorder. *Journal of Clinical Psychology, 48*(4), 553-560.

Rossberg, J. I., Karterud, S., Pedersen, G., & Friis, S. (2007). An empirical study of countertransference reactions toward patients with personality disorders. *Comprehensive Psychiatry, 48*(3), 225-230.

Rüsch, N., Hölzer, A., Schramm, E., Jacob, G.A., Lieb, K., Hermann, C, Bohus, M., & Corrigan, P.W. (2006). Self stigma in women with borderline personality disorder and women with social phobia. *Journal of Nervous Mental Disorders, 194(10),* 766–773.

Ryle, A. (1995). Transference and countertransference variations in the course of the cognitive-analytic therapy of two borderline patients: The relation to the diagrammatic reformulation of self-states. *British Journal of Medical Psychology, 68*(2), 109-124.

Saunders, K.E.A., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review, *Journal of Affective Disorders,139*(3), 205-216.

Thomas, H. (no date). Quality assessment tool for quantitative studies. Effective public health practice project. Toronto: McMaster University, Retrieved from http://www.ephpp.ca/tools.html on February 2015

University of York (2015), The International Prospective register of Systematic reviews website www.crd.york.ac.uk, accessed on 23/01/2015.

Wheelis, J., & Gunderson, J. G. (1998). A little cream and sugar: Psychotherapy with a borderline patient. *The American Journal of Psychiatry, 155*(1), 114-122.

Yeomans, F. (1993). When a therapist overindulges a demanding borderline patient. *Hospital & Community Psychiatry, 44*(4), 334-336.

Winship, G. (2010). Attitudes and perceptions of mental health nurses towards borderline personality disorder clients in acute mental health settings: A review of the literature, *Journal of Psychiatric and Mental Health Nursing, 17,* 657-662.

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# An Exploration of the Emotional Experiences of Therapists when utilising a Dialectical Behaviour Therapy Approach with clients with a Borderline Personality Disorder Diagnosis. What are the factors that have influenced that experience?

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Chapter 2: Empirical Paper

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# Chapter 2. Empirical paper

## 2.1 Abstract

Individuals with Borderline Personality Disorder (BPD) may present with high risk behaviours such as deliberate self-harm, suicidal thoughts or attempts. Therapists report a variety of emotional experiences when engaging with this client group. Dialectical Behaviour Therapy (DBT) is a multi-modal psychological intervention designed for use with BPD. It has been hypothesised that the structure of DBT and its key components may provide support to the therapist and prevent negative emotional experiences. The aim of this study was to explore the emotional experiences of therapists whilst implementing a DBT approach. Nine semi-structured interviews were conducted and the transcripts analysed using Interpretative Phenomenological Analysis. The analysis established five themes within the data; 1) Developing an allegiance to DBT; 2) Learning to share responsibility; 3) Adjusting to the boundaries in DBT; 4) DBT contains therapists' emotions; and 5) Needing support from others; i) Consult providing a secure base; ii) Needing support from the wider organisation. In conclusion, therapists' emotions appeared to be contained by DBT and therefore it may be an attractive approach to utilise for clinical work with individuals with BPD.

Keywords: Borderline Personality Disorder, Dialectical Behaviour Therapy, Interpretative Phenomenological Analysis, Emotions, Therapist.

## 2.2 Introduction

Borderline Personality disorder (BPD) is a "*pervasive pattern of instability of interpersonal relationships, self-image and affects and marked impulsivity*" (American Psychiatric Association, 2013; p663). It is estimated to affect one percent of the United Kingdom population (Coid, *et al.,* 2006). Suicide attempts and deliberate self-harm may be frequent within this population; between 70 and 75% of individuals treated with BPD have made at least one life-threatening act of self-harm and the rate of completed suicides is eight to ten percent (Black, *et al.,* 2004; APA, 2013). Therefore, therapists working with this high-risk client group are likely to discuss suicide and feel concern for their client's safety on a regular basis. Individuals with BPD are also likely to express heightened emotions during their sessions, for their mood to be labile and for their interpersonal interactions to be fraught (Lieb *et al.,* 2004). Research has identified several difficulties therapists typically experience when working with this client group including: slow progress, modest outcomes, clients wanting to disengage or demonstrating behaviours that interfere with therapy, and inducing strong emotional reactions in the therapist (Livesley, 2001; Linehan 1993a).

When compared to depressed clients, individuals with BPD are more likely to evoke negative emotional reactions from their therapists (Liebman & Burnette, 2013). Patients with BPD triggered the highest levels of dominance, hostility, difficulty, anger and irritation and the least amount of liking, empathy and nurturance in therapists (Bourke & Grenyer, 2013; McIntyre & Schwartz, 1998). However, therapists were no less engaged or interested in BPD clients and were more positively challenged than while working with depressed clients (Brody & Farber, 1996). The main themes identified in case studies about therapists' emotions when working with BPD are feeling anxious as a result of attempting to maintain boundaries, feeling controlled or out of control, feeling liked or special, feeling pressure to be a good therapist or having concerns they are a bad therapist and feeling responsible or over-involved (Carsky & Yeomans, 2012; Poggi, 1992). Those working with patients who are suicidal and self-harming have higher stress levels, greater emotional distress and experience trepidation and concern about working with this client group (Bourke & Grenyer, 2010; Burnard *et al.,* 2000; Loughrey *et al.,* 1997; Melchior *et al.,* 1997; Brody & Farber, 1996).

Supervision appeared to have a greater role for therapists working with individuals with BPD (Bourke & Grenyer, 2013). Clinicians with special training in BPD were more empathic and thought the condition was less chronic (Liebman & Burnette, 2013). Herschell *et al.* (2014) found that participating in Dialectical Behaviour Therapy training was associated with an improvement in therapists' attitudes towards clients with BPD.

### 2.2.1 Dialectical Behaviour therapy

Dialectical Behaviour Therapy (DBT) was designed for the treatment of BPD, has demonstrated efficacy (Linehan *et al.,*1991; Linehan *et al.,* 1993b; & Linehan *et al.,* 1994) and is recommended in the National Institute for Health and Clinical Excellence guidelines (2009) for use with this population. DBT is a multi-modal therapy with individual and skills group sessions conducted on a weekly basis, alongside DBT consultation (or 'consult' as it is colloquially known as) for all therapists, which is an essential component of the treatment. Linehan (1993c) suggested the structure of the therapy, alongside its key components can provide support to the therapist and prevent negative emotional experiences such as burn out. Some of the components of DBT hypothesised to reduce the emotional impact of the work include: team work, structured peer support, supervision and mindfulness training for the therapist. Despite the suggestion these factors may influence DBT therapists' emotional experiences, this has not been researched to date.

