A PORTFOLIO OF RESEARCH WORK

Including an investigation of:
The therapeutic relationship with clients who meet the diagnostic criteria for borderline personality disorder

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Submitted to the University of Surrey in partial fulfilment of the degree of Practitioner Doctorate (PsychD) in Psychotherapeutic and Counselling Psychology

November 2016
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**Statement of Anonymity**

To ensure the confidentiality and anonymity of clients, supervisors and research participants, as well as any individuals reported by interviewed clients or participants, all potentially identifying information has either been omitted or replaced with pseudonyms throughout this portfolio.
Acknowledgements
I would like to dedicate this portfolio to my partner Andrew and my daughter Ophelia. Without their patience, support and love this achievement would not have been possible. Thank you for being there for me and putting up with me. I would like to give a huge thanks to my family, particularly my mum, who is not always able to be here with me, but is always there for me. To my friends, I say thank you for not giving up on me even though I have not been able to be much of a friend for a while.

I would like to extend a big thank you to my supervisor, Dr Ben Rumble for providing me with valuable guidance, insight and support on my research. Your words of encouragement, and often just plain reason, helped me see the light at the end of the tunnel in some dark moments of stuck-ness! I am extremely grateful to all the participants who took part in my studies; I have learned so much from you and I hope others have too.

To the course team at Surrey University, past and present, I extend my sincere thanks for your dedication to the provision of a stimulating learning environment which was such a pleasure to be part of, even when it was difficult. I thank my fellow students for creating an amazing community of support, but perhaps even more importantly I thank you for all the fun we had.

To all my placement supervisors and colleagues, I greatly appreciate you sharing your knowledge, and providing inspiration and encouragement over my years of training. I am grateful to my personal psychotherapist for helping me make sense of the huge developmental changes I experienced in the three years I worked with her. Last, but definitely not least, to all the clients I have worked with, it has been a privilege to have known and worked with you. You probably taught me the most.
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Abstract
This research portfolio comprises a culmination of research work spanning four years of part-time training on the Practitioner Doctorate course in Psychotherapeutic and Counselling Psychology (PsychD) at the University of Surrey. It contains three research reports: a literature review, and two qualitative studies. The literature review explored the extant literature on the therapeutic relationship with clients who meet the diagnostic criteria for borderline personality disorder (BPD). The first empirical study used an interpretative phenomenological analysis to gain an understanding of the experience of the therapeutic relationship for clients who meet the criteria for BPD. In the second empirical study a Foucauldian discourse analysis was carried out to investigate how the therapeutic relationship was constructed in dialectical behaviour therapy and whether these discursive constructs disrupt the dominant pejorative discourses on BPD. Clinical implications for both empirical studies are discussed in light of their findings.
Introduction

This section contains the three pieces of research completed during my training; a literature review, and two qualitative studies. It begins with my literature review written in the first year, which explored how the therapeutic relationship with clients who meet the diagnostic criteria for borderline personality disorder (BPD) has been understood in the literature to date. What became apparent from this endeavour was that the purpose of much of the extant research was an attempt to find the ‘active ingredients’ of the therapeutic relationship and their predictive value in terms of successful therapy outcomes. Critique of this form of enquiry was centred on the view that research methods based on realist epistemologies cannot adequately capture the complex relational processes involved in the client/therapist relationship, which may also particularly apply to clients with BPD. A need was therefore identified for future research to employ more exploratory, in-depth, qualitative research which focuses on interpersonal aspects. The relevance of the client’s perspective was also identified as being of value in recent studies.

My second-year research project developed out of the findings from the literature review and an interpretative phenomenological exploration was undertaken with clients who met the criteria for BPD to gain an understanding of their experience of the therapeutic relationship. The themes which emerged from the analysis of the interviews were: 'contained/uncontained'; 'perceptions of therapist'; and 'issues of control'. The importance of the therapeutic relationship was exemplified and the findings were fairly consistent with the extant theoretical and clinical discourses on the therapeutic relationship with this client group. However, this type of research enables a different way of engaging with the material; it is not concerned with finding factors which clinicians may then be able to apply to their practice in the form of techniques or attitudes. Instead, it provides an alternative way of understanding the phenomena which may not be strictly technically applicable, but has the potential to engender a more direct empathic understanding which can influence clinical practice with this client group through a deeper understanding of their subjective experience of the therapeutic relationship.

After conducting the second-year study from the client’s perspective, I was curious to explore the therapeutic relationship with clients who meet the criteria for BPD from the perspective of the therapist. However, I became aware during the research process, of the context specific nature of the interview and whilst the purpose of my study was to gain
insight into the participants experience of the therapeutic relationship, the actual object of analysis was the interview transcript. Interpretative phenomenological analysis makes assumptions about language being an unmediated form of expression and I became interested in exploring the constitutive nature of language; that it constructs rather than describes reality. While carrying out my literature review in my first year, I was struck by the pejorative – negative and blaming – language that has been used to describe individuals with BPD. If language constructs objects, rather than just describes them, I wondered what impact this might have on therapists working with clients with BPD, and in particular how it might affect the therapeutic relationship. For my final year research project, I conducted a Foucauldian discourse analysis (FDA) of interviews with DBT therapists to gain an understanding of the ways in which the therapeutic relationship was constructed in their talk; how particular ‘ways-of-seeing’ the world and ‘ways-of-being’ in the world were afforded and to investigate whether these discursive constructs disrupt the dominant pejorative discourses on BPD. The discourses identified – biomedical, collegial, and intimacy, facilitated certain ways of being with the client, such as ‘expert’, ‘collaborator’ and ‘confidant’. The therapeutic relationship was not constructed in negative terms and could be viewed as a site of resistance to the discourses which ‘other’ and pathologize clients who meet the criteria for BPD. This is of particular relevance to counselling psychology, which starts from valuing relationship.

I should also like to draw the reader’s attention to a conference abstract reproduced at the end of this section. It is from a poster I presented at the Division of Counselling Psychology conference in July 2016 based on my IPA study.
A review of the literature on the therapeutic relationship with clients who meet the diagnostic criteria for borderline personality disorder

Abstract
This paper presents a review of the literature on the therapeutic relationship with clients who meet the diagnostic criteria for borderline personality disorder (BPD). The therapeutic relationship is now recognized as a vital feature of the therapeutic process and positive therapy outcomes. One of the main characteristics of BPD is the experience of difficulties in the interpersonal domain. Clinical practice and research evidence suggest that these difficulties are often replicated in some way in the therapeutic relationship. This paper gives an overview of the conceptualization of the therapeutic relationship in the various therapeutic practices for working with clients who experience BPD symptoms. From this, the therapeutic alliance emerges as a significant factor in therapy efficacy for this client group. After a brief history of the development of the concept of the therapeutic alliance, the research on how the therapeutic alliance is established and maintained is assessed. The limitations of current research into the therapeutic relationship with BPD clients is investigated and gaps in the available literature identified. The implications, and possible future directions for research are discussed, in particular the relevance of this for counselling psychologists, particularly those working with clients who meet the criteria for BPD.

Key words: Borderline Personality Disorder (BPD); therapeutic relationship; therapeutic alliance; relational; interpersonal
Introduction
Borderline personality disorder (BPD) is the diagnosis given to individuals experiencing a range of affect, identity and interpersonal difficulties which they find debilitating (Bateman, 2012; Krawitz & Jackson, 2008; Linehan, 1993). One of the main characteristics of BPD is experiencing difficulties in the interpersonal domain. The difficulties in relating with others in their personal life, experienced by individuals with BPD, is usually replicated in some way in the context of therapy (Bateman, 2012). It is recognized that establishing a therapeutic relationship is not easy given that the BPD client’s problems are mainly manifested in this interpersonal domain (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). The therapeutic relationship is now recognized as a vital feature of the therapeutic process and positive therapy outcomes (Norcross, 2011; Wampold, 2001). This paper gives an overview of the conceptualization of the therapeutic relationship in the various therapeutic practices for working with clients who experience BPD symptoms. It highlights the work of theorists with an integrative perspective who have attempted to combine the common factors of the different approaches into a set of therapeutic techniques and practices which address the breadth of BPD symptomology. The evidence they draw on suggests that one of the elements of therapy for BPD which is associated with good therapeutic outcomes and client retention is the therapeutic relationship (Clarkin, Cain, & Livesley, 2015; Livesley, 2012; McMain, Boritz, & Leybman, 2015; Paris, 2015).

The research literature on these aspects of the therapeutic relationship is critically appraised and it is noted that the majority of research focuses on the therapeutic alliance. A brief outline of the development of the concept of the therapeutic alliance follows, before investigating the limitations of current research into the therapeutic relationship with BPD clients and gaps in the available literature. Much of the research on the therapeutic alliance, in general, and in specialized BPD therapies, is concerned with isolating factors which contribute to good therapy outcomes. This is critiqued on the basis that the therapeutic relationship is complex, intersubjective, dynamic and process-oriented, and therefore more careful, thorough research into the communication between therapists and clients, utilizing a range of methodologies, is required (Butler & Strupp, 1986; Horvath, 2005; Orlinsky & Ronnestad, 2000; Safran & Muran, 2006). Lastly, the implications, and possible future directions for research in this area are discussed, culminating in the question for the researcher’s research project which follows. This is discussed with regard to the relevance
of this for counselling psychologists, particularly those working with clients who meet the criteria for BPD.

Method

A narrative approach was adopted to determine the source of materials and the structure of the review. The main purpose was to provide a survey, or overview of the existing empirical research and theory, including some history of the concepts under scrutiny. However, it also evaluates the theories to date to some extent and identifies possible gaps in the literature that further research could address.

Search strategy

Searches of databases, websites and library catalogues were conducted in an iterative manner during 2013 to retrieve articles related to the therapeutic relationship and BPD. These were updated in 2016. Key articles were obtained primarily from PsycINFO, PsycARTICLES, PsycBOOKS, Psychology & Behavioral Sciences Collection, Medline and the Cochrane Library. Search terms included “therapeutic relationship,” “therapeutic alliance,” “working alliance,” “therapy relationship,” “borderline personality disorder,” and “BPD” Journal articles, books and grey material were retrieved mainly from psychology and mental health fields of study. The reference lists of each article were reviewed in detail to find additional material. (A detailed account of the search strategy can be found in Appendix A).

Inclusion/exclusion criteria

Severe BPD population studies were excluded mainly for practical reasons of conducting future research with this population. For example, gaining ethical approval to conduct research in forensic and high security locations, and potential difficulty recruiting participants from this population.

Studies involving BPD in adolescents were excluded mainly because it is still a contentious issue and where diagnoses are made in adolescents, they are usually offered specialized treatment, often as part of an ‘early intervention’ care package (Miller, Muehlenkamp, & Jacobson, 2008).
Due to the exclusion of these studies, the main focus of the review was on research investigating the therapeutic relationship with the client group of those diagnosed with ‘moderate to severe’ BPD who would mainly be accessing out-patient and community secondary care services in the NHS, particularly specialist personality disorder services, as well as a minority receiving care in private clinics.

**BPD and the therapeutic relationship**

**Definition of BPD**

According to the Diagnostic and Statistical Manual for Mental Disorders (DSM-5), BPD involves a prevalent pattern of unstable relationships and unstable self-image as well as increased impulsivity, with onset usually in early adulthood (American Psychiatric Association, 2013). A diagnosis can be made if the client presents with at least five of the nine criteria for BPD which include: fear of abandonment; black and white thinking, particularly in relation to others, i.e. idealisation and devaluation of others; identity disturbance; impulsiveness such as binge eating or substance abuse; suicidal, para-suicidal and self-harm behaviours; affective instability, or extreme mood swings; chronic feelings of emptiness; inappropriate anger; and paranoid ideation and/or dissociation (American Psychiatric Association, 2013). It is thought to affect between 2% (American Psychiatric Association, 2013) and 6% (Grant et al., 2008) of the population and around 70% with a diagnosis of BPD are women (Grant et al., 2008). There is also a high instance of co-morbidity with other mental health problems such as depression and anxiety.

BPD is a highly contentious diagnosis with confusion and disagreement about its validity and reliability as a distinct disorder, stimulating debate regarding its usefulness within psychology, psychoanalysis and psychiatry (NICE, 2009). Bender (2011) points out that there are 256 ways to meet criteria for BPD because the categories are broad and open to interpretation. It has been described as a ‘wastebasket’ diagnosis with no conceptual clarity between the conflicting ideas derived from disparate psychological, psychoanalytic, biological and genetic theories (Aronson, 1985). Defining it as a ‘motley diagnosis’ Tyrer (1999) questions its validity as it is so heterogeneous, other than to direct the clinician to “difficult behaviour that requires intervention.” (Tyrer, 1999, p. 2096). He suggests it should be re-classified in the DSM with mood disorders as a form of persistent unstable mood. With regards to the term ‘borderline’ Millon (2011) points out, “unless the word is
used to signify a class that borders on something then it has no clinical or descriptive meaning at all.” (Millon, 2011, p. 891). The term ‘borderline’ used to refer to the psychoanalytic understanding, originated by Stern (1938), of a certain type of patient who did not fit into either neurotic or psychotic group, whom he described as “difficult to handle effectively by any psychotherapeutic method.” (Stern, 1938, p. 467). The ‘borderline patient’ acquired some coherence as an actual ‘personality organization’ in the object relations school. Such patients were understood as lacking a clear identity as a result of relational deficits in early, pre-oedipal development (Kernberg, 1975). However, the psychoanalytic definition accounted for only a minor part of the classification when it first appeared in the DSM 3 in 1980 (American Psychiatric Association, 1980). Millon (2011) wonders whether BPD is a ‘reality’ or a ‘psychiatric fad’.