However, research has begun to explore the impact of utilising a DBT approach upon the therapist. Miller *et al.* (2011) and Perseius *et al.,* (2007) describe newly trained DBT therapists and their experiences of learning and implementing the approach. Perseius et al. (2007) explored stress and burnout in professionals when starting to utilise DBT with young women who self-harm. The study reported an increase in the level of burnout experienced by therapists during the initial six months, which was attributed to the demands of learning a new therapy and beginning to implement it. The qualitative results from a small number of interviews suggest clinicians found benefit from utilising mindfulness skills, teamwork and supervision. The study did not compare the clinicians to a control group and had a small sample size, which impacts upon the ability to generalise the findings and draw conclusions. Miller *et al*. (2011) conducted a pilot study which

explored physiological measures of stress in counsellor trainees utilising a DBT approach. They also found that DBT counsellors initially experienced higher levels of stress as assessed by measuring their cortisol levels. Over the duration of the intervention (12 months) the cortisol levels steadily reduced and DBT counsellors experienced less physiological stress than the control group, who were counsellors in training utilising a psychodynamic therapy. Miller *et al*. (2011) attributed these changes to the structure of the DBT model, namely the clear treatment targets, consultation and mindfulness practice. The study had a very small sample size which suggests further research is required to support these findings.

Research has begun to explore the experience of therapists when first implementing a DBT approach and how this may affect burnout, but to date studies have not explored the emotional experiences of therapists whilst utilising DBT. The existing research has focussed upon negative emotional reactions such as stress and burnout, and appears to have neglected exploring the positive emotional reactions therapists may experience. Evidence suggests experienced clinicians may have more positive reactions to BPD clients (Liebman & Burnette, 2013; McIntyre & Schwartz, 1998). Therefore, the findings described by Perseius *et al*. (2007) and Miller *et al.* (2011) may be due to the participants' level of experience, and an exploration of those who have more experience working with people with BPD, may find more positive emotional experiences. The aim of the current study was to explore the emotional experiences of clinicians who have utilised DBT for at least a year. The research objectives were:

- To explore the participants' use of DBT.
- To examine participants' emotional experiences when working within a DBT framework.
- To gain an insight into the participants' views about what may influence the emotional impact of the therapeutic work.

The method chosen to explore this was Interpretative Phenomenological Analysis (IPA). The aim of IPA is to explore how participants make sense of their world and the meaning they attribute to their experience. It involves a detailed examination of the participants' experiences and is concerned with their personal perceptions or accounts of the event (Smith, 2003). IPA was chosen to allow an in-depth analysis of the

therapists' perceptions of the work they undertake and how they make sense of their personal and social world whilst working with individuals with BPD. This approach was chosen to flexibly explore their experiences without preconceived hypotheses. Other qualitative research methods are available, such as Grounded theory (Charmaz, 2006), Discourse analysis (Parker, 1992) or Narrative analysis (Crossley, 2000). Despite some similarities, each method has a different focus. IPA was chosen due to its focus on the experiences of participants and its attempt to explore their perceptions and understandings. Its interpretative stance allows the participants' responses to be explored in depth (Smith, Flowers & Larkin, 2009).

## 2.3 Method

### 2.3.1 Participants

Participants were recruited from DBT consultation teams within an NHS Foundation Trust. The Trust was chosen for its geographical location and because it had several established DBT consultation teams. In an attempt to ensure the participants were as homogenous as possible, only teams providing DBT to adults were approached. The lead practitioners of three DBT consultation teams were contacted via email, provided with an information sheet and asked if they would like to participate. After an expression of interest was made, the researcher attended each consultation team to discuss the research with the other members. The inclusion criteria for participation were: participants to be individual DBT therapists with a core profession in psychology, nursing, social work or an allied health profession, who had received the intensive DBT training and worked with clients for a minimum of one year since part one of their intensive training. The consultation team members who met the inclusion criteria were then provided with an information sheet and consent form. Nine DBT therapists met the criteria and all agreed to participate. The nine participants were from three different consultation teams; four members came from one consultation team, three from another and two members from the final team. Smith, Flowers and Larkin (2009) suggest between four and ten interviews are an appropriate number for IPA professional doctorate research. Individual appointments were made to conduct interviews. The participant demographics can be seen in Table 9.

*Table 9. Participant demographics*

| | N | |
|---|---|---|
| Primary Discipline | | |
| Occupational Therapist | 2 | |
| Community Psychiatric Nurse | 1 | |
| Clinical Psychologist | 3 | |
| (Cognitive behavioural) therapist | 1 | |
| Approved Mental health Act practitioner | 1 | |
| Psychotherapist | 1 | |
| Gender | | |
| Female | 8 (89%) | |
| Male | 1 (11%) | |
| Years of professional training | | Mean= 3.66 |
| 2 | 1 | |
| 3 | 5 | |
| 4 | 1 | |
| 5 | 1 | |
| 7 | 1 | |
| Level of DBT training | | |
| Intensive training with the British Isles DBT team | 9 | |
| Experience working with clients with BPD prior to DBT training | | |
| Step 4 IAPT | 2 | |
| Community Mental Health Team | 4 | |
| Therapeutic community | 2 | |
| Assertive Outreach Team | 1 | |
| Specialist Personality Disorder unit | 1 | |
| Care co-ordinating | 2 | |
| Experience working in mental health (years) | | Mean= |
| 10-15 | 4 | 18.88yrs |
| 15-20 | 0 | |
| 20-25 | 3 | Range= |
| 25-30 | 2 | 10-28yrs |
| Other approaches used when working with people with BPD | | |
| Cognitive Analytic Therapy | 4 | |
| Cognitive Behavioural Therapy | 4 | |
| Psychodynamic/Psychoanalytic | 3 | |
| Acceptance & commitment therapy | 1 | |
| Mindfulness | 1 | |
| Eclectic | 1 | |
| Therapeutic community | 2 | |
| Attachment theory | 1 | |
| Solution focused therapy | 2 | |
| Relate counselling skills | 1 | |
| Systemic approaches | 1 | |
| Social skills | 1 | |
| Anxiety management | 1 | |
| Structured clinical management | 1 | |

### 2.3.2 Ethical considerations

Ethical approval was sought and granted by the University Committee on Research Ethics at the University of Liverpool.

### 2.3.3 Reflexivity and consideration of bias

In line with IPA's phenomenological underpinnings, it is important that researchers reflect and attempt to "bracket off" their prior experiences. When submitting the research proposal, the researcher considered her starting position and the biases that may occur because of this: *"I received the intensive DBT training when working as an Assistant Psychologist and subsequently worked into DBT consultation teams. I have acted as both an individual therapist and a facilitator in the skills group. At times whilst implementing DBT, I have experienced strong emotions and was curious how similar my experiences were to others using the approach. I am aware that Marsha Linehan claims the structure of the therapy acts to contain both the patient and therapist and was interested in whether this impacts upon the emotional experiences of the therapist. I was also curious if there were any features of the therapy which influence the emotional experiences of the therapist, such as therapists being encouraged to practice mindfulness or the presence of the consultation team.*

*I found the use of mindfulness very useful in my role as a therapist and have the expectation that mindfulness may be a factor participants highlight as influencing their emotional well-being. I am less certain how influential participants will find the consultation team, as some teams may feel more supportive or effective than others. Whilst writing the interview schedule I was aware my DBT experience and interest influenced the questions I formulated. My experience as a DBT therapist has obviously inspired my interest in researching this area and I am aware that when analysing the transcripts, my experience is likely to influence my interpretations. However, this means I am familiar with DBT concepts and some of the experiences the participants may discuss. I may find that I identify with some of the experiences they describe, but I will also be open to other experiences and therefore my research may establish something that is novel about the experiences of the participants".* (Written September 2013).

Several steps were taken to prevent the researcher's DBT experience influencing the analysis and potentially causing bias. The Researcher continued to reflect throughout the research process and observed her thoughts and emotions by making reflective notes, having discussions with research and clinical supervisors and contributing to an IPA peer group. On one occasion the researcher was concerned that a pertinent theme in one interview appeared to mirror a theme from her own clinical work. For this reason the external research supervisor was asked to review the themes from the interview with this potential bias in mind. However, this theme was grounded in the data and therefore the supervisor validated the theme. A further interview was validated in this way by the internal research supervisor. Several versions of the interview schedule were drafted and reviewed by the research supervisors, the Research committee and Ethics committee. The themes from the cross case analysis were validated by the supervisors and their feedback incorporated into the analysis to ensure the themes were representative of the data.

### 2.3.4 Procedure

The interview schedule was created using the procedure outlined in Smith (2003) ensuring the questions were open and neutral. A practice interview was conducted with the external supervisor prior to the first interview, to establish any difficulties with the questions, and the interview schedule was modified following this. To begin the interviews, demographic information was collected. A semi-structured interview was conducted to facilitate rapport, provide greater flexibility and allow the interviews to explore areas that may not have been anticipated (Smith, 2003). The average length of the interviews was 46 minutes, with the shortest interview being 19 minutes and the longest 62. There may be several explanations as to why one interview was shorter. Following the interview the participant stated they "weren't very good at interviews" and the researcher noted that the participant's communication was concise. The researcher also reflected that this was the first interview to be conducted and therefore their inexperience of interviewing as a researcher may have impacted upon its length e.g. because of a reluctance to prompt. The interviews were recorded using a

Dictaphone. Seven of the recordings were transcribed by an independent transcriber approved by the University. The main researcher transcribed two interviews to become more familiar with the process and the participant data.

## 2.4 Analysis

The transcripts from the interviews were analysed utilising the IPA methods described in Smith, Flowers and Larkin (2009). To begin, the interview was listened to with the transcript and notes made about any features not captured by the transcript e.g. tone of voice. The transcripts were read several times and exploratory comments made considering the data at a descriptive, linguistic and conceptual level. From the exploratory comments, emerging themes were noted which included psychological terminology and theories. The emergent themes were then clustered by establishing connections between them to create super-ordinate themes. To do this, the emergent themes were typed, printed and then cut out. The themes which offered parallel or similar understandings were clustered together. Themes that were oppositional were positioned as opposite poles of the same spectrum. A table was then created to act as a graphical representation of the superordinate themes. The author's interpretations were reviewed by the research supervisors for two of the transcripts to ensure the quality and validate the themes. The subsequent transcripts were then analysed following the same process, with efforts made to 'bracket off' the knowledge gained from previous transcripts, to allow new themes to emerge with each case. Once all the transcripts were analysed, the super-ordinate themes for the nine interviews were printed out and connections or patterns between them were established, searching for similarities and differences. A summary of the themes for the group can be seen in Table 10 below.

*Table 10. The themes from the cross case analysis*

| Themes | |
|---|---|
| *"It doesn't feel alien anymore"*: Developing an allegiance to DBT | |
| *"Whose responsibility is it?"*: Learning to share responsibility | |
| "*A fine line*": Adjusting to the boundaries in DBT | |
| DBT contains therapists' emotions | |
| Needing support from others | 5.1 Consult providing a secure base<br>5.2 Needing support from the wider organisation |

In the following section, quotes from participants can be seen in italics and quotation marks. The line number, where the quote can be found in the transcript, follows the quote in brackets.

### 2.4.1 *"It doesn't feel alien anymore"*: Developing an allegiance to DBT

All participants had undertaken a process of adaptation to the therapy. Jackie describes how she 'cut her teeth' on the new therapy: "*It's kind of like teething isn't it?...you learn by your mistakes"* (199). Jackie's comment suggests it may be painful whilst in the infancy of DBT. Here Lisa describes how she now feels about using the diary card: *"We'll do that now…it doesn't feel alien anymore"* (52). The use of the word alien suggests the card felt unfamiliar and strange to Lisa at first and that she has since adapted to it.

Initially, therapists reported feeling anxious about their abilities within DBT and they experienced doubts about whether they were adhering to the model: "*you start thinking…is it my fault? Did I, did I do it wrong?...wasn't I using the techniques right?"* (Lisa, 44). Lisa appears to be questioning her abilities, which was a common feature in the interviews when participants spoke of the period after training. In Sarah's interview, being "on track" or wanting to be was a common theme, demonstrating her desire to adhere to the model: "*sometimes people want to talk about other stuff….it can sometimes be tricky to validate their want to talk about that, but keep them to track in terms of …whatever's*

*showing up on their diary card"* (Sarah, 103). In the next quote, the repetition of "keep plodding on" suggests Jackie had to persevere through the early stages of DBT: *"and so I got a little bit sort of, well I'm obviously not very good at this… that was a big battle for me to… keep plodding on, keep plodding on"* (l53). Adapting to DBT appeared to be easier for those who had no previous training in a therapeutic approach. Participants who were experienced in another therapy appeared to struggle to assimilate DBT into their repertoire. Sarah describes the difficulties she experienced when learning DBT: *"I was feeling…is this instead of...I'm not sure that I wanted to be instead of….I value my CAT and…where is that going to go…I see where it sits alongside really now"* (Sarah, 906). In some instances, it felt as though the therapist remained loyal to their previous approach. In the following exchange Susan appears to experience guilt at the thought she may be more enthusiastic about DBT:

***Susan:*** *"Other people who are not in DBT have noticed that, so me old CBT colleagues that I work with still and managers who sent me on the course".*

***Interviewer:*** *"They can see a difference?"*

***Susan***: *"They do, they definitely see that it's changed me".*

***Interviewer:*** *"And what do you think they can see?"*

***Susan:*** *"Enthusiasm, excitement. I'm not saying I was never enthusiastic in me old job or the job that I still do, cos I'm still a CBT therapist"* (223).

Susan remains loyal to her previous approach as she asserts clearly that she remains a CBT therapist. This suggests there may be a struggle assimilating DBT into her professional identity. Susan's need to say she was enthusiastic in her old job, suggests she feels protective of her previous therapy.

Participants appeared to find it easier to adapt, if DBT was congruent with a previous approach or interest as demonstrated by Kate: "*there are parts of it that… really interest me….the mindfulness component, which I was using before anyway"* (337). However, Susan found it more difficult: *"The*

*mindfulness has been probably the skill I've most struggled with and it took me a lot longer to get on board with that"* (70). DBT is a third wave Cognitive behavioural therapy (CBT) and therefore many of the techniques may have felt familiar for Susan. However, mindfulness is not present in CBT and this may explain why Susan struggled with it.