In addition to this, BPD has a stigma associated with it which is high in intensity and prevalence compared with other mental illnesses. BPD clients are often viewed as ‘manipulative’ and ‘attention-seeking’ and more in control of their actions than those diagnosed with other conditions, such as depression or schizophrenia (Lewis & Appleby, 1988; Markham & Trower, 2003). Nehls (1999) found that a major theme in her study of BPD clients was that the diagnosis was more of a label than a diagnosis. One participant described it as, “…being labelled and judged versus diagnosed and treated…Once given that label, you can never argue or get rid of it” (Nehls, 1999, p. 288). The effects of stigma on therapists working with BPD clients may negatively impact on the therapy. However this is an under-researched area and little is known about the effects of stigma as an independent factor in therapeutic possesses (Aviram, Brodsky, & Stanley, 2006). According to these views BPD is a stigmatized, difficult to define diagnostic entity, which seems to render the establishment of an ‘object’ of enquiry problematic. These issues are addressed in various ways in this paper, in terms of the impact they may have on the notion of the therapeutic relationship with clients with such a diagnosis. They account for some of the difference and complexity in theorizing about and conducting research on the relationship from the diverse range of therapeutic practices and approaches involved.

Whilst there is no clearly defined aetiology of BPD, there is a general consensus amongst psychologists that a number of factors; genetic, biological, social and psychological are contributing factors (NICE, 2009). There are high rates of child abuse – emotional, sexual, physical and abuse due to neglect – reported by individuals with BPD. Estimates of between
40-70% have experienced sexual abuse as children (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). There is no direct causal relationship between child abuse and BPD. It is thought to be a significant factor which is mediated by other elements; environmental, such as caregiver response to the abuse. Other possible factors include a genetic vulnerability to emotional dysregulation. One twin study has shown high concordance rates in monozygotic pairs which suggests a strong genetic effect in the development of the disorder. Research has focused on personality traits which are thought to underlie BPD, such as neuroticism, impulsivity, anxiousness, affective lability, and insecure attachment, and supports the notion that there are strong genetic influences. However this research is scant and inconclusive (Skodol et al., 2002). Insecure attachment processes associated with BPD can also be thought of as developing in environments where family relationships are problematic, and abuse occurs (Bornovalova et al., 2013; NICE, 2009; Stepp, Lazarus, & Byrd, 2016; Zlotnick et al., 2003). There is some evidence to suggest that individuals with BPD may differ neurologically from those without the condition. King-Casas’ (2008), fMRI study showed a lack of activity in the region of the brain associated with the ability to recognize social behaviour norms in BPD clients. In a related study, oxytocin, which is known to increase trust and attachment behaviours, was found to significantly impede the pro-social behaviour in the BPD group (Bartz et al., 2011). The significance of these findings is that individuals with BPD may have a substantially different neural structure, although this could be due to epigenetic programming, whereby an individual’s developmental history of abuse, trauma, or an invalidating environment, influences biological processes leading to BPD symptomology (Prados et al., 2015).

The various psychotherapeutic approaches to understanding and treating BPD differ in the weight they give to these factors and the aspect of psychological development and functioning which is most affected or impaired (Clarkin et al., 2015). For example, dialectical behavioural therapy (DBT) emphasises the biological underpinnings of emotion dysregulation compounded by an invalidating environment (Linehan, 1993). Whereas, mentalization based treatment (MBT) focuses primarily on the early attachment environment and hypothesises that a lack of mirroring affective states by the carer to the infant results in an inability for an intentional being to form (Bateman & Fonagy, 2004). The aetiological pathways, in terms of the relative weight accorded the particular elements and the theoretical frameworks of the different approaches shape the way the therapeutic relationship is formulated. They determine the relative importance of the therapeutic
relationship within the therapeutic practice and its role as either a necessary precursor which enables therapy to proceed or a mechanism for change, and the variations in between.

The therapeutic relationship and BPD
The symptoms associated with BPD can have a profound effect on an individual’s life, particularly their interpersonal relationships. The subjective experience of the individual often involve particular patterns of relating to others often characterized by desperate need for closeness with others, especially romantic partners, which may mean idealizing others initially. Then, often, in order to pre-empt abandonment, significant others are devalued and pushed away (Krawitz & Jackson, 2008). Individuals with BPD experience emotion much more intensely, for longer periods and have less control over their emotions, generally than those without BPD. Marsha Linehan described people with BPD as like “[…] the psychological equivalent of third-degree-burn patients. They simply have, so to speak, no emotional skin. Even the slightest touch or movement can create immense suffering.” (Linehan, 1993).

The difficulties in relating with others in their personal life, experienced by individuals with BPD, is usually replicated in some way in the context of therapy (Bateman, 2012). Evidence from individual studies and meta-analyses over the past thirty years or more, strongly supports the effectiveness of psychotherapy for treating BPD (American Psychiatric Association, 2006; Barnicot, Katsakou, Marougka, & Priebe, 2011; Lieb et al., 2004; NICE, 2009; Stoffers et al., 2012). Furthermore, the therapy relationship is highly correlated with therapy effectiveness as shown in several meta-analyses into the effectiveness of psychotherapy, across models and utilizing a variety of methods, ranging from RCTs to case studies (Ardito & Rabellino, 2011; Horvath & Symonds, 1991; Norcross, 2011; Wampold, 2001). These findings suggest that there is a common factor among the plethora of therapy types, which has led some to talk of the ‘dodo bird effect’. Based on the story of Alice in Wonderland, where the Dodo bird pronounces all are winners and offers all the contestants prizes (Steffen, 2013). Moreover, the findings suggest that not only does the therapeutic relationship correlate with therapy effectiveness, but that it is predictive of successful therapy outcomes across all therapy approaches and independent of the measures used (Ardito & Rabellino, 2011; Falkenström, Granström, & Holmqvist, 2013; Horvath & Symonds, 1991). Findings from studies with BPD clients are comparable, supporting the
view that the therapeutic relationship is of central importance across most psychotherapy models and treatment programs for BPD (Bedics, Atkins, Comtois, & Linehan, 2012a; Clarkin et al., 2015; Smith Benjamin, 2002; Spinhoven et al., 2007). However, it is recognized that establishing a therapeutic relationship is not easy given that the BPD client’s problems are mainly manifested in this interpersonal domain (Spinhoven et al., 2007).

The majority of research on the therapeutic relationship with clients who meet the criteria for BPD, focuses on the therapeutic alliance. The therapeutic or working alliance refers to the aspect of the therapeutic relationship which applies to the ability of the client and therapist to work co-operatively together (Clarkson, 2003). Before moving on to critically survey the research on the therapeutic alliance in the context of working with client who meet the criteria for BPD, this review will outline the development of the concept of the therapeutic alliance.

The therapeutic alliance

The therapeutic alliance has its roots in Freud’s (1912) theorization of transference; the therapeutic relationship distorted by the client’s unconscious projections of thoughts and feelings based on past experiences of others on to the therapist. Describing it as the ‘vehicle of success’ in therapy, Freud suggested that the possibility of positive attachment developing between the client’s healthy part of the self and the therapist, which is not only based on the projections by the client onto the therapist, as potentially beneficial (Freud, 1912). He later refined this concept to refer to the development of a ‘real relationship’ between the client’s ‘conscious, reality-based self’ and the ‘real’ therapist which facilitates the healing process (cited in Gelso, 2014; Horvath & Luborsky, 1993). Greenson (1967), extended the concept of a collaborative, reality-based relationship further, with a tripartite model of his ‘working alliance’. Meissner (2007) also posits that the therapeutic relationship consists of three elements; ‘the therapeutic alliance’, ‘transference and countertransference’ (the responses evoked in the therapist by the client’s unconscious projections) and the ‘real relationship’. The elements are thought to interact with each other, but that it is important to separate them for research and reflective practice purposes. In her integrative model of the therapeutic relationship, Clarkson (2003) added two more elements; ‘the reparative/developmentally needed relationship’ and the ‘transpersonal
relationship’ and defined the working alliance as “[T]he part of client-psychotherapist relationship that enables the client and therapist to work together even when either or both of them don’t want to.” (Clarkson, 2003, p. 8). The importance of the alliance is that it facilitates the work in other aspects of the therapeutic relationship, allowing the client to stand back from and reflect on the processes in therapy (Meissner, 2007).

Bordin’s (1979) ‘pan-theoretical’ concept introduced the notion that the working alliance is; “one of the keys, if not the key to the change process.” (Bordin, 1979, p. 252). In this respect, it is similar to Roger’s (1951) formulation of the change process in therapy, in which he identified three core conditions, offered by the therapist – empathic understanding, unconditional positive regard and congruence – as not only necessary, but also sufficient, to facilitate change. However, for Bordin the working alliance is the component that enables the patient to collaborate with the therapist and follow the treatment plan, rather than being curative in and of itself (Catty, 2004). Bordin (1979), drawing on concepts from cognitive therapy, such as Beck’s (1967) ‘empirical collaboration’, differentiated the working alliance into the ‘agreement’ between client and therapist on ‘goals’, ‘tasks’ and ‘bonds’. Goals are an agreement on what the client is trying to achieve in the particular form of therapy they are engaged in; so for example in psychodynamic therapy the overall goal would be for the client to achieve a more integrated sense of self, whereas in a behaviour therapy the goal may be much more narrowly defined to improving an aspect of the client’s life. Tasks refer to what is expected of the therapist and client in the process, such as observing behaviour in a behaviour therapy or attending to bodily sensations in gestalt therapy. With the exception of person-centred therapy where the tasks are not explicitly stipulated, tasks can help movement towards the therapy goal through the ability of the therapist to link the task with the client’s understanding of their difficulties and desire to change. Bonds describe the attachment and trust which is developed in the relationship. With therapies which focus attention on the more defended levels of a client’s inner world, a deeper bond is required (Bordin, 1979).

The different aspects of the therapeutic alliance need to interact in order to work in a coherent fashion. In this sense, the working alliance is model specific. Ulvenes et al. (2012) conducted a study which illustrates this. They investigated the interaction between therapist actions and the formation of the bond on symptom reduction for BPD clients in short-term dynamic therapy and cognitive therapy. They found that in the dynamic therapy, the
avoidance of affect suppressed the effect of the bond and resulted in lower symptom
reduction, however in the cognitive therapy group, the suppression of affect had a positive
effect on the bond and greater symptom reduction was reported. What this means is that a
cognitive therapy will have different goals and tasks to a dynamic therapy. Therefore,
whilst the therapist may be asking the client to focus on a description of feeling when
working on core beliefs, for example, they generally do not engage with the mood or
behaviour of the client in the here and now, between therapist and client. If the therapist
does utilize these techniques, they are not deemed to be engaging in the alliance as it has
been established for this particular type of therapy (Ulvenes et al., 2012).

A number of measures have been developed to assess the therapeutic alliance; Ardito and
Rabellino (2011) identify ten of the most frequently used measures in a review on the
alliance and outcome of psychotherapy. The majority consist of the scales which measure
aspects of the therapeutic alliance from the perspective of either the therapist, the client or
an observer – or a combination of them. Most are self-report measures with between 6 and
145 items and rely on scales ranging from 2 to 5 dimensions. One of the most frequently
used instruments is the WAI, which is based on Bordin’s tripartite model of the working
alliance. Horvath and Greenberg (1989a) developed the WAI to measure, not just the
outcome variance but to capture the constituents of the working alliance, regardless of the
therapist’s theoretical orientation. The items consist of questions regarding the relationship
which can be coded according to the three aspects of the working alliance. For example the
WAI client form consists of questions such as:

• I feel uncomfortable with………and I agree about the things I will need to do in
  therapy to help improve my situation (tasks).
• I am worried about the outcome of these sessions (goals).
• ………and I understand each other (bonds).

(Horvath & Greenberg, 1989b)

Other measures have been developed from a specific theoretical viewpoint, raising
questions about whether different factors are being measured. However, correlations
between the scales have been shown to be consistent and the different measures seem to
evaluate the same core therapeutic processes (Ardito & Rabellino, 2011). For example,
Stiles and colleagues (2002) assessed the convergent validity of the Agnew Relationship
Measure (ARM) and the Working Alliance Inventory (WAI) in a study of two clinical trials
of short-term therapy for depression and found that the ARM’s core alliance scales (bond, partnership and confidence) strongly correlated with the WAI’s scales (bond, tasks, and goals) (Agnew-Davies, Stiles, Hardy, & Shapiro, 1998).