There were several processes involved in adapting to DBT. Participants often became more objective about their ability and acknowledged there was a development of skills involved: "*realising there's far, far too much…you can only do what you can do, and then we'll just get better at it"* (Jackie, 817). There was also the sense that DBT was learnt through the experience of doing it: "*it was that case of, there's a list of skills, and I've got all the theoretical knowledge….and I don't really know how those skills work or how to put them in place, or when's best to use them, and actually, I'm only learning that by working with people"* (Catherine, 177). Those who already had another therapeutic approach, often needed to make sense of DBT within their existing knowledge: *"cause you get to look and you think, oh right, OK, so what you call that, is actually called that, in another language"* (Kate, 294). Here, Sarah highlights the need for participants to put aside their previous approach to learn DBT: *"you can't learn tennis using a badminton racket"* (Sarah, 461).

The participants resolved the conflict between the two approaches once they observed evidence of the effectiveness of DBT. Here Catherine describes how it felt to utilise DBT to manage a client's suicidal thoughts: *"and then getting that relief when you find out that person is still OK, and actually they're back in group, they're back in individual…..and then that reassurance, that feeling….that sense of oh, right, the model can work and I can cope with this"* (223). The repetition of the word "can" suggests a certainty in the efficacy of the approach and a confidence in her abilities. The participants appeared to develop an allegiance to DBT: *"and I just had to keep….telling myself to let go, that I'd done everything DBTish, and that it was her responsibility and whatever the outcome was that we'd done as much as we could to prepare"* (Jackie 533).

### 2.4.2 *"Whose responsibility is it?"*: Learning to share responsibility

This theme refers to an experience reported by seven participants. There was a sense that DBT encouraged participants to share responsibility amongst everyone involved in the programme which included consultation (Consult) members and clients. In some instances, there appeared to be difficulties associated with attempting to share responsibility. Frustration seemed to arise when clients struggled to take responsibility for keeping themselves safe, as evidenced in this example from Kate: *"oh for goodness' sake, when I talked to her, I was trying to elicit her skills and…it was just kind of almost like, don't know, don't know, don't know"* (243). There were occasions when the participant appeared to feel responsible for the client's lack of progress as voiced by Jackie: *"I just could not get this client to chain, so I then perceived that it was obviously something I was doing wrong"* (50). Kate also reported similar experiences*: "I do tend to… take control a bit, and try to want to sort things out, and I have to watch that with her"* (210). However, participants demonstrated an ability to view their responsibility objectively. Catherine demonstrates how she notices and reflects on her responsibility: *"I might start, be starting to feel responsible for that, but actually whose responsibility is it? Actually…it's that person, it's their emotion, it's their situation…it's not mine"* (447). Kate also describes how she notices and manages her sense of responsibility: *"I suppose I could quite easily fall into that responsibility of trying to make it right again, and I need to pull back from that"* (Kate, 248).

Participants viewed Consult as a place to share responsibility: *"I think another thing is because we were new to it, what we didn't realise is actually….although I was building her up to finishing with me after a year, we could have actually carried on longer"* (104). Jackie repeats the word 'we' in this sentence demonstrating the responsibility for not realising was shared by the Consult. Consultation teams varied in their ability to share responsibility. Some participants reported that colleagues distanced themselves from or allowed others to take responsibility: *"when it comes to doing the group…you will be assigned…people to work with, and those people will just look at you and go, well have you done the photocopying?"* (Lisa, 645). Ian also describes this occurring: "*keeping people on*

*task can be tricky, and I suppose…people almost like making you responsible for doing that, and not…assuming the level of responsibility themselves"* (244). When responsibility was not shared, this appeared to create frustration within the participant, as described by Lisa here: *"if people are not pulling their weight…then other people are going to go, get exasperated*" (661).

### 2.4.3 "*A fine line*": Adjusting to the boundaries in DBT

This theme highlighted participants' struggle with the boundaries within DBT. Linehan (1993b) describes the concept of a dialectic by explaining that reality consists of internal polarised forces (thesis and antithesis) and that the synthesis of these creates a new set of polarised forces. She quotes Goldberg who suggested ideas contain their own contradictions and that truths stand side by side (Goldberg, 1980). As its name suggests Dialectical Behaviour Therapy contains several dialectics, one dialectic is the client being encouraged to change whilst also being asked to gain an acceptance of their reality (Linehan, 1993b). A dialectic emerged within the participants' responses in this theme. In some respects, DBT was viewed as having fewer boundaries and in others as having more than other approaches. At one end, the dialectic described the therapist feeling affected by the client and struggling to maintain boundaries. At the other end, participants were grateful for the boundaries enforced by DBT.

Participants inferred the boundaries were different within DBT and therapists expected to share more. Polly describes the difference between the traditional approach to self-disclosure and the DBT approach: *"we're used to in the NHS of…I'm a blank canvas, you don't need to know if I've got any children, I'm not telling you where I'm going on holiday, that kind of thing, in the DBT, that's not seen as being off limits......it's a justifiable question, and it needs to be validated with an honest answer"* (721). Participants demonstrated how they work collaboratively with clients, such as this example from Catherine: *"This isn't about you being different, this isn't about you being ill…these are skills that we can all benefit from, and this is what happened when I tried it out. So I'm asking you to do the*

*same things as what I'm prepared to do…it can be a great field leveller I think"* (145).

Therapists' described their emotions being affected by clients and Jenny describes the impact of listening to her client's self-harm behaviours: *"a lot of the behaviours are around cutting and inserting things into the skin and you come away and I feel like they've got under my skin"* (85). Kate describes being left with anxiety about her client: "*I worry about her when I'm not here, and I'm thinking, oh, is she OK?"* (227). In some instances it appeared that participants went beyond feeling affected by clients, to almost becoming the client. Here Polly switches between first and third person with ease as though she and the client are one: *"she was a similar age to me, and came from this kind of background, and came into DBT very much in a paradox of, I want to give up this, cause I realise it's going to kill me, versus, this is the only thing that helps me to feel safe and alive, and in control of myself, and so if I stop it, there was a real fear that she, for her that she would com, just completely fall apart and disintegrate"* (252). In this example, Kate reflects how her emotions mirror those of the client: *"you run the gamut of emotions with it, and I think that's, in a way, reflects the clients that you have, and their emotions"* (447).

There were examples of participants struggling to maintain the boundary. Lisa describes meeting with a client after she was discharged from DBT: *"I would see her every few weeks and it wasn't in a conventional therapeutic sense, we'd have a coffee…just to keep an eye on what was going on"* (803). Kate demonstrates an awareness of how she could be influenced to cross boundaries with her client: *"so she's come really to see me as a mum and I have to keep distancing myself and that does bring out quite a lot in me because I do tend to mother people"* (208). At times, feeling there were no boundaries was anxiety provoking for the participants. Polly describes feeling unsure about sharing information with clients and her anxiety about this is demonstrated by her repetition of the word it's: *"you're treading a line between I'm not actually off-loading to you because I'm kind of like, having therapy by sort of speaking to you…it's, it's, it's, it's a, it's a fine line that I think has developed with us all"* (715).