Despite this the therapeutic alliance is a contentious construct; with different meaning depending on the psychotherapeutic approach. This is most apparent between the psychoanalytic perspective and other psychotherapies because of the relative weight placed on the ‘rational’ function of the alliance, which contrasts with the main function of psychoanalysis which is to work with unconscious material (Catty, 2004). However, there are points of disagreement within the non-psychanalytic therapy traditions as well. For example, Tee and Kazantzis argue that (2011) collaborative empiricism, as conceived by Beck (1967) is not fully accounted for in the working alliance in cognitive therapy. Collaboration is not just ‘agreement’ on tasks and goals, but actively encouraging the client to take the lead in goal setting and tasks; genuinely sharing the work of empirically evaluating the client’s beliefs, not only agreeing on a therapeutic plan. In this account the working alliance fails to measure one of the key constructs of cognitive therapy (which is also of central importance to cognitive behavioural therapy (CBT)) in outcome research (Tee & Kazantzis, 2011).

The complexities and limitations of the alliance construct are addressed in this review later, however theory and research on the specific ways the therapeutic relationship is conceptualized and studied in relation to BPD is explored first.

Theory and research on the therapeutic relationship with BPD clients

In terms of empirical research the therapeutic relationship in relation to BPD has not been extensively researched (Levy, Beeney, Wasserman, & Clarkin, 2010). In the latest Cochrane report on psychological therapies for people with borderline personality disorder, which analysed data on research from 28 randomised studies, involving 1804 participants, comparing BPD interventions to controls from 1872 to 2010, only four measured therapeutic alliance or relationship factors directly (Stoffers et al., 2012). Having said that there are also a number of studies specifically looking at the therapeutic relationship in the context of therapy with clients with a BPD diagnosis. However, the majority of theoretical assumptions about this particular relationship seem to be extrapolated from theory and
empirical research on the therapeutic relationship more generally. The following section outlines the different ways of understanding BPD according to the therapeutic approach, and briefly describes the therapeutic interventions prescribed by the various approaches. The role and relative importance of the therapeutic relationship is looked at and the theoretical and empirical underpinnings associated with them investigated. It is not an exhaustive list of therapies, but rather a brief outline of those most commonly provided and practiced to treat BPD.

**Cognitive behavioural therapies**

**Cognitive behavioural therapy (CBT):**

CBT as modified for work with BPD clients, places emphasis on early schemas and core beliefs (Davidson, 2008). Schema allow the individual to code, organize and make sense of the vast array of stimuli that impact on them from without and within and are condensed into cognitions. Dysfunctional schemas (i.e., causing the individual distress) consist of propositional statements, such as, ‘if I am ignored, then I am unlovable’ and ‘core beliefs’; the fundamental beliefs about ourselves, which usually remain consistent across different situations. Padesky’s (2004) ‘old system, new system’ of developing new beliefs and rules for living based on new schemas can be utilized including behavioural experiments to ‘test drive’ the new system, before getting rid of the old one. It is thought to foster a sense of security and hope in clients with BPD symptomology (Beck et al., 2004). Empirical evidence for CBT for BPD include three controlled studies (Stoffers et al., 2012). In a single trial comparing CBT with treatment as usual (TAU) there were no statistically significant between group differences. However the results showed a trend for improving some outcomes for both groups (Davidson et al., 2006).

In CBT for BPD, collaboration on therapy tasks and validation of clients’ emotional states and goals is crucial. The therapist stance is being genuine and acknowledging their own limitations (Cash, Hardy, Kellett, & Parry, 2014). However, it is recognized that client’s maladaptive schemas will likely impact on the therapeutic alliance by activating therapists’ cognitive schemas (Spinhoven et al., 2007). Therefore, therapists need to be skilled at self-monitoring their own dysfunctional thoughts to keep them positive and hopeful in relation to their clients. The therapeutic relationship is viewed as a vehicle for change, in that a trusting, collaborative, positive relationship is seen as a priority in order to enable the ‘nuts
and bolts’ work of therapy to proceed (Newman, 2007). There is some evidence to suggest that the correlation between the therapeutic alliance and symptom improvement may be the inverse of how it is usually interpreted, that is, it is symptom improvement which instigates enhancement of the alliance (Derubeis, Brotman, & Gibbons, 2005). However, it is probably a more complex reciprocal process that occurs between the relational and technical aspects of CBT.

**Dialectical behavioural therapy (DBT):**

DBT is one of a number of treatments which are ‘manual-based’; that is they consist of recommended packages of care which require specialized staff training and can be applied to different settings (Wampold, 2001). DBT is the most empirically supported therapy for BPD and recommended by the National Institute for Health and Care Excellence (NICE) (2009) for women with BPD, who are at high risk of suicidal and/or self harming behaviour. DBT is a behavioural therapy based on a biosocial theory that places particular emphasis on the aetiology of BPD resulting from the transactions over time between a genetic pre-disposition of emotional sensitivity with an invalidating environment (Robins & Koons, 2000). DBT is designed to treat the client holistically, moving dialectically from polarities to syntheses. The therapist facilitates this by accepting the client where they are in the present (even if suicidal or self-harming) and at the same time encourages the client to change (Linehan, 1993). Mindfulness is a core component to help clients become more aware of emotional states, as well as distress tolerance, emotion regulation, interpersonal effectiveness and self-management being actively taught. The year-long program consists of a weekly skills acquisition group and weekly individual therapy with phone coaching with the therapist at pre-determined times. The therapists take part in a weekly group consultation meeting where they aim to be non-judgemental, provide support and offer strategies to each other (Linehan, 1993).

The therapeutic relationship in DBT is also dialectical in the sense that it is not only a vehicle for delivering the mechanisms of change (as in other cognitive behavioural therapies), but also a mechanism of change as well. Conceptualized as ‘relating behaviours’, it is the therapists’ responses in the moment-by-moment interaction with clients which shapes the relationship. The emphasis is on maximum effectiveness in any given moment in order to facilitate behavioural change in the client and help them achieve
their goals. The therapist stance in DBT is warm and genuine. Therapists are encouraged to pay close attention to internal processes and self-disclose to clients in appropriate ways, in order to mitigate the client’s experience of a history of continuous invalidation of emotional communication (Swales & Heard, 2007).

Despite its theoretical importance in the DBT literature, there is not a huge amount of empirical research on the therapy relationship. It is worth mentioning, however, that one of the earliest studies into DBT was on the effect of reducing therapist stress by shifting perceptions of the client from hostile to friendly. Therapist ratings that were consistent with non-pejorative conceptualization were associated with better therapy outcomes (Shearin & Linehan, 1992). Further studies have supported these findings (Bedics, Atkins, Harned, & Linehan, 2015). Another theory-driven study, tested four hypotheses of the therapeutic relationship and patient introject in DBT. The authors surmised from their findings that therapists, balancing autonomy and control, maintaining a non-pejorative stance toward the patient, and the use of warmth and autonomy was a contingency for “improved intrapsychic outcome” (Bedics, Atkins, Comtois, & Linehan, 2012b, pp. 237-238). However, a study comparing DBT, transference focused psychotherapy (TFP) and a dynamic supportive treatment found less intrapsychic improvement in the DBT group. This referred to reflective function and attachment organization, which it could be argued are important relationship constituents and conclude, therefore, that the therapy relationship model they were testing did not have the predicted outcome (Levy et al., 2006). Furthermore, in her longitudinal investigation into the therapeutic relationship in DBT, Little (2011) found that patterns of therapeutic alliance across time did not predict therapy outcome and suggested that more qualitative research was required to better understand the quality of the relationship. These apparent contradictions highlight the difficulty of making sense of the research when the variables are defined in different ways according to the approach, method and research question.

**Integrated approaches**

**Interpersonal psychotherapy (IPT):**

IPT is a manual-based psychotherapy originally developed for brief therapy for depression (Weissman & Klerman, 1990). It is based on the ideas of the interpersonal school of Sullivan (1953) and Bowlby’s (1988) attachment theory, which emphasise the importance
of early relationships on development and has more recently been adopted for BPD (Markowitz, Skodol, & Bleiberg, 2006). Adopting a medical model position, IPT views psychological problems as mental illnesses, and the therapist takes an expert position on diagnosis, emphasising the client’s ‘sick role’ in order to alleviate self-blame (Bateman, 2012). Research is scant; one unpublished study where most of the control group dropped out of the program, but where self-reported symptoms declined in the IPT group and therapist engagement and high verbal activity were identified as helpful factors. In addition, the investigators thought that giving permission to the clients to attend sporadically over the 12 session treatment – missing sessions when experiencing intense affect or anger – may have helped them complete the course (Markowitz et al., 2006).

In general, the therapist stance is warm, positive and hopeful, with the intention of inspiring confidence in the client that recovery is possible. However, the therapeutic relationship is not a focus of therapy. In order to prevent interpersonal conflict within the therapeutic encounter, the BPD clients’ interpersonal relationships outside the therapy room are the sole focus and interpretations are avoided. An emphasis on appraising the complexity of relationships is adopted to encourage flexibility on interpersonal interactions (Bateman, 2012; Markowitz et al., 2006).

Schema therapy (ST):
Originally named schema-focused cognitive therapy for BPD, schema therapy, ST integrates schema theory from cognitive therapy with the interpersonal focus of attachment theory and the object relations school of psychodynamic therapy (Young, 1999). It combines the use of a number of techniques, such as ‘two chair’ and ‘empty chair’ work, drawn from approaches such as Gestalt, as well as experiential techniques, such as, imagery, role play and letter writing (Kellogg & Young, 2006). A recent comprehensive review of ST concluded that for a relatively new therapy, with few efficacy studies it compared favourably to psychodynamic therapy on all BPD symptomology outcome measures. However the authors of the review, draw attention to the fact that there were few effectiveness studies, particularly those investigating the specific elements of ST, which would enable analyses of the particular factors producing successful outcomes (Sempértegui, Karreman, Arntz, & Bekker, 2012).
The therapeutic relationship in ST is viewed as a mechanism of change, primarily through the intervention of ‘limited reparenting’. Based on the assumption that BPD clients did not have their emotional needs met by early carers, the therapist attempts to compensate for this by behaving ‘as if’ they were a parental figure; providing a safe, stable and accepting space with less emphasis on problem solving and more demonstrative empathy at the beginning of therapy. This in and of itself is thought to bring about positive change (Arntz & van Genderen, 2009). The influence of the therapeutic alliance on outcomes in the largest study to date on ST, comparing it with TFP, was found to be significant and favoured ST. Furthermore when treatment condition was controlled for, attrition rates were found to correlate with client’s perception of the alliance early in the therapy, but only for ST, suggesting that the alliance was more important in ST than TFP, and thereby agreeing with Young’s model (Spinhoven et al., 2007).

_Cognitive analytic therapy (CAT):_  
CAT is a highly structured time-limited therapy combining elements of object relations theory and cognitive therapy and has been used to treat clients with BPD including in specialist services (Ryle & Kerr, 2002). CAT is thought to be particularly applicable to treating BPD because of its focus on interpersonal difficulties. The concept of the self in CAT is relational and constituted by an internalised repertoire of relationship patterns, originating in infancy with early caregivers and developed throughout life. BPD is thus seen as a product of punitive, inflexible patterns in relating. Therapy involves working collaboratively with clients to ‘reformulate’ their relationship difficulties by analysing their ‘reciprocal role’ patterns (Ryle, 1997). In terms of empirical research, CAT’s evidence of efficacy is limited. In the only efficacy study for non-group CAT compared with TAU included clients with a range of personality disorders. The CAT group showed improvement on interpersonal functioning compared with the TAU group lending support to the interpersonal focus of CAT’s theory of BPD aetiology and the mechanism for change in therapy (Clarke, Thomas, & James, 2013).

The therapeutic relationship is central to facilitating change in CAT and is operationalized by the constant monitoring of the clients’ reciprocal role patterns, particularly emotional state switches. Therapists make use of countertransference responses to clients in order to recognise reciprocal role enactments with clients and attempt to avoid colluding with them.
In this way change is thought to occur through the constant attention to processes in the present between therapist and client (Ryle & Kerr, 2002). Preliminary evidence supports this, with good outcomes linked to CAT therapists preventing ruptures in the alliance by recognizing reciprocal role enactments and focusing attention on them (Bennett, Parry, & Ryle, 2006).

**Psychodynamic therapies**

**Psychodynamic psychotherapy:**

Psychodynamic psychotherapy, is considered more of an approach than a definitive therapy. It has its roots in classical psychoanalysis, and both have the resolution of unconscious conflict as a goal. But whereas the latter is a long term treatment aimed at restructuring the personality, psychodynamic psychotherapy is a relatively brief intervention with more of a focus on symptomatic change (Roth & Fonagy, 2005). Psychodynamic psychotherapy is often characterized as lacking in an empirical ‘evidence base’ compared to cognitive behavioural therapies in particular. However, Shedler (2010) argues that this could be due to a selective dissemination of research findings and that empirical evidence does support the efficacy of psychodynamic psychotherapy, including interventions for BPD clients, and that effect sizes are as large as those reported for other therapies. These include studies reporting significant improvements in target symptoms, general symptoms, interpersonal problems, and contentedness with life (Leichsenring, Masuhr, Jaeger, Dally, & Streeck, 2010). Furthermore, Levy (2008) points out that ‘lasting change’ as a result of psychotherapy is of central importance, not least because of the entrenched and long-standing nature of BPD, and that research findings favour psychodynamic approaches in long-term follow ups.