At the other end of the dialectic, participants spoke of enjoying the boundaries in DBT: *"They know the rules, and if they start doing things like turning up late, or not coming…you've already talked about what's going to happen"* (Lisa, 477). Ian enjoyed the pre-treatment phase of DBT and the boundaries it provided: *"I like the idea of having a structured hierarchy of interventions and aims, which are kind of predetermined in a contract"* (79). There was also the sense that participants wanted to maintain their professional identity. In her interview, Polly spoke passionately about the equality between professionals and clients: "*where, people get validated and people, there's reflection and it's all shared, so there's not seen the same traditional boundary between therapist and client that there is in other therapies, that doesn't sort of get breached, it's more permeable"* (740). However, during the interview process Polly appeared to struggle to relinquish the therapist or professional role, as demonstrated by this exchange:

***Interviewer:*** *"I think you said about healthy, a few times, that the group feels healthy. Could you clarify for me…what you mean by healthy?"*

***Polly:*** *"OK, I'm going to clarify something else"*

***Interviewer:*** *"Yeah, haha."*

***Polly:*** *"As we go along"*

***Interviewer:*** *"Yeah".*

***Polly:*** *"Only that I'm conscious of kind of like the dynamic that we're in"* (153).

In this exchange, Polly takes control when she says there is something else she wants to clarify. By wanting to explore the dynamic between her and the interviewer she maintains her professional identity.

### 2.4.4 DBT contains therapists' emotions

The participants described and demonstrated how DBT helped manage their emotions. Jackie describes the emotions she experienced pre and post DBT: *"I'd go home, and I'd be thinking, oh God, I wonder if they're all right….but now, I don't…I'll allow myself the emotion (anxiety), but then I can use some different things to actually bring myself down"* (613). Eight participants described their personal use of DBT skills and how these helped manage their emotions. Many of the participants described how they felt contained by the structure of the therapy and the support of the consultation team.

The most widely reported skill was the use of mindfulness to notice and observe emotions. Jackie describes how she uses mindfulness*: "I look at it (the emotion) and go, right OK, so you're fearful, or whatever I feel that it is, and I just see it as petals dropping to the floor"* (625). Catherine describes her use of mindfulness: *"so being aware of, oh, my irritation's coming up, OK, that's not going to be helpful in this situation, what can I do to just try and bring that down"* (422). Participants described mindfulness positively, often referring to their lives outside of DBT and work: *"I really like the mindfulness, because that helps me, on a personal level, to keep being more mindful, relaxed, able to do my job, able to cope at home, able to kind of live a nicer, better quality of life"* (Polly, 486). As well as reporting the use of skills, there were often occasions during the interview when participants appeared to be utilising DBT skills. For example, Catherine appears to be using 'radical acceptance' to acknowledge there are clients she cannot offer a service: *"that disappointment that people come through and there are referrals that we're having to say, no, because the model is at it is, the resources are as they are, and we can't accept anyone else"* (243). When Jackie speaks of doubting her ability within DBT she appears to be cheer-leading herself: "*I try, and just go with the flow, and just say, you're doing the best that you can"* (385). During her interview, Kate began to challenge her negative thoughts about her abilities: *"What are the facts….what's the evidence for me feeling like I don't know what I'm doing here, and that, I should probably be better if I've got more knowledge"* (298).

Many therapists described how they felt contained by the structure of the therapy. Ian described his use of a framework to manage difficulties within the Consult meeting: *"so my approach is to try and work within the, the framework.....for conducting a Consult meeting and to encourage openness of expression, tolerance of criticism, non-defensive approach and to try and work towards some resolution"* (463). Sarah described how the way DBT conceptualises behaviours, reduced the emotion she experienced: *"when you're looking at people's emotional distress...it's obviously still difficult to work with, and to sit with sometimes, but, I think the, translating that into... a behavioural understanding of what people are experiencing and what people can do to manage that moment, is slightly different...I think because of the structure around DBT, it feels an awful lot more contained"* (923). Occasionally there was a sense that participants were almost hiding behind DBT and its structure, in order to avoid discussing more emotional content. For example, here is Jenny's response to the first question asked of her: *"The structure's really helpful, Consults really helpful. I think...the text and the manual together are really really useful. The text is great cos it gives you that background understanding of the philosophy of it"* (100). Often the participants' response to the first question was to talk about the structure of DBT and at times their answer could have been a quote from a text book.

Participants also reported using Consult to contain emotions. Sarah described how she was concerned that she would influence her client's decision about whether to continue therapy*: "I was feeling a bit exhausted with it all, and I was thinking, for me, it, it would have been easier to....her not to (stay)...I knew I had to discuss it in the Consult...cause I was worried....that would come across to her"* (270). Sarah demonstrated how she uses Consult to express her emotions, therefore allowing her to contain them in therapy.

### 2.4.5 Needing support from others

#### *2.4.5.1 "I know that I've got a team to go back to": Consult providing a secure base*

Every participant mentioned utilising the support of the consultation team. The main function of Consult appeared to be that it allowed members to feel they were part of something bigger than themselves which prevented isolation. In this example, Jenny's repetition of the word "we" demonstrates her alliance to the Consult and the strength of their team: "*because any issues that we've got in Consult, the queries that have come up, we've been able to take to the training days and we've been able to, we've come away clearer about what we should be doing"* (108). This example from Polly highlights how their Consult interact as equals: "*none of us seemed to feel that we needed to be the one who was most heard, or always listened to. We seemed to...for some reason…leave our egos at the door"* (91). By leaving their "ego" it suggests the members are leaving behind their individual agendas and working towards a shared goal of producing the best group they can. The consultation team also shared experiences and knowledge. Here Sarah described how Consult shared their training experience: "*we were all trained together, so we were all approaching it at the same time, we all had the similar kind of questions and issues that we kind of think through together"* (663). Kate's example suggests her experience feels validated because its shared with others: *"but I've noticed…we all have a little bit of a…look of...doom when it's our turn to run the group"* (509). The systemic nature of the DBT programme allowed the participants to gain a knowledge or experience of one another's individual clients. This left participants feeling more confident about the advice given by others, as described here by Kate: "*which means that when it comes to things like supervision, you already know who that person is, you don't just know from the, the colleague, you know yourself as well…it feels to me like I've got a greater understanding anyway, of that person, and that other people have of mine"* (427).

In participants' descriptions of Consult it became apparent that it was providing a secure base. Participants spoke of feeling they were not alone when working with a client. They felt the Consult supported them and were safe in the knowledge they could return there and ask for help or share any emotions they were left with. This example from Kate suggests she feels comfortable and secure within Consult: *"that kind of ability to just come on a weekly basis, and breathe out… and just be exactly the way…you want to be, and feel like everybody there has got your back"* (430). Kate's reference to breathing out suggests she is containing emotion from her individual work and once she arrives at Consult she is able to share this and let it go. Knowing that Consult have *"her back"*, suggests Kate has allowed herself to be vulnerable within the team and is safe in the knowledge of their support. Participants often needed to make themselves vulnerable within Consult, in order to benefit from it: "*I can say…I don't know what I'm doing here, or I'm struggling with this person, or oh my God, you know, what the hell is going on?… and I've got other people around that will sit and say, what about this? Have you tried this?"* (Kate, 45). At times Consult members also needed to challenge one another: *"But it also makes you think as well… because people will pick you up on stuff and say, Now hang on a minute"* (Jenny, 261). In order to challenge one another, Consult needs to feel supportive and comfortable, to allow participants to place themselves in what can feel like a vulnerable position. When they took difficulties to Consult, participants spoke of being certain they would be offered ideas: "*if you've had a bad day, and you come into Consult and you say…I don't know where I'm going with this. You can be sure that people will offer you stuff"* (Jenny 260). Jenny's use of the word "sure" demonstrates faith that Consult will help her and implies she feels safe because of that. Participants knew they had Consult as a secure base to return to, therefore, they felt confident to separate to do their individual work: "*I know that… I'm never on my own, because even if I'm on my own with a client…and I'm struggling, I know that I've got a team to go back to, to say, this was really difficult, I didn't know (how) to deal with it"* (Catherine, 16).