The therapeutic relationship in the psychodynamic tradition is viewed as a mechanism of change. The development of the therapeutic relationship is thought to reflect the client’s early relational experiences with caregivers. In psychodynamic theory, the first five years of development are significant because it is in these early years, that neurological development, sense of self and the way we learn to relate to others are established. These patterns of relating are thought to be repeated in the therapeutic relationship as the client ‘transfers’ their maladaptive patterns onto the therapist. There are different schools of thought on the value of ‘interpreting’ BPD clients’ behaviour and speech content and
particularly about transference interpretations; the client’s specific way of relating to the therapist (Higa & Gedo, 2012). In the following sections two specialized treatments for BPD that are contained within the psychodynamic tradition take different stances on the issue.

**Transference focused psychotherapy (TFP):**

TFP is a manual-based treatment based on Kernberg’s (1975) object relations model for understanding BPD. In this model BPD symptomology stems from a lack in ‘identity integration’, arising out of early development, whereby the child felt the need to disown parts of themselves, particularly strong emotions such as aggression, and feeling they are not loved for being fully themselves (Kernberg, 2016). Caregivers would typically be unable to contain such emotions, leading to emotional dysregulation in the child and conflict arising, often in the form of love or approval being withheld as well as the possibility of rejection or even abandonment. The child in these life circumstances can begin to doubt their self-worth, their capacity to develop relationships outside of the family and even the possibility of existence outside the relationship; therefore, the threat of abandonment can be experienced by the child as the potential annihilation of the self. Because the child does not get to share their emotions with caregivers and be given appropriate feedback, they do not get the opportunity to own their emotions, and may split them off and deposit them in others. This has ramifications for future relationships, including the adult client’s relationship with their therapist (Clarkin, Yeomans, & Kernberg, 2006; Fletcher, 2010).

Empirical support for TFPs superiority over TAU is fairly robust (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Yeomans, Levy, & Caligor, 2013). It also showed advantages over DBT, and a supportive treatment control on 10 of 12 variables across six domains compared with DBT’s 5 and the control, 6 and predicted significant symptom improvement of impulsivity, irritability, verbal assault and direct assault (Clarkin et al., 2007). However, as already mentioned ST scored higher on therapeutic alliance measures than TFP in the study investigating whether the alliance is a mediator of change (Spinhoven et al., 2007).
Central to TFT is the consideration of the transference in the incremental interactions between the client and therapist, in order to draw the client’s attention to their thoughts, emotions and the associated assumptions they may make that are outside of awareness (Clarkin et al., 2006). However, this is practiced within a safe ‘holding’ environment where the client’s negative affect can be ‘contained’. Emotional states are then able to be identified and explored within the here-and-now interactions between client and therapist, which enables the client to take a more objective view of their self and other relating patterns and develop the ability to regulate emotion more effectively (Yeomans et al., 2013). The therapeutic relationship is thereby viewed as a key mechanism of change.

*Mentalization based treatment (MBT):*

Mentalization based treatment (MBT) focuses primarily on the early attachment environment. Attachment theory proposes that patterns of behaviour, through repeated self-other interactions with earliest caregivers, become an ‘internal working model’ for the way we relate to others throughout our lives (Bowlby, 1980). These attachment behaviours, particularly how individuals seek help and comfort, and how or whether they expect to receive it, are activated in times of stress. Attachment behaviour for adults are categorized as ‘secure’ or ‘insecure’ with a number of sub-categories of insecure type; dismissing, pre-occupied and unresolved. Unresolved denotes not a completely separate category, but rather a state of disorganization from any of the other styles. It represents a behaviour strategy which is directly related to childhood loss or trauma and is usually a transient state (Riggs, Jacobovitz, & Hazen, 2002). Disorganized attachment style is thought to be the most predominant attachment style in BPD clients. The links to actual early childhood trauma and adult behaviours which appear to replicate the insecurely-attached infant are common features among the BPD population. These behaviours include fear of abandonment and clinging as well as fearfulness of dependency needs.

MBT hypothesises that a lack of ‘mirroring’ affective states by the carer to the infant results in an inability for an intentional being to form. Mirroring is the process whereby the infant learns to understand and form representations of their emotional states via the interaction with caregivers who mirror their affective states, which is then internalized by the infant. The ability to mentalize, or infer the mind states of others and oneself is greatly reduced in BPD clients. Bateman and Fonagy (2004) conceptualize BPD as a ‘disorder of attachment’
and that the locus for change in BPD clients involves improved regulation of interpersonal relationships through changes in the neuropsychological processes underpinning social interactions. MBT treatment consists of encouraging clients to reflect on their own thoughts and feelings, and to begin to understand the intentionality of others (Bateman & Fonagy, 2016). There is a de-emphasis on deep unconscious processes and the aim of therapy is not to invoke insight, but develop mentalization and thus complex mental states are avoided and ‘small interpretations’ are made about the clients ideation which is only just out of conscious awareness (Fonagy & Bateman, 2006).

Empirical research on MBT therapy outcomes consist of more studies in naturalistic settings, measuring effectiveness. MBT is the first BPD specific treatment to conduct a long term follow up of 8 years, in which improvements across a range of factors were maintained or further improved, such as diagnostic status; 13% compared with 87% TAU (Bateman & Fonagy, 2008).

The therapeutic relationship is viewed as a mechanism of change in that it is through engaging with the therapist, the client’s attachment system is aroused which is a necessary part of the process, alongside mentalizing about self-other relationships, of moving the pattern of arousal closer to a secure attachment. Maintaining a balance between the intensity of the attachment and the level of mentalization complexity demanded by the therapist of the client is thus of upmost importance (Fonagy & Bateman, 2006). Monitoring therapy outcomes has become standard practice in MBT and some findings suggest that positive outcomes are related to individual clinicians, which could suggest some differences in clinician’s ability to repair ruptures in the alliance. Further research is needed to look at therapist qualities which minimise ruptures. (Bateman & Fonagy, 2016)

Dynamic deconstructive psychotherapy (DDP):
According to DDP, BPD clients suffer from a deficit in three neurocognitive abilities: ‘association’, the ability to identify emotions; ‘attribution’, the ability to view self and others; and ‘ideal other and alterity-real other’, to be able to look upon oneself and others objectively (Gregory & Remen, 2008). The development of a strong therapeutic alliance is the primary task for the initial stage of treatment in DDP. To establish the alliance, ‘ideal other’ techniques such as empathy, mirroring and psychoeducation are adopted. This allows
the therapist to become a containing presence for the client, before encouraging the client to recognize the therapist as a ‘real other’ and develop a sense of ‘objectivity’ about themselves and the therapist (Gregory & Remen, 2008).

Only one study investigating DDP efficacy has been carried out; an RCT comparing DDP to TAU. Observers rated the use of the techniques the therapists adopted to address the three neurological deficits identified in DDP. The therapeutic alliance was found to be related to improvements in BPD symptoms and alcohol misuse. At a thirty month follow up improvements in BPD symptoms and substance misuse were maintained for the DDP group (Goldman & Gregory, 2010). The findings from the DDP research draw attention to the way in which most outcome measures across the various therapeutic models are very similar, that is they all show improvement compared to TAU. What are often missing from these accounts are the variables which influence the therapy outcome (Clarkin et al., 2015; Livesley, 2012).

However, the DDP research also investigated the particular factors of the model which were thought to instigate change and whether they only applied to DDP. It compared techniques, which were associated with change over a range of outcome measures with similar techniques in other therapy models for BPD (Goldman & Gregory, 2010). The results indicated that different techniques worked for different aspects of BPD symptomatology, which suggests that the various psychotherapies may address particular sets of symptoms in individuals with a diagnosis of BPD. For example the ‘association’ techniques include building sequential narratives of interpersonal encounters which is similar to the ‘chain analyses’ of events and associated emotions leading up to an episode of self harm or extreme emotional dysregulation used in DBT. The concept of ‘attribution’ is similar to polarized representations of self and other in object relations theory which underpins TFP and ‘ideal other’ techniques such as empathy, mirroring and psychoeducation are employed in most BPD therapies. The authors suggest that existing treatments can be refined and effective techniques incorporated in order to be able to provide interventions which take account of the individual client’s particular presentation (Goldman & Gregory, 2010).

There is a growing trend in the field to look for overlap and common factors across the various psychotherapeutic treatments for BPD. Commonalities in the conceptualization and practice of the therapeutic relationship are included and often seen as central to an
integrated approach (Clarkin et al., 2015; Critchfield, 2012; Livesley, 2012; McMain et al., 2015; Nelson, Beutler, & Castonguay, 2012; Paris, 2015; Smith Benjamin, 2002). In person centred therapy (PCT), the therapeutic relationship is viewed as the mechanism of change in therapy (Rogers, 1957/2007). Some theorists from a person-centred perspective suggest that other approaches have assimilated its basic tenets of empathy, unconditional positive regard and genuineness. They argue that the success of ‘mainstream’ BPD therapies, lies not in the adoption of particular techniques, but in their ‘common factors’, particularly the interpersonal aspects of therapy (Quinn, 2011).

An integrated approach to therapy for people with BPD

Integrated approaches have begun to be developed to address concerns about therapists’ adherence to a particular approach, which mean that clients do not benefit from treatments which could target different domains of difficulty within the heterogeneous range of symptomology in BPD, such as for example, emotional dysregulation and poor mentalization skills (Clarkin et al., 2015; Critchfield, 2012; Livesley, 2012; McMain et al., 2015; Nelson et al., 2012; Paris, 2015; Smith Benjamin, 2002). Objections have also been raised about manual-based approaches per se, because they restrict the freedom of the therapist and by pointing out that the therapist is not a ‘technique dispensing machine’ (Wampold, 2001). Furthermore, individuals who meet the diagnostic criteria for BPD seek help in a variety of settings and not all therapists or psychology services work with BPD clients according to a specific ‘treatment program’.

There are calls to move beyond the ‘horse race’ approach to measuring outcomes from competing schools of therapy (Bender, 2011). There is concern that the specific techniques employed by manual-based treatment therapists are not only, not useful for all clients but that there is little empirical evidence to show their effectiveness. This suggests that whilst there is evidence that, for example, MBT works, it does not indicate that it because of mentalization per se and the same could be said for DBT and the dialectic of acceptance and change (Clarkin et al., 2015). Research outcomes have been very similar across treatments, and it is thought to be more productive to look for specific methods and techniques and to determine why they work. (Bender, 2011; Clarkin et al., 2015; Livesley, 2012).
Although each treatment package focuses on different aspects of the BPD symptomology and none are comprehensive enough to address all domains, there are many areas of overlap among them. These include similar techniques utilized, such as, the ‘hierarchy of targets’ approach, in both DBT and TFP, whereby suicidal or self-harming behaviours take precedent, and working through past traumas come at a later stage in the therapy (Clarkin et al., 2015; Linehan, 1993). Paris (2015) suggests that DBT even has a model for transference in the concept of ‘therapy interfering behaviour’, which can refer to interpersonal difficulties between therapist and client (Linehan, 1993). Furthermore, mentalization in MBT has many similarities with the mindfulness is used in DBT to help the client become more aware of their own and others emotions (Paris, 2015). Mentalization may also be part of the underlying processes in both DBT chain analyses and through the corrective emotional experience clients receive with reparenting techniques of schema therapy as they both result in a more coherent sense of self and others (Montgomery-Graham, 2016). Fonagy (2015) suggests mentalization may be a common feature of all successful therapies. Other, more general factors for therapy with BPD clients to be incorporated into an integrated approach include the importance of client self-efficacy or agency (Knox, 2011; Links, 2015). Debate centres around what form the integration should take. Whether it be assimilative and based on a main theoretical approach with other techniques utilized, or technically eclectic, taking what works from the range of therapies and utilizing them to tailor individual treatments for BPD clients (Nelson et al., 2012).

The ‘common factor’ which is consistent across all the therapies for BPD, is the therapeutic relationship. Clarkin and colleagues (2015) argue that there is no empirical evidence that the manual-based treatments work because of the specific theory of BPD they adopt or techniques that they offer. Rather, mechanisms of change work because the client and therapist each contribute to an interaction which develops over time. Therefore, techniques need to be understood in the context of the relationship between a particular client and a particular therapist, taking into account all the non-diagnostic characteristics of that client. In their four-part model, ‘monitoring the relationship’ is a key component. It is in effect a combination of therapeutic alliance, overcoming ruptures in the alliance and management of transference and countertransference. This involves three techniques: observing how the client relates to the therapist; an awareness of behaviours which might signify that the client will end therapy prematurely; using the relationship to explore how the client may engage
in unproductive ways with others outside the therapy and the therapist’s reflections on their own feelings towards the client which may impact on the alliance (Clarkin et al., 2015).

The therapeutic relationship appears to be the main area of convergence among those with different approaches towards integration (Nelson et al., 2012). Of particular importance is the role of the therapeutic alliance in early treatment. This involves: attunement to the clients worldview; an awareness of relationships outside therapy to guide the interpersonal stance of the therapist and build the alliance; and of vital importance, monitoring the alliance for responses to clinical interventions and adjusting for therapy effectiveness and therapist interactional style (Bender, 2005). However, gaps have also been acknowledged, such as, the identification of actual strategies to facilitate a good therapy relationship with BPD clients. Therapist responsiveness, a relatively new construct in the literature, is identified as an area for development and further research. It speaks to the ability to tailor interventions to a client’s characteristics and behaviours in the unfolding of the therapy process (McMain et al., 2015). Kramer and colleagues (2014) describe a relational-technique variable called the motive-oriented therapeutic relationship (MOTR) which focuses on the individual motives of clients and helps conceptualize difficult relational patterns within a meaningful framework. Its strength of analysis lies in the monitoring of moment-to-moment verbal and non-verbal interactions, focusing on relationship ‘stakes’ within sessions (Kramer et al., 2014).

The awareness of maladaptive interpersonal schema is also thought to be important for maintaining the alliance and overcoming ruptures, in particular, by recognition of enactments by clients and working to understand the underlying schema, across therapy models. The client’s subjective experience of this type of intervention is to feel understood, accepted and validated by the therapist (Dimaggio, 2015). These examples point to a more process-oriented focus for future research on the therapeutic relationship, identifying factors which contribute to outcomes and adherence in therapy. To date, research into the concept of the therapeutic alliance, particularly in terms of BPD therapies, has focused mainly on the relationship between the alliance and therapy outcomes (Catty, 2004). In research on CAT for BPD, for example, the vicissitudes of the therapy process are not taken into account, as the alliance is mainly measured in correlational studies so ruptures and repairs are masked (Bennett et al., 2006). However, there is a growing area of research into more interactional processes such as ruptures and repairs in the alliance in psychotherapy
in general, which suggests that research on BPD treatments may follow suit, given the general consensus on the importance of the therapeutic relationship and the motivation expressed to understand it better. The following section will briefly address some of the limitations with the research on the alliance in general before looking at some of the new directions research is taking, particularly with regards to BPD therapies.

Limitations of therapeutic alliance research and new directions

The broadest critique of the therapeutic alliance construct, is in terms of its categorization as a ‘nonspecific’ variable, as opposed to ‘specific’ therapy techniques. The specific/nonspecific dichotomy is now seen as unhelpful; it played a role in identifying the relationship as a factor which had an impact on outcome, but the search for the ‘active ingredients’ in the relationship has led to inconsistent results (Butler & Strupp, 1986). Alliance research that links process to outcome often has results which are highly consistent over a range of studies within the different perspectives of therapist, client and independent rater, but are less reliable across these perspectives (Orlinsky & Ronnestad, 2000). Further research into the therapeutic alliance could therefore focus on comparing therapist and client assessments, as client’s ratings are more predictive of outcome (Ardito & Rabellino, 2011). However, according to Marcus and colleagues (2009) in their exploration of the ‘one-with-many’ design, i.e., the (one) therapist working with (many) clients, dyadic reciprocity was supported. In fact, their primary finding was that alliance ratings were mainly relational, with clients reporting high alliance with a therapist who reported similarly, but that was not replicated among other clients that therapist was working with (Marcus et al., 2009). This suggests that a shift in focus onto the relational aspects of the alliance adopting methods which capture its interactional nature. Horvath (2005) postulates that the development of measures were undertaken too early in the history of alliance research, which then defined the parameters for the understanding of the concept and prevented a full examination of its effects and limitations. He suggests more debate is needed. These leading theorists in the field highlight the limitations of research which focuses solely on the alliance and seem to be calling for, in some form or other a move away from the type of research which looks to internal mechanisms to explain the perceptions of the various observers, to a more relational focus on the therapeutic relationship.
Orlinsky & Ronnestad (2000) suggest that research into relational aspects of psychotherapy from that inspired by Rogers’ (1951) core-conditions thesis to the decades of research stimulated by Bordin’s (1979) pan-theoretical working alliance model is inconsistent because it relies on a realist epistemology and that there is a need for research which takes a more complex view of interpersonal reality. The status of RCT’s as yielding the best evidence has been widely criticised for a number of reasons. True RCTs cannot be conducted in psychotherapy because they tend to not meet at least one, usually more, of the basic requirements: a double blind design; impartiality of the researchers; or a placebo control (Bolsover, 2007; Shapiro & Paley, 2002). Furthermore, medical RCTs are able to compare definable features of a treatment in large numbers of patients, whereas it is much more difficult to isolate and compare different aspects of psychotherapy treatment in the context of the dyadic therapeutic encounter (Bolsover, 2007). Moreover, RCTs require a highly homogenous sample, due to strict exclusion criteria which does not fit clinical reality (Persons & Silberschatz, 1998). Other problems with validity involve the problem of unmatched control samples, who are often people remaining on the waiting list and concerns over unanalysed data from those who drop out of the study (Fairfax, 2008). Naturalistic studies have more ecological validity because they measure how effective a service is to clients who present to psychotherapy services in the community. However they still tend to focus on comparison with TAU and measure simple symptom reduction (Bender, 2011; Levy, 2008; Wachtel, 2010; Wampold, 2001).

In their critique of the concept, Safran and Muran (2006) argue that, the alliance accounts for less, in terms of outcome than other measures of the relationship, such as ‘therapist allegiance’ and ‘the individual therapist’ (based on Wampold, 2001). Furthermore, their concern is that by trying to separate the transference from the alliance, as most studies do, the possibility arises that not all aspects of the relationship are being worked with in the therapy. For example, what may seem like an alliance may in fact be the client’s compliance. In their work on therapeutic ruptures, the authors address this issue by differentiating between two types; confrontation and withdrawal. Therefore, it is easier to ascertain whether a client is participating in the alliance, or possibly a withdrawal rupture which is taking the form of compliance. They are interested in more research being conducted into understanding how relational factors impact in the change process (Safran & Muran, 2006). They admit to feeling ambivalent about the usefulness of the alliance construct, but not about the importance of focusing more broadly on understanding the role
that relational factors play in the change process as well as being mindful of the relational context in which all other facets of the therapeutic process unfold. (Safran & Muran, 2006) This has instigated the move to new directions in therapy relationship research which focuses on ruptures and impasses in the alliance (Safran, Muran, & Shaker, 2014; Safran, Muran, Demaria, et al., 2014; Safran, Muran, & Eubanks-Carter, 2011). This includes studying rupture and repair in BPD treatments (Muran et al., 2009).

New directions into therapeutic relationship research include studying the ‘real relationship’, which is very under-researched compared to the alliance. This aspect of the relationship concerning therapists’ genuineness, and facility to self-disclose has been shown to be important in the work with BPD clients. Moreover, promoting awareness that the therapeutic relationship does not equate to the alliance as well as more theoretically-driven research to define the therapeutic relationship is felt to be needed (Catty, 2004; Gelso, 2014; Gelso & Silberberg, 2016). There also appears to be room for developing a more qualitative line of enquiry into how the therapeutic relationship is experienced by both the client and therapist. Using an example from the WAI item list, a question such as, ‘I feel that my therapist understands me’, could be explored further to find out in what ways clients may experience the therapist as ‘understanding’ them.

The value of qualitative research is often overlooked when questions of the efficacy therapeutic practice arise. However, in their mixed methods study on DBT-informed therapeutic communities, McFetridge and Coakes (2007), noted that while the qualitative themes tended to mirror the conclusions drawn in the evaluative measures, they also described the process of change, providing a richer, more detailed account of the process. The researchers considered these accounts to have important clinical implications, such as preparing new clients for the “difficult and painful process” they are about to embark on and attempting to understand the premature cessation of therapy (McFetridge & Coakes, 2010, p. 414). This could also apply to therapy relationship research with clients who meet the criteria for BPD, with client and therapist description of the relationship providing a richer more detailed account of how they experience it, which could offer significance insights relevant to clinical practice.
Qualitative research
There is a paucity of qualitative studies on the therapeutic relationship with BPD clients. Only one study was found for this review which directly focused on the therapeutic relationship. It explored the aspect of negative affect in the relationship in DBT with their case studies of two clients with different therapy outcomes, which they attributed to therapist response to the clients’ initial hostility and attacks (Burckell & McMain, 2011). However, in some studies, the therapeutic relationship was identified in the analysis as a theme. Some examples include, Hodgetts and colleagues (2007), explored clients’ experiences of DBT and found that the therapeutic relationship was, “[…] consistently identified within participant’s accounts as being important.” (Hodgetts et al., 2007, p. 176). In her doctoral thesis on the client’s experience of ‘recovery’ from BPD, Tsakopoulou (2009) identified ‘resilient therapeutic relationship’ as an important theme, which one participant highlighted in this way: “I like the way people don’t give up on you and they persist and push you.” (Tsakopoulou, 2009, p. 73). Langley and Klopper (2005) identified ‘trust’, which is crucial for the establishment of a strong therapeutic relationship, as an overarching theme in interviews with clients and clinicians in South Africa. In a recent study, Rizq (2012) reported that therapists working with BPD clients in primary care settings were, “managing feelings of inadequacy”, that there was a “sense of failure” in the therapy and of “letting the client down”, which indirectly refer to relationship factors (Rizq, 2012, p. 37). Another study into therapists experiences of working with BPD client, but from a community mental health team perspective, identified the ‘complexity of the therapeutic relationship’ as a major theme (Mendes, 2002). Rossiter’s (2008) study on DBT therapists’ clinical experience found DBT practice reduced pessimism and a “heightened sense of moral responsibility that further strengthened the capacity for therapeutic intimacy.” (Rossiter, 2008, p. 140).

These qualitative studies on therapy with clients with a diagnosis of BPD identified aspects of the therapeutic relationship within their themes. This appears to indicate a potential for qualitative research which focuses more directly on the relationship for this client group.

Conclusion
This literature review explored how the therapeutic relationship with clients who meet the diagnostic criteria for BPD has been understood in the literature to date. The findings
suggest that the purpose of much of the extant research was an attempt to find the ‘active ingredients’ of the therapeutic relationship and their predictive value in terms of successful therapy outcomes. Critique of this form of enquiry was centred on the view that research methods based on realist epistemologies cannot adequately capture the complex relational processes involved in the client/therapist relationship, which may also particularly apply to clients with BPD. The majority of the criticism levelled at the body of research on the therapeutic relationship with clients who meet the diagnostic criteria for BPD relates to the suitability of RCTs for psychotherapy research and the lack of clear links between the treatment methodology and improvements in client welfare (Bender, 2011; Clarkin et al., 2015; Livesley, 2012). This has led to calls for more qualitative research to be carried out to help determine what works for clients across the various treatments and what may cause clients to drop out of treatment so frequently, including, it is suggested, further research to help us better understand the parameters which determine the role of technique and relationship understanding the process of change in the treatment of patients with borderline personality disorder (Spinhoven et al., 2007).

However, is this just another dichotomy in the same vein as specific/non-specific factors? By setting up another dualism in the concepts of relational/technical do we not risk getting stuck attempting to define what technique or therapist behaviour belongs in which category? It may not be possible to separate the variables out any further, and they will probably always diverge along the lines of the therapeutic approach to some extent. One direction to take is Safran, Muran and colleagues’ (2014) micro analysis of therapist/client interaction. Another possibility is to step back and view the process of therapy more holistically. In order to identify and develop strategies which facilitate positive therapeutic relationships with clients who meet the criteria for BPD, an understanding of the experience of the therapeutic relationship for such clients would be of value. Future research could utilize a phenomenological approach as an efficacious method for the facilitation of meaningful expression of participants’ experience. A need was therefore identified for future research to employ more exploratory, in-depth, qualitative research which focuses on interpersonal aspects. The relevance of the client’s perspective was also identified as being of value in recent studies.

Research into the therapeutic relationship with clients who meet the diagnostic criteria for BPD is of importance to counselling psychology. The therapeutic relationship is the
cornerstone of the therapeutic encounter for counselling psychologists, whose training requires an understanding of the therapeutic relationship and alliance as conceptualised by each model (Bond, 1994). Furthermore counselling psychology values the humanistic basis of therapeutic practice; the ‘being with’ aspect of the process (Steffen, 2013). It also advocates a pluralistic approach towards therapy which allows counselling psychologists to be responsive to clients’ individual needs and tailor their approach to their client (Cooper & McLeod, 2007). Counselling psychology engages with the concept of psychological ‘disorder’ in a way that does not completely reject psychiatric diagnostic criteria, but attempts to engage critically with it, with an emphasis on the individual and their unique experience.