Naturally there were some occasions when there were difficulties in Consult. Three participants expressed frustration about practical issues: "*there's two of us running the group and the group's due to start at 10, and you're there looking at the clock at 10 to 10, and the other therapist isn't there, and you're thinking, we haven't decided who's doing what bit, where are they? I've put all the tables out"* (Catherine, 558). Sarah described an avoidance of issues within their Consult: *"I've been a little bit, kind of, head in the sand about it really, and…as a team, we need to address it"* (Sarah, 577). In another consultation team, there was the sense that previous difficulties had not been resolved: *"it feels to me as though we can keep a lid on things at, at, at, at its worst, we sort of keep a lid on things and we can behave in a civilised way"* (Ian, 195). By stating there is a "lid on it", it infers the equilibrium is volatile and the potential for difficulties to re-occur. Ian's repetition of the word "at" suggests he may be feeling anxious about the difficulties re-emerging. Lisa sums up the impact a confrontation in Consult can have: *"can be more difficult than a difficult client really, cause the client goes away…after the hour, but you've got, the… working week with your… colleagues"* (680).

Despite all therapies containing supervision, the presence of the Consult in DBT appeared to provide more than standard supervision. *"And they were all really supportive…and I really appreciated that, because, in, in other therapies….you can go a month without getting supervision for it"* (Lisa, 509). *"(DBT) definitely offers more on top. The fact that I'm meeting weekly with support is great in the consult meetings, so yeah it's a luxury really that ain't it?"* (Susan, 206).

#### *2.4.5.2 "That's where the problems started to creep in": Needing support from the wider organisation*

Six participants described difficulties implementing DBT, due to a lack of support from those in more senior positions. The DBT programmes were in demand, with participants reporting there was pressure to include more clients. The programmes were valued by the wider organisation, as highlighted by Ian: *"the service director is also quite pleased with the service and wants to talk about it to commissioners as being an example of something we do quite well"* (787). However, it appeared that managers often lacked an awareness of the time and resources involved in DBT: "*we get managers saying have you got any space in DBT to take another one? And we're having to say no, it's a year and I've got two patients and I can't take any more"* (Jenny, 306). Sarah spoke of the difficulties when first establishing the programme and is speaking as a senior member of staff: *"oh so you mean we need to kind of rethink case loads and, oh, this is going to be every week that you need to go to Consult, for an hour and a half?...so yeah, that's where the problems started to creep in"* (767).

Participants did not always feel supported by their managers to implement DBT. Jenny spoke of feeling pressured to take another client and then when she did: *"I've had loads of difficulties getting…a therapy room to see my DBT patient and it's still not resolved"* (134). This suggests that sometimes, participants were not receiving a basic resource. Ian also had an example of when managers have wanted DBT, but have not provided the resources: *"(staff) were very interested and very motivated to be involved, but they were also being told that there's no additional time to… do the work that you're being told you can do really"* (735). Participants described conflict when implementing DBT. A common theme for Jackie was wanting to do things right: *"I think when you're doing a full time job, it almost feels like you're doing, we're really desperately trying to make a good job at this, and we just don't have the time to do as well as"* (379). When Jackie says "feels like you're doing", she may have wanted to say it feels you are doing a bad job. Being unable to give DBT the time she feels it requires is likely to create conflict within Jackie, causing anxiety. Jenny describes

her conflict when attempting to implement DBT: *"I could feel myself getting quite wilful and stubborn and thinking I can't... and then also upset, thinking how am I being put in this position where they are wanting me to do all this, but they're not going to increase my hours"* (160). Jenny appears to feel forced into this position and unsupported.

Many of the participants were required to fight for DBT by attempting to secure resources. In the following example, Ian's use of the word "carved" suggests members toiled for DBT and the effects of this will last: *"those who stayed…have just …carved out a space in their working week when they can do DBT and… over the course of time, it's just been accepted"* (747). Here Catherine talks as though she is attempting to gain a commitment from the managers for DBT: *"if we're going to do this, then these are the resources and the time that we need, and that's going to make a big impact at other professionals in the future because this person couldn't really learn skills, that means they're out of services, long term"* (614). Catherine explains how she was able to manage her competing demands: "*I've been able to juggle my main job, with this job quite effectively, I've been supported by my community team, to carry on doing this work, because they've seen some good results from it"* (358).

## 2.5 Discussion

The aim of this study was to explore the emotional experiences of clinicians, who have utilised DBT for at least a year, and whether there were factors in a DBT approach which influence these. This was explored by conducting semi-structured interviews and analysing the transcripts using IPA. This established five themes: 1) *"It doesn't feel alien anymore"*: Developing an allegiance to DBT;
2) *"Whose responsibility is it?"*: Learning to share responsibility; 3) "*A fine line*": Adjusting to the boundaries in DBT; 4) DBT contains therapists' emotions; and 5) Needing support from others; i) "*I know that I've got a team to go back to*": Consult providing a secure base; ii) "*That's where the problems started to creep in*": Needing support from the wider organisation.

The findings in theme one, namely the participants' accounts of their experiences in the early stages of DBT, doubting their abilities until they eventually adapted to the therapy and became more confident within it, may lend support to the findings of Miller *et al*. (2011) who found trainee therapists experienced less stress after 12 months of implementing DBT. They also lend support to the findings of Perseius *et al*. (2007), that DBT increases stress in the initial stages due to the requirement to learn new techniques. This theme suggested that eventually the participants developed an allegiance to DBT. Therapy allegiance is a common term in the research exploring psychological therapy outcomes and describes the extent to which a therapist believes in the efficacy of the therapy they are delivering (Messer & Wampold, 2002). The concept of allegiance may help explain the difficulties experienced by therapists who had previous experience of or familiarity with another approach. If therapists have already gained experience in another therapy and witnessed the efficacy of this, they are likely to have developed an allegiance to it, accounting for the sense of loyalty some of the therapists held towards their previous approach.

The second theme in this study, that therapists can feel responsible for clients' progress or safety, are common themes in case studies written about working with individuals with BPD (Bot, 1997; Poggi, 1992). Colli *et al.,* (2014) found that therapists can experience helpless or inadequate countertransference, which means the therapist feels responsible when the client is deteriorating or distressed. The participants in this study describe feeling frustration when responsibility was not shared. This finding may be unique to DBT and other group approaches for working with individuals with BPD and therefore further research may consider exploring it.

The third theme relates to the participants adjusting to the boundaries in DBT. Research suggests that when working with individuals with BPD, therapists can experience difficulties in maintaining boundaries. Case studies describe examples of therapists struggling with boundaries and potentially crossing them (Carsky & Yeomans, 2012; Wheelis & Gunderson, 1998; Bot, 1997; Poggi, 1992). Other research has shown that therapists can also respond by becoming more stringent with

boundaries with their BPD clients, being less likely to allow sessions to overrun or not thinking about the client when not at work (Brody & Farber, 1996).