This review highlighted the lack of research to date which captures the relational complexity of therapy. Moreover, there is virtually no research exploring the relationship from the client’s perspective, or even the therapist’s in any depth. This suggests a need for further research which employs the ethos and values of counselling psychology as a guide.
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Appendix A

Strategy for Literature Search

A variety of approaches were utilised to identify and select the literature for this research.

1. Computer-based searches:

Results of some of the main articles identified from electronic database searches. These were the parameters for each of the searches:


- No publication date parameters.

- No criteria specified regarding status of publication, such as ‘peer-reviewed’.

A. Searches via the EBSCOhost interface:

PsycINFO, PsycARTICLES, PsycBOOKS, Psychology & Behavioral Sciences Collection, Medline

- Search yielded just over 2000 results. The most relevant and useful articles included:


**PsycTESTS**

- Search yielded just over 120 results. The most relevant and useful measures included:


**B. Other websites:**

**PubMed**

- Search yielded just over 230 results. The most relevant and useful articles included:


**PEP Web**

- Search yielded just over 10 results. The most relevant and useful articles included:

**ProQuest**

- Search yielded just over 950 results. The most relevant and useful articles included:


**Cochrane Library**

- Search yielded just over 15 results. The most relevant and useful articles included:


**Grey literature: Govt/org websites (eg NICE HCPC BPS etc)**

- The most relevant and useful articles included:


**2. Library catalogues - University of Surrey and City, University of London**

**Books**

- Search yielded just over 680 results combined. The most relevant and useful books included:


Theses/dissertations (University of Surrey library catalogue)
- Search yielded just over 390 results. The most relevant and useful theses included:
  
  Mendes, A. (2002). *The Experiences of Psychologists Working with Clients with Borderline Personality Disorder: An Interpretative Phenomenological Analysis.* (Professional doctorate), University of Surrey.


3. Reference lists
Additional studies were located in the reference lists of the articles and books identified through the database and catalogue searches. Once I had established the key names who had written important literature in the field I searched for other publications of theirs.

4. Key journals
The back lists of journals also provided relevant articles. These journals included:

  Counselling Psychology Review
  Journal of Clinical Psychology
Appendix B

Submitting articles to CPR

Introduction

Counselling Psychology Review is the Division of Counselling Psychology’s quarterly peer reviewed research publication. It brings together high quality research pertinent to the work of Counselling Psychologists. It primarily focuses upon work being undertaken in the UK but it is also likely to be of interest to international colleagues and those in related therapeutic disciplines. The content is pluralist in nature, with its focus being on excellent work rather than methodological or paradigmatic preference, and submissions are invited in the following areas:

- papers reporting original empirical investigations (qualitative, quantitative or mixed methods);
- case studies, provided these are presented within a research frame;
- theoretical papers, provided that these provide original insights that are rigorously based in the empirical and/or theoretical literature;
- systematic review articles;
- methodological papers.

Notes for Contributors

1. Length:

Papers should normally be no more than 5000 words (including abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

2. Manuscript requirements:

- The front page (which will be removed prior to anonymous review) should give the author(s)’s name, current professional/ training affiliation and contact details. One author should be identified as the author responsible for correspondence. A statement should be included to state that the paper has not been published elsewhere and is not under consideration elsewhere. Contact details will be published if the paper is accepted.
- Apart from the front page, the document should be free of information identifying the author(s).
- Authors should follow the Society’s guidelines for the use of non-sexist language and all references must be presented in the Society’s style, which is similar to APA style (the Style Guide, available from the Society, or downloadable from http://www.bps.org.uk/publications/submission-guidelines/).
- For articles containing original research, a structured abstract of up to 250 words should be included with the headings: Background/Aims/Objectives, Methodology/Methods, Results/Findings, Discussion/Conclusions. Review articles should use these headings: Purpose, Methods, Results/Findings, Discussion/Conclusions.
• Approximately five key words should be provided for each paper.
• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
• Graphs, diagrams, etc., must have titles.
• Submissions should be sent as e-mail attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add ‘CPR Submission’ in the e-mail subject bar. Please expect an e-mail acknowledgment of your submission.
• Proofs of accepted papers will be sent to authors as e-mail attachments for minor corrections only. These will need to be returned promptly.
"Sometimes I’d think she was a manipulator and other times she was the best thing since sliced bread”: An interpretative phenomenological analysis of the experience of the therapeutic relationship for clients who meet the diagnostic criteria for borderline personality disorder

Abstract

BPD is associated with a range of difficulties involving interpersonal problems. The symptoms of BPD can have a profound effect on an individual’s interpersonal relationships, which are usually replicated in some way in the context of therapy. The current research study aimed to explore how individuals who meet the criteria for borderline personality disorder (BPD) experience the therapeutic relationship. The type of knowledge it intended to generate was not concerned with finding an objective truth, instead data collected was understood to be context and situation dependent and its aim was to produce a meaningful account of the experience for the client with BPD. A qualitative paradigm was therefore appropriate and an interpretative phenomenological analysis (IPA) was carried out in order to elicit rich detailed accounts of the participants' experience. Interviews were conducted with seven participants and an analysis of their transcripts carried out according to IPA guidelines. Three distinctive master themes emerged from the analysis: 'contained/uncontained'; 'perceptions of therapist'; and 'issues of control'. Participants experienced the therapy relationship, as fluid and changeable. On the whole, it was felt to be containing; within it they felt understood, safe and accepted. However, periods of feeling uncontained were also reported. The therapist was experienced at different times, variously, as ideal; genuine; or someone one needed to please and was often subject to change suddenly, usually from a caring to negative figure. Within the relationship, control was experienced as being with either the therapist, the participant or located between them. It is hoped that this research will contribute to a greater understanding of the subjective experience of the therapy relationship for clients with BPD.

Key words: Borderline Personality Disorder; BPD; therapeutic relationship; interpretative phenomenological analysis; IPA
Introduction

Definition of BPD

BPD is associated with a range of difficulties involving interpersonal problems, intense and fluctuating emotional experiences, self-harm and suicide (Krawitz & Jackson, 2008). Whilst there is no clear aetiology of BPD, the general consensus amongst psychologists is that the contributing factors are biological, genetic and social. There is a high prevalence of childhood sexual abuse as well as emotional and physical neglect amongst individuals diagnosed with the condition (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; B. D. Perry, 2009; J. C. Perry, Herman, Van Der Kolk, & Hoke, 1990; Sperry, 2016).

Although this paper makes use of the concept of ‘BPD’ it should be noted there is considerable discussion around whether the diagnosis is a valid or useful one. In terms of validity, the criteria for a diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders edition five (DSM-5) include: fear of abandonment; black and white thinking, such as idealisation and devaluation of others; identity disturbance; suicidal, parasuicidal and self-harm behaviours; labile mood; chronic feelings of emptiness and paranoid ideation and/or dissociation (American Psychiatric Association, 2013). This raises questions of the legitimacy of a single diagnosis, given there are 256 ways to meet criteria for BPD because the categories are broad and open to interpretation (Bender, 2011).

In terms of usefulness, receiving a diagnosis is controversial. From the limited number of studies reflecting client perspectives it has been reported mainly as a negative experience, often tantamount to being labelled, and the focus of ‘treatment’ geared towards ‘fixing’ the ‘disorder’. The individual with their unique life experiences, individual coping strategies and capacity for change is perceived to be less important (Nehls, 1999). However, other accounts suggest diagnosis can be experienced as a relief because it offers an explanation of the difficulties and distress individuals experience and the knowledge that there are others with the condition can feel less isolating. Furthermore, being seen by mental health professionals as ‘sick’ rather than ‘bad’ may be perceived by clients as positive and help to reduce stigma (Gallop et al cited in Steffen, 2013). Researching within the context of Counselling Psychology, with an emphasis on the individual varying experiences of distress which bring about the types of behaviour clients may adopt in order to cope, as opposed to further defining the ‘disorder’, this study will involve balancing the utility of
the concept with a commitment to using it as a vehicle for exploring subjectivity. It will use the term client 'with BPD' whilst being mindful of the fact that implies that the client 'has' a disorder, and an awareness of them as individuals who have experienced distress and suffering, which has driven them to "despair and desperate actions which may become entrenched within their behavioural repertoire" (Steffen, 2013, p. 66).

**BPD and the therapeutic relationship**

In recent years, specific treatments for BPD have been developed, notably dialectical behavioural therapy (DBT) and mentalization-based treatment (MBT) (Barnicot, Katsakou, Marougka, & Priebe, 2011). However, some researchers (Clarkin, Cain, & Livesley, 2015; Livesley, 2012) suggest that these specialized therapeutic interventions contain areas of overlap such as: an attachment relationship; transference and countertransference and the therapeutic relationship. Furthermore, there is little evidence linking treatment efficacy explicitly with specific techniques. Clarkin and colleagues (2015) propose that these mechanisms work because the client and therapist each “contribute to an interaction which develops over time” not because the therapist is a “technique dispensing machine”. This suggests that the therapeutic relationship is now recognized as a vital feature of the therapeutic process and therapy outcomes regardless of model or technique (Norcross, 2011; Wampold, 2001).

The symptoms associated with BPD can have a profound effect on an individual’s interpersonal relationships, which are usually replicated in some way in the context of therapy (Bateman, 2012). Therapists’ experiences of working with BPD highlight the difficulties in the relationship. Negative transference, coping with client self-harm and suicide danger, feeling ‘manipulated’, difficulties maintaining boundaries are often cited (Kernberg, 1975). In a recent study, Rizq reported that therapists working with BPD clients were, “managing feelings of inadequacy”, that there was a “sense of failure” in the therapy and of “letting the client down” which indirectly refer to relationship factors (2012, p. 37). Another study into therapists experiences of working with BPD client, but from a community mental health team perspective, identified the ‘complexity of the therapeutic relationship’ as a major theme (Mendes, 2002).
The therapeutic relationship is therefore viewed as of central importance for BPD clients, but establishing a therapeutic relationship can be difficult because the interpersonal domain is problematic (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). Moreover, it is also not clear how well clinical diagnoses or research findings are able to capture the experiences of people with BPD (Ramon, Castillo, & Morant, 2001). Horvath (2000) suggests there is evidence that therapists and clients do not necessarily agree on change or outcome of psychotherapy and most research has been performed from the therapists’ point of view. Clients’ subjective assessment of their therapeutic relationship has been found to have more impact on outcome than therapists’ actual behaviour. Furthermore, there is a dearth of empirical research on the therapeutic relationship in which the client’s subjective perspective is investigated (Bedi, 2006).

In more recent years some qualitative studies have been undertaken looking at the experience of BPD treatments from the client’s perspective, which begin to open up the possibility of gaining a more in-depth understanding of the experiences of BPD. What is of particular relevance to the current study is that they all refer to the therapeutic relationship in some form, which highlights the importance of the relationship from the perspective of the client diagnosed with BPD. Hodgetts et al., (2007), explored clients’ experiences of dialectical behaviour therapy (DBT) and found that the therapeutic relationship was, “consistently identified within participant’s accounts as being important” (Hodgetts et al., 2007, p. 176). In her doctoral thesis on the client’s experience of ‘recovery’ from BPD, Tsakopoulou (2009) identified ‘resilient therapeutic relationship’ as an important theme, which one participant highlighted in this way: “I like the way people don’t give up on you and they persist and push you” (Tsakopoulou, 2009, p. 73). In her study of the efficacy of individual treatment components of DBT, Araminta (2000) found that clients who reported to have most benefited from the program, placed high importance on the therapeutic relationship, particularly the non-judgemental and validating qualities of their therapist. Langley and Klopper (2005) identified ‘trust’, which is crucial for the establishment of a strong therapeutic relationship, as an overarching theme in their study of clients with BPD and clinicians in South Africa, which adopted ‘interpretative descriptive approach’.

Only one study was identified which directly focused on the therapeutic relationship. It explored the aspect of negative affect in the relationship in DBT in case studies of two clients with different therapy outcomes, which they attributed to therapist response to the
clients’ initial hostility and attacks (Burckell & McMain, 2011). These qualitative studies on therapy with clients with a diagnosis of BPD identified aspects of the therapeutic relationship within their themes. This study builds on this, by focusing more directly on the relationship from the perspective of this client group in an exploratory, in-depth manner. It asks: How do clients who meet the diagnostic criteria for BPD experience the relationship with their therapists?

Aims and Objectives
The objective of this study was to elicit detailed description of how individuals who meet the criteria for BPD understand and give meaning to their experience of the relationship with their therapist. The research aimed to gain a deeper understanding of their experiences than what may be yielded from other qualitative measures such as structured interviews or self-report questionnaires. In addition, it aimed to be useful in terms of providing information to enable therapists to increase awareness of the clients’ experience of the therapeutic relationship. This is of particular relevance to Counselling Psychology as a branch of applied psychology, which starts from valuing relationship. Furthermore, it involves listening to our clients to determine how to progress and evolve. In addition, it is important for Counselling Psychology to work within evidence based practice with respect to relationship.

Method
The epistemological underpinnings of this research are critically realist (Sayer, 2000; Willig, 2008). The type of knowledge it intended to generate was not concerned with finding an objective truth, instead data collected is understood to be context and situation dependent and its aim is to produce a meaningful account of both the researcher and participant’s world, creating inter-subjective meanings (Madill, Jordan, & Shirley, 2000). However, it does not adopt a purely relativist stance. IPA was therefore chosen as a guide to method. Proponents of IPA propose that through the inductive process of conducting research using methods such as IPA, gaining a deeper understanding of human experience, can enable researchers to build a body of knowledge which can slowly begin to make some general claims (Smith, Flowers, & Larkin, 2009)
Qualitative research involves the empirical study of the experience and behaviour of humans and utilizes methods which aim to explore and investigate the individual to gain an in-depth understanding. The method of inquiry is 'idiographic'; it focuses on understanding the individual, in their uniqueness and complexity. It is differentiated from quantitative methods which adopt a 'nomothetic' method which is concerned with the discovery of general patterns and universal laws to explain human behaviour, and developing methods with which to predict behaviour (Ponterotto, 2005). A qualitative method was appropriate for the present study with its focus on understanding individual experience as opposed to identifying common factors among a sample which are then used to generalize to whole populations. The data generated from this research can only claim to pertain to the individuals who took part. There was no attempt to generalise to the wider population of clients who meet the criteria for BPD.

Furthermore, a qualitative approach recognises the role the researcher plays in the research process. As opposed to traditional subject/object dualism, the researcher does not play the role of 'thinker', engaged in passive contemplation about an 'object' (Sayer, 2000). Rather the researcher is an active participant in the process; they influence the research process by the choices they make regarding what is to be studied, how the study shall be carried out, and most importantly the way they interpret the data (Finlay, 2002). A reflexive approach was adopted for this research; an awareness of my thoughts, assumptions and motivations which would influence the study and a continual re-evaluation of these during the research process.

According to IPA, researcher and participant are engaged in a process of co-construction of meaning to better understand the participant’s lifeworld. This ‘double hermeneutic’ involves the participant making sense of their world with the researcher trying to make sense of the participant's understanding. In order to reflect on the participant’s account with an open view and an awareness of one’s assumptions and biases, IPA advocates the phenomenological practice of a dynamic form of ‘bracketing’ which involves the development of a self-reflexive position from which to engage with the data as a co-producer of meaning making (Smith et al., 2009). This process also enabled the disparity between assumptions about the therapeutic relationship for clients with BPD, including those held by the researcher, and what was experienced by the participants to come to the fore and facilitate a critique of prevailing attitudes and notions. In IPA, the researcher is
trying both to gain a view from in the participant's shoes (as far as that is possible), and to stand slightly to one side, analysing the text and seeing what makes sense for them. One key aspect of the method is the hermeneutic circle, which involves the dialectical process of working from the particular to the whole. This can be applied to a number of associations, such as the particular participant in relation to the whole group; the word in a transcript and the sentence it is contained in; the single episode described by a participant and their whole life; the single interview and the research project (Smith et al., 2009).

A phenomenological approach, like IPA, offered a framework for the study of a client's experience of the therapeutic relationship. It facilitated an idiographic account of individual experience and the attempt to capture the first person experience as closely as a third person account can (Smith, 2004). As a starting point for enquiry into the experience of the therapeutic relationship for clients who meet the criteria for BPD, it was thought to be more fitting than a grounded theory approach, for example, which operates at a more abstract level of theory generation (Charmaz, 2008). Likewise, a discursive approach which may look at the ways language constructs the participant's understanding of the relationship would not convey their subjective experience (Willig, 2003).

Participants
In keeping with IPA procedure this research sought out a homogenous sample, that is, people with a diagnosis of BPD who concurred with their diagnosis. The recruitment of participants, therefore, followed a homogenous purposive strategy. Because the aim of this research was to understand the lived experience of particular individuals (individuals who met the diagnostic criteria for BPD) in a particular context (in a therapy relationship) the specificity of the sample was important. For this type of research, based on inductive reasoning, the findings will not be generalizable to a wider population in the manner espoused by a nomothetic approach, however, if each case is dealt with in detail, with a focus on its specificity, further studies may add to it and gradually, cumulatively, more general assertions may be made (Smith et al., 2009).

The criteria for inclusion in the study were as follows: That the potential participant will have been diagnosed with BPD and that they have had experience of working with an individual adult counsellor or psychotherapist in the past five years (the time limit was to
ensure that participant’s memories will be fresh enough to go into sufficient detail) and that they not be therapy at the time of recruitment. This was primarily an ethical decision; it was thought that participants may not be as psychologically stable if currently in therapy and that participating in this study may have adverse effects on their existing relationship with their therapist, particularly if there were difficulties in that relationship.

Participants were recruited via social media. Initially, a website was created with the information contained in the information sheet [Please see appendix E]. Then, a Twitter account was set up and a Facebook page created with the purpose of 'tweeting' and 'posting' recruitment notices. These contained a link to the website, which contained the contact email address of the researcher. On Twitter, groups and individuals that expressed an explicit BPD identity were 'followed' and a similar strategy was adopted via ' friending' on Facebook. The researcher was in turn followed and friended by them and others who had come across the researcher's profiles via others' pages. The recruitment could be described as following a 'snowballing' technique of sorts, but not at the direct request of the researcher (Sadler, Lee, Lim, & Fullerton, 2010). The recruitment notices were further re-tweeted and re-posted by followers of followers and friends of friends, so to speak. At the point where an individual expressed an interest in taking part, they emailed me. On the few occasions where I was contacted via Twitter or Facebook, a message was sent containing the contact email address and communication continued from there.

In keeping with the study's idiographic framework, only a small number of participants were recruited (Smith et al., 2009). Interviewing a small number of participants enables the researcher to generate a rich and detailed analysis of each individual participant; focusing on one case, then moving on to analyse each in turn before examining the data for emerging patterns and convergent themes. Out of ten people who expressed interest in the study, seven people met the research criteria and were recruited.

All seven participants were women. Six participants were white British and one was white of non-British origin. They were aged between 24 and 46, with their ages evenly ranged. Every participant reported that they had received a diagnosis of BPD. In addition to informing me of their diagnosis, the participants gave more details about what it was like to 'have' BPD and what they identified as the main features for them. All of their accounts described criteria included in the DSM-5 to diagnose BPD (American Psychiatric
The types of individual therapy each participant had been engaged in over the previous five years was diverse and included interpersonal psychotherapy (IPT), DBT, CBT, MBT and psychoanalytic psychotherapy. All therapists were women except one. Each participant had had more than one experience of therapy, which also involved working in a different modality; one participant experienced a constant, if gradual change in her relationship with her humanistic counsellor as she retrained in psychoanalytic psychotherapy. The length of therapy varied; ranging from sixteen sessions to ten years. Five participants also detailed contact with psychiatrists and other mental health professionals in both in-patient and community settings. Despite the variation in the therapist's theoretical orientation, length of therapy and contact with other mental health professionals, the common factor was that all participants had been engaged in a relationship with their therapist and this was the focus of this research.

Procedure
One semi-structured interview was conducted with each participant separately in locations chosen in consultation with the participant, such as, interview rooms in colleges and libraries. One interview was conducted over Skype because the participant was abroad at the time. There is some debate about the use of Skype for research interviews, with concern regarding issues, such as, the ability to develop rapport, being weighed against the opportunities which are afforded by being able to interview a participant you would not otherwise be able to (For a review see Lo Iacono, Symonds, & Brown, 2016). I felt it did not have the same quality as the other interviews but while transcribing it I noted that there was an actual dialogue and that particular participant shared a great deal of her personal experience. The length of time of the interviews varied between 45 and 90 minutes depending mostly on the time constraints of the participants. The interviews were audio recorded.

The interview schedule contained the type of questions designed to elicit a rich, descriptive account of the participants’ experiences (Please see interview schedule appendix G). In an attempt to be non-directive, and for the interview to be as open as possible, an interview agenda of three questions with prompts were used as a guide to be used flexibly to allow the participant to lead the conversation and share their experience. Funnelling is a process used in IPA to help facilitate this process and help engage participants in the conversation.
Utilizing this method, I started with broad questions such as; 'What do you remember about your therapist?' before moving onto more specific issues. This enabled the participant to formulate their own views, and the interview was less likely to be biased in favour of my prior concerns (Smith et al., 2009). The schedule was modified a number of times; from the original set of questions compiled for the research proposal which was based on previous IPA research on relationships, to the revised schedule after conducting the pilot interview and a further simplification after the second interview. The schedule evolved in a sense as a result of the participants’ willingness to talk about living with BPD, what it was like to be diagnosed and the experiences of mental health services in general. Consequently, all questions aimed at easing the participant into the interview process were taken out and were not required for any of the interviews.

The interviews were transcribed verbatim to a line numbered transcript. An IPA study is concerned with the semantic content of the interview, therefore only the words spoken, obvious pauses and non-verbal utterances such as laughter were transcribed. During the transcription process immersion into the participant's world was aimed for to get a sense of the interview as a whole and to note what stood out initially and begin the process of wondering why that was more salient than other parts.

Moving from the whole, to the particular, engaging in the process of the hermeneutic circle, each transcript was analysed for thematic structure with no attempt to impose theoretical constructs, but rather, allow the themes to emerge from the data, enabling me to gain an understanding of the layers of meaning inherent in the phenomena for the participants. Following the strategies outlined as IPA common processes, the transcripts were re-read and detailed initial notes were made in the margins. The notes reflected the core concerns of IPA; the phenomenological, lived world experiences, with comments that kept close to the descriptive content in the text and the interpretative which involved focusing on language and positing more abstract concepts in order to attempt to grasp the patterns of meaning in the text (Smith et al., 2009).

Using the set of data provided by the initial notes, emergent themes were looked for. This involved an engagement with the transcript, but also a shift away from it as the narrative flow of the text was broken up and a more interpretative stance was adopted. Themes emerged which reflected the participant's words as well as my interpretation. The themes
seemed to capture and express an understanding of that particular part of the text, but with the transcript as a whole also being reflected. Once themes had been identified for the whole of the transcript, the process of searching for connections was undertaken. Themes were examined for similarities and differences and clusters of similar themes were analysed to develop 'super-ordinate' themes. Not all themes were subsumed under the super-ordinate structure; some were discarded because they were not specifically relevant to the experience of the therapy relationship and others were single themes which did not relate to any of the others. The table of themes from the first interview contained six super-ordinate themes each with themes ranging in number from two to twelve. This process was repeated for each of the transcripts, with an attempt to bracket the new knowledge produced from the previous participant's accounts and to look at the transcript with fresh eyes. The process is an iterative one, where I was constantly moving back and forth from the part to the whole at various stages throughout the research process. At each stage the meaning of the text offers a different perspective, as well as how it relates to the research as a whole.

The final stage of the analysis involved searching for patterns of convergence and divergence across all the interviews, using the tables of themes to identify similar super-ordinate themes as well as develop new themes to be termed 'master' themes for the whole data set. The process was also one of distillation as sets of themes had to be reduced and many had to be excluded. This was where the individual differences between participants became most apparent. The decision to not include themes that had seemed quite central to an individual participant's experience was a difficult one. However, what emerged was a robust whole; a master table of themes and sub themes which reflected the lived experience of all the participants' therapy relationships.

In order to assess the validity of the research process, a 'mini-audit' was conducted by the research supervisor. The purpose of this audit was to check that the information produced was credible, not whether it represented 'the truth' (Smith et al., 2009). The research supervisor checked the annotations on two example transcripts for validity in relation to the text and offered insights on the process of creating tables of emergent themes through to the final master table of themes. Validity in this context refers to the interpretations being grounded in the text. Interpretations may well move away from the original text of the participant, however, provided that the steps to arriving at them are well documented, and that they serve to illuminate what IPA is concerned with, namely, Husserl’s ‘the things
themselves the interpretations may be considered acceptable. It is difficult to always be capable of discerning this for oneself, whilst conducting the analysis and my supervisor was able to offer that level of objectivity, insofar as they were not as involved in the process (Gee, 2011). The main concern was that the data was produced with transparency and rigor and that a discernible 'paper trail' was evident.

**Ethical considerations**

This research project received favourable ethical opinion from University of Surrey Faculty of Arts and Human Sciences Ethics Committee (Please see letter of approval appendix D). I used the ethical policies of the BPS and the HCPC to guide my decisions on ethical issues and to inform my general ethical stance while carrying out this project (British Psychological Society, 2014; Health and Care Professions Council, 2016).

Those who participated in this study could be considered a vulnerable group because of the difficulties they experience due to having a diagnosis of BPD. An important part of the recruitment process was ensuring that the potential participants were not in crisis and considered to be in a stable psychological state. The participant's current treatment status, lifestyle 'choices' and living situation were useful markers of stability. Furthermore, my experience as a therapist working with this client group places me in a position to be able to identify signs that a participant may be at risk of, for example, being re-traumatised. In addition, through the process of consent being sought at every step of the process as well as the right of the participant to opt-out of the research project at any time up to two weeks after the interview, there were many opportunities to check in with the participant to ascertain whether they were experiencing any difficulties or distress. After the interview participants were de-briefed to ascertain whether they needed further information or support. In addition, information about support organisations were provided [Please see information sheet appendix E and consent form appendix F].