The fourth theme related to participants' emotions being contained by DBT. The factors which enabled this were the participants' use of DBT skills, the structure of the therapy and the presence of the consultation team. These findings appear to provide support to the suggestions made by Linehan (1993b) and Miller *et al*. (2011) and the findings of Perseius *et al*. (2007), namely that the structure of DBT, the supervision, team work, peer support and use of mindfulness are helpful aspects of the approach to reduce the emotional impact of the work. However, the findings from this study suggest that whilst therapists are predominately utilising mindfulness skills, they appear to utilise a greater range of the DBT skills to help them contain the emotions they experience as a result of implementing the therapy.

The fifth theme related to the participants requiring support from others and included two parts. The first was that they considered the consultation team to be a secure base and the second that they required support from the wider organisation. The predominance of the Consult within the interviews appears to support the research of Bourke and Grenyer (2013), who suggested that supervision has a greater role for therapists working with individuals with BPD, than with other client groups. However, the findings from the current study suggest that the participants' view of Consult is more than it merely providing weekly supervision. Participants appeared to view it as allowing them to feel part of something and connected to others. Participants did report gaining professional advice and ideas from their colleagues, but they also spoke of feeling safe, comfortable and supported. Participants spoke of feeling unsupported by the wider organisation to implement DBT. Again this supports the findings of Perseius *et al*. (2007) who briefly mention that a lack of understanding from leaders creates stress for those involved in DBT. Swales, Taylor and Hibbs (2012) found that support from the organisation was a commonly cited challenge when implementing DBT. Carmel, Rose and Fruzzetti (2013) found that a lack of investment from the organisation was a barrier to the

implementation of DBT programmes and clinicians struggled to manage their caseloads and the demands from DBT.

Of interest is that within many of the super-ordinate themes from the individual participant interviews, there were dialectics e.g. poles or extremes of the same concept. That applies for instance to the super-ordinate theme of “Facilitator as professional versus facilitator as collaborator dialectic” within Catherine's interview. This theme described the dialectic within her experiences as a facilitator. On occasions Catherine felt her role as facilitator meant being a professional and she had an awareness of being more powerful than the client. On other occasions she described her role as facilitator as collaborating with the client and being equal with them. This interesting observation reflects the dialectical nature of DBT.

### 2.5.1 Strengths and Limitations

This study has added to the limited research in this area and lent support to the suggestions of Linehan (1993b) as to which aspects of the approach may be beneficial for therapists. This study is the first to utilise a robust qualitative method such as IPA to explore the emotional experiences of therapists whilst they are utilising DBT. Doing so allowed a greater insight into the experience of therapists and the exploration of novel insights into this phenomenon. The research supervisors each studied the exploratory comments, emergent themes and super-ordinate themes from an interview each to ensure the author's interpretations were grounded in the data. Also the use of quotes from the participants allow the reader of this paper to verify the interpretations made and help demonstrate the relationship between the interpretative analysis and the participants' extracts. Yardley (2000) proposes that including participant extracts demonstrating the themes are grounded in the data, suggests sensitivity to the context for participants, which is an important characteristic in good quality IPA studies.

The participants were recruited from three different consultation teams, therefore there may be questions about the homogeneity of the sample. It was felt that none of the consultation teams could have provided enough participants on their own (four was the greatest number of participants who met the inclusion criteria within a Consult), therefore the decision was made that recruiting participants who met the criteria from three teams in the locality would be acceptable. Attempts were made to ensure the homogeneity of the sample by recruiting participants working therapeutically with adults with BPD and specifying the level of training received and the amount of time that occurred since. One male therapist was included in the sample, which could raise questions again about the homogeneity of the sample. However, a study by McIntyre and Schwarz (1998) demonstrated that therapist gender had no impact upon the emotions that therapists experience. Therefore, the inclusion of therapists from both genders should not impact upon the findings. Susan had substantially fewer quotes within the text than the other participants and this may be due to her interview being the shortest, at only 19 minutes in length. The length of the interview may have impacted upon the quality of the data obtained and subsequent analysis. However, the short duration of the interview may be explained by the tendency for Susan's answers to be concise and descriptive. Despite its shorter duration and Susan having fewer quotes in the text, the reader still gains a sense of the difficulties she experienced in adapting to DBT and an insight into her experience.

### 2.5.2 Clinical implications of the findings

These findings may be interesting to anyone working with individuals with BPD who would like more support with their emotions, as they appear to suggest that DBT helps contain the emotions therapists experience. The clinical implication of this is that DBT therapists may cope better with the emotions they experience whilst engaging in therapy with individuals with BPD and therefore may be less susceptible to the effects of negative consequences such as burn out.

Some of the findings may have implications for how successful a DBT intervention could be when working with clients with a BPD diagnosis. Both therapy allegiance and the strength of the therapeutic relationship have been demonstrated to impact positively on the outcome of psychological interventions. The finding in the current study that therapists develop an allegiance to DBT, has positive implications for the outcome of the therapy and suggests that therapists may become more successful when utilising it. Also the therapists' increased ability to contain their emotions, may decrease the likelihood of them expressing or demonstrating negative emotions towards their client, impacting positively upon the therapeutic relationship, again facilitating the success of the intervention.

The findings described in theme one may be of interest to those within their first year of implementing DBT and may help validate and normalise their experiences. It may also be encouraging to note there is a process of adaptation to DBT and that participants reported feeling more confident in the approach with time and experience. These findings may increase awareness of the requirements from therapists to implement a DBT approach, and may help reduce the attrition of staff, that many of the participants reported from their consultation teams, when first setting up the programme. After reading these findings, services may be encouraged to find out more about DBT and the resources involved in implementing the approach. The findings suggest that clinicians may need to work with service managers before commencing DBT, to inform them of the resources required and gain a commitment for these before the programme is implemented.

### 2.5.3 Further research

Within the first theme *"It doesn't feel alien anymore"*: Developing an allegiance to DBT, there were a substantial number of super-ordinate themes from each participant, exploring the process of adaptation with nuances between them. A future research study may consider exploring this process of adaptation further by establishing the processes that occur for DBT therapists. A grounded theory methodology may be appropriate to establish a model of development.

### 2.5.4 Conclusions

This study describes the emotional experiences of therapists whilst implementing DBT. Five themes emerged from the analysis referring to a process of developing an allegiance to the therapy, learning to share responsibility, adjusting to the boundaries of the approach, that several aspects of the approach contain the emotions therapists experience and that therapists require support from others when implementing DBT. The findings suggest therapists' emotions are contained by the therapy and therefore DBT may be an attractive approach to utilise for clinical work with individuals with BPD.

## References

American Psychiatric Association, 2013, *Diagnostic and statistical manual of mental disorders* (Fifth ed.), Arlington, VA, American Psychiatric Publishing.

Black, DW, Blum, N, Pfohl, B and Hale, N 2004, 'Suicidal behaviour in borderline personality disorder: prevalence, risk factors, prediction and prevention'. *Journal of Personality Disorders*, vol.18, pp. 226-239.

Bot, S 1997, 'Overcoming my model of goodness as a psychotherapist: setting boundaries - the case of Tina', *Women & Therapy,* vol. 20, pp. 127-130.

Bourke, ME and Grenyer, BFS 2010, 'Psychotherapists' response to borderline personality disorder: a core conflictual relationship theme analysis', *Psychotherapy Research,* vol. 20(6), pp. 680-691.

Bourke, ME and Grenyer, BFS 2013, 'Therapists' accounts of psychotherapy process associated with treating patients with borderline personality disorder', *Journal of Personality Disorders, vol.* 27(6), pp. 735-745.

Brody, EM. and Farber, BA 1996, 'The effect of therapist experience and patient diagnosis on countertransference'. *Psychotherapy,* vol.33*,* pp.372-380.

Burnard, P, Edwards, D, Fothergill, A, Hannigan, B, and Coyle, D 2000, 'Community health nurses in wales: self-report stressors and coping strategies'. *Journal of Psychiatric and Mental Health*

*Nursing*, vol.7, pp. 523-528.

Carmel, A, Rose, ML, and Fruzzetti, AE 2013, 'Barriers and solutions to implementing dialectical behaviour therapy in a public behavioural health system', *Administration and Policy in Mental Health and Mental Health Services Research,* vol.41, pp. 608-614, DOI: 10.1007/s10488-013-0504-6

Carsky, M, and Yeomans, F 2012, 'Overwhelming patients and overwhelmed therapists'. *Psychodynamic Psychiatry,* vol. 40(1)*,* pp. 75-90.

Charmaz, K 2006, *Constructing grounded theory: a practical guide through qualitative analysis,* London, Sage.

Coid, J, Yang, M, Tyrer, P, Roberts, A and Ulrich, S 2006, 'Prevalence and correlates of personality disorder in great britain', *The British Journal of Psychiatry,* DOI: 10.1192/bjp.188.5.423

Colli, A, Tanzilli, A, Dimaggio, G, & Lingiardi, V 2014, 'Patient personality and therapist response: an empirical investigation'. *The American Journal of Psychiatry,* vol. 171(1), pp. 102-108.

Crossley, ML 2000, *Introducing narrative psychology: self, trauma and the construction of meaning,* Buckingham, Open University Press.

Goldberg, C 1980, 'The utilization and limitations of paradoxical intervention in group psychotherapy', *International Journal of Group Psychotherapy*, 30, pp. 287-297.

Herschell, AD, Lindhiem, OJ, Kogan, JN,Celedonia, KL, and Stein, BD 2014, ‘Evaluation of an implementation initiative for embedding dialectical behaviour therapy in community settings’, *Evaluation and Program Planning,* vol. *43*, pp. 55-63.

Lieb, K, Zanarini, MC, Schmahl, C, Linehan, MM, and Bohus, M 2004, ‘Borderline personality disorder’. *Lancet,* vol. 364, pp. 453–461.

Liebman, RE and Burnette, M 2013, ‘It's not you, it's me: An examination of clinician and client level influences on countertransference toward borderline personality disorder’. Amer*ican Journal of Orthopsychiatry*, *vol.83* (1), pp. 115-125.

Linehan, MM, Armstrong, HE, Suarez, A, Allmon, D and Heard, HL 1991, ‘Cognitive-behavioral treatment of chronically parasuicidal borderline patients’, *Archives of General Psychiatry,* vol.48, pp. 1060–1064.

Linehan, MM 1993a, *Cognitive behavioural treatment of borderline personality disorder*, London, Guildford press.

Linehan, MM, Heard, HL, and Armstrong, HE 1993b, ‘Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients’, *Archives of General Psychiatry,* vol.*50,* pp. 971–974.

Linehan, MM 1993c, *The skills training manual for treating borderline personality disorder,* London, The Guildford press.

Linehan, MM, Tutek, DA, Heard, HL and Armstrong, HE 1994, ‘Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients’, *American Journal of Psychiatry,* vol. 151*,* pp. 1771–1776.

Livesley, J 2001, *Handbook of personality disorders: theory, research and treatmen,*. London, The Guildford press.

Loughrey, L, Jackson, J, Molla, P, & Wobbleton, J 1997, ‘Patient self-mutilation: when nursing becomes a nightmare’. *Journal of Psychosocial Nursing and Mental Health Services*, vol. 35(4), pp. 30–34.

McIntyre, SM and Schwartz, RC 1998, ‘Therapists' differential countertransference reactions toward clients with major depression or borderline personality disorder’. *Journal of Clinical Psychology,* vol. 54(7), pp. 923-931.

Melchior, MEW, Bours, GJJ, Schmitz, P and Wittich, Y 1997, ‘Burnout in psychiatric nursing: A meta-analysis of related variable’. *Journal of Psychiatric and Mental Health Nursing*, vol. 4, pp. 193-201.

Messer, SB. & Wampold, BE 2002, ‘Let's face facts: Common factors are more potent than specific therapy ingredients’, *Clinical Psychology: Science and Practice*, vol. 9, pp. 21-25

Miller, G.D, Iverson, KM, Kemmelmeier, M, Maclane, C, Pistorello, J, Fruzzetti, Watkins, MM, Pruitt, LD, Oser, M, Katrichak, BM, Erikson, KM and Crenshaw, KY 2011, ‘A preliminary examination of burnout amongst counsellor trainees treating clients with recent suicidal

ideation and borderline traits'. *Counselor education and supervision,* vol. *50*, pp. 344-359.

National Institute for Health and Clinical Excellence 2009, Borderline personality disorder – the NICE guideline on treatment and management, Leicester, UK, NICE, Royal College of Psychiatrists and the British Psychological Society.

Parker, I 1992, *Discourse dynamics: critical analysis for social and individual psychology,*. London and New York, Routledge.

Perseius, KI, Kaver, A, Ekdahl, S, Asberg, M and Samuelsson, M 2007, 'Stress and burnout in psychiatric professionals when starting to use dialectical behaviour therapy in the work with young self-harming women showing borderline personality symptoms', *Journal of Psychiatric and Mental Health Nursing,* vol. *14*, pp. 635-643.

Poggi, RG 1992, 'Short-term hospitalization - an aspect of the psychoanalytic treatment of character disturbance'. *Bulletin of the Menninger Clinic,* vol.56(1), pp. 95-112.

Smith, JA 2003, *Qualitative psychology: a practical guide to research methods,*Trowbridge, The Cromwell Press.

Smith, JA, Flowers, P & Larkin, M 2009, *Interpretative phenomenological analysis: theory, method and research,* London, SAGE Publications Ltd.

Swales, MA, Taylor, B and Hibbs, RAB 2012, ‘Implementing Dialectical behaviour therapy: Programme survival in routine healthcare settings’, *Journal of Mental Health,* vol. 21(6), pp. 548-555.

Wheelis, J, and Gunderson, JG 1998, ‘A little cream and sugar: Psychotherapy with a borderline patient’. *The American Journal of Psychiatry,* vol. 155(1), pp. 114-122.

Yardley, L 2000, ‘Dilemmas in qualitative health research’. *Psychology and Health,* vol.15, pp. 215-228