In terms of data protection, the researcher abided by the regulations concerning data protection stipulated by the Information Compliance Unit at the University of Surrey. They are summarised as follows: data will be kept locked in the researcher’s home for three years and stored electronically for ten years at the University of Surrey before being destroyed.
The research project used social media for recruitment purposes [please see procedure section for details of how it was carried out]. There is little guidance published on the ethical dimension of using social media for social research (see Henderson, Johnson, & Auld, 2013). However, what was available was the policy documents from two research bodies – one in the UK and one in the US – which were available online. They both stipulated that they would not require a review of the research if it was only descriptive information, for the purpose of recruitment that was being posted.

[For more information please go to: http://www.hhs.gov/ohrp/policy/clinicaltrials.html and/or http://www.esrc.ac.uk/_images/framework-for-research-ethics_tcm8-33470.pdf]

Research validity and credibility
In order to establish the credibility and validity of the research in a rigorous manner Yardley’s (2000) criteria was adopted for ensuring quality in qualitative research. This included:

‘Sensitivity to context’. This ensured that I was, as the researcher, familiar with the existing literature both on the topic and the method of research. My chosen method of analysis showed sensitivity to the data, in that it was an in-depth analysis of in-depth interviews of the participants’ personal experience. I showed sensitivity to the participants by the nature of the enquiry – wanting to learn from them – and also the manner in which the research was carried out, including the aim to maintain anonymity.

‘Commitment, rigour, transparency and coherence’. Refers to the thoroughness of the research concerning the process of data collection and analysis. The research was rigorous and shows transparency in discussions of the rationale for the study, the method adopted and the detailed, in-depth analysis of the data.

‘Impact and importance’. The current study aimed to have importance in terms of providing information to enable therapists to increase awareness of BPD clients’ experience of the therapeutic relationship. This is of particular relevance to Counselling Psychology, which places relationship at the centre of the therapeutic work. Furthermore, it involves listening to clients to determine how to progress and to produce the kind of research data which
provides rich accounts of client subjective experience, which may be of benefit in clinical practice.

Analysis
Three distinctive master themes emerged from the analysis: 'contained/uncontained'; 'perceptions of therapist'; and 'issues of control'. Table 1 below illustrates these master themes with their related sub-themes. The themes are discreet but also have a degree of overlap and impact on one another. This fluidity was in part due to the interconnectedness of the themes by the experience of trust within the therapy relationships. Trust did not emerge as an independent theme; rather, it permeated all the others. Trust was spoken about by all the participants explicitly as something that they had difficulty with at the beginning of the relationship with their therapists, but within their accounts there were many subsequent examples of checking the therapists' trustworthiness, sometimes consciously, but mostly it seemed, unconsciously. In order to protect the participants' identity, all names have been changed throughout this report.
Table 1. Master themes and sub-themes

<table>
<thead>
<tr>
<th>Master theme 1</th>
<th>Master theme 2</th>
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<tbody>
<tr>
<td><strong>Contained/uncontained</strong></td>
<td><strong>Perceptions of therapist</strong></td>
<td><strong>Issues of control</strong></td>
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<tr>
<td>Sub-theme 1</td>
<td>Sub-theme 1</td>
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<tr>
<td><strong>Being understood on a deeper level:</strong> &quot;I don’t know how she did it, but she did. She just seemed to know&quot;</td>
<td><strong>Shifting perceptions:</strong> &quot;She just became another person that had let me down&quot;</td>
<td><strong>Empowerment:</strong> &quot;It was about handing it over to you&quot;</td>
</tr>
<tr>
<td>Sub-theme 2</td>
<td>Sub-theme 2</td>
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<td><strong>Bad aspects of self accepted:</strong> &quot;It was safe to talk about it and safe to feel that bad&quot;</td>
<td><strong>Ideal therapist:</strong> &quot;What I saw as an emotionally whole, grown up, mature adult&quot;</td>
<td><strong>Collaboration:</strong> &quot;He asked me, sort of, what worked for me and he said he would show me techniques&quot;</td>
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<tr>
<td>Sub-theme 3</td>
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<tr>
<td><strong>Evidence of care:</strong> &quot;She, like, put my boots and my wet socks on the, on her radiator, and it was just really, like, a little sweet, like, weird thing to do&quot;</td>
<td><strong>Wanting to please:</strong> &quot;I’d give them the answers that I thought they wanted to know&quot;</td>
<td><strong>Control of ending:</strong> &quot;I mean, if she decided when it ended, I think I would have felt more abandoned&quot;</td>
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<tr>
<td>Sub-theme 4</td>
<td>Sub-theme 4</td>
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<tr>
<td><strong>Feeling uncontained:</strong> &quot;Often I’d just feel like I’ve got no clothes on!&quot;</td>
<td><strong>Authentic:</strong> &quot;You could bring things to her that were really bad and she might look shocked&quot;</td>
<td><strong>Doing to:</strong> &quot;This is your homework for next week and you’re going to do X, Y, Z.&quot;</td>
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[Please see appendix B for extended tables including all participant quotes for each sub-theme and appendix C for table indicating participant representation and location in transcript].
**Master theme 1: Contained/uncontained**

Most of the participants experienced the therapy relationship as having, at least some of the time, a containing quality; feeling understood, safe and accepted. The therapist was someone they felt they could bring all aspects of themselves to – ‘good' and 'bad' – and not be judged. For all the participants, this was intensified by the experience of feeling they were understood beyond what they presented to the therapist, as well as demonstrations of care by the therapist.

Containment, on the whole, appeared linked to feeling positive about the therapy relationship; often contrasting it with negative relationships with other mental health staff. Participants seemed motivated to talk about what was good about the therapy relationship and what worked for them. However, their narratives also included negative experiences – sometimes quite extreme – and it was important to represent them as well. The theme represents the experience of containment as a fluid continuum with positive and negative experienced at different times within the therapy relationship. Therefore, feeling uncontained was incorporated into this master theme.

**Sub-theme 1: Being understood on a deeper level**

Every participant reported moments when they felt their therapist was attuned to them in ways they found surprising. For some it even felt as though the therapist knew them better than they did themselves. At the beginning of therapy Carol felt reluctant to disclose particular personal aspects of herself, but she found that trust in her therapist grew the more she felt her therapist understood her. She recalled that:

"She just seemed to know when, when it was right to say, ‘No, come on [encouragingly], you know, we can... you know, have a think about it and talk about it and...’ And then other times she’d say, ‘OK, well, we’ll come back to that another time.’ "I don’t know how she did it, but she did. She just seemed to know".

For Carol, this intuition provided a kind of proof that her therapist understood her. She noticed that when she allowed her therapist to 'push' her and consequently experience and attempt to understand her difficult emotional states, she came out the other side thinking it had been the right thing to do.
Mandy reported a similar process whereby she felt her therapist was able to discern whether or not she had made an attempt at a set therapy task:

"Erm... she knew that I hadn’t really tried even if I didn’t".

Initially Mandy felt angry because she didn't believe her therapist could possibly know how difficult these tasks were for her. However, like Carol, she found that as trust in her therapist and the therapy process increased the more Mandy felt the therapist's insights were 'right'. Framing therapist behaviour as correct or not was a thread running throughout the interviews, with the inverse applied to the participant; if one was right, the other must be wrong.

Being understood on a deeper level also meant the therapist seemed aware of aspects of the participants' self which they were not. Dawn spoke about how she had developed a coping strategy in life which involved not allowing herself to feel emotions in order to not experience extreme emotional pain. However, she was not aware of this until her therapist noticed it:

"And she said to me, ‘You’ve just told me all of that as if you’re reading out a shopping list [surprised].’ And I began to realise that my emotional doors were locked firmly".

By contrast, Teresa was aware on some level that she downplayed the impact the relationship with her parents had on her, however it was important for her that her therapist noticed:

"[I] ’ve always just been really, like,... I don’t know, just really flippant, especially about my dad and stuff. And... [pause]... you know, she totally just... called me on it, basically [chuckles]."

Her chuckle at the end of this statement seemed indicative of the mode of relating this account; there was a sense of wryness which could probably only come with some distance from the events being recalled. There was also a sense of gentle self-deprecation which was
perhaps made possible by the positioning of the current self looking back to a former more naïve, less self-aware self.

**Sub-theme 2: Bad aspects of self accepted**

Following on from the previous theme, the noticing of unacceptable or shameful aspects of the self – often experienced by the participants as 'bad' – were then felt to be accepted by the therapist. The feeling of containment this engendered was expressed by Hannah:

"There was somewhere where I could go when I was feeling... really low and it was safe to talk about it and safe to feel that bad."

Hannah found it relatively easy to bring those parts of herself to her therapist; she recalled having therapy in the past where she felt she had 'emptied herself' with just talking and now was ready to take the risk and play a more active part in making a change in her life. However, others described how they disclosed aspects of themselves a bit at a time, almost as though they were testing the waters before taking the plunge. Mandy remembered:

"[I] started letting... little bits of information out and they weren't sort of pounced upon as being... the end of the world."

For Jane the experience of shame was perhaps more present for her; it may have been difficult for her to talk about it outside the safety of the therapy relationship. When she described her experience of disclosing shameful behaviour she began to talk in the third person, possibly indicating a desire to distance herself from the painful memory, whilst at the same time describing the acceptance she felt by her therapist:

"[I]t was hard because there's an element of shame... And you'd come out and you'd say, 'Oh, I don't know why I said it,' and she said, 'Well, it's good that you can admit it,' and she never made me feel terrible about it."

Another feature of acceptance was the therapists' ability to help transform the 'badness' into something which could be begun to be thought about and understood. This was Teresa's experience:
"[W]hen I eventually could say some things, she was, like... [pause] very matter of fact about it, but also very much like... [pause], 'Well, this wasn’t your fault,' so..."

Acceptance by the therapist was not always accepted at first by the participant in the therapy relationship. Teresa recalled that she thought she must have 'tricked' her therapist somehow into accepting her. It took her a long time to trust her therapist's acceptance of the whole of her.

Connected to acceptance, one of the most difficult experiences the participants reported was feeling negatively towards their therapist. Most of the participants spoke of their concern that their therapist would not accept them after they had expressed negative feelings towards them. Dawn remembered being frightened that her therapist would reject her:

"If I felt angry at her, I’d always be scared that she wouldn’t want me anymore. She’d always say, you know, ‘You’re welcome here whatever your feelings. Whatever you bring, you’re welcome.’"

Underlying this sub-theme was the assumption made by most the participants, before they started therapy, that they would encounter someone who would judge them and not tolerate any negative thoughts, feelings of behaviour directed at them. Over time, and as they were able to disclose more they were able to experience the therapist as accepting for at least some of the time. The overall impression was that the experience of the therapy relationship as containing was very fragile; easily disrupted by either doubts about the integrity of the therapist, or negative perceptions of the self by the participants.

**Sub-theme 3: Evidence of care**

One of the ways the participants experienced the therapy relationship, as one in which they felt accepted, was by demonstrable displays of care. These tangible expressions were felt to be a kind of proof that the therapist cared about them and did not just think of them as a 'number' nor that the therapist was just a professional doing a job. For Anna, this was about being treated as an individual:
"[S]he really listened and really wanted to help, ‘cos she’d, like, improvise, possibly, erm, and, and work things out, you know, it’s, like tailored that to me."

Being treated as an individual was also important for Carol but for her it was the experience of her life narrative being held in mind by her therapist. This may have had the containing effect of feeling that she was being held in the mind of her therapist in between therapy sessions, providing a kind of continuity to the relationship. Carol recalled being surprised by her therapist's memory:

"She’d pull stuff out sometimes and I’d think, ‘Well, I told you that about... you know, two months ago [surprised]. How can you remember that now [impressed]?’

Sometimes the ordinary was transformed into something extraordinary within the therapy relationship. Teresa remembered experiencing something quite simple her therapist did as significant because it enabled her to see the human side of her therapist and therefore her care felt more credible. She recounts:

"[S]he, like, put my boots and my wet socks on the, on her radiator, and it was just really, like, a little sweet, like, weird thing to do."

Another form of behaviour which was interpreted as evidence of care was of the therapist 'fighting the participant's corner'. Hannah's impression was that the service she was receiving treatment under would not have extended the length of her course of therapy without some effort being made by her therapist:

"[H]aving [...] him on my side, erm... it really worked [enthusiastically]. Erm... and... [pause]... I’m sure that they had to argue for me to be able to stay there for longer."

Underlying this sub-theme, as with the theme around acceptance, was the sense that the therapist was going beyond the participants' expectations. This was highlighted by Teresa's thoughts on her therapist's considerate actions with her wet clothes; they were sweet, but also weird, probably because they were not quite as she expected. It seemed likely that their
expectations were low to start with and this could be partly accounted for by the participant’s previous experience with mental health services and staff. Many had negative stories to tell of stigmatisation and a lack of care. By contrast the experience of working with a therapist who showed they care was another way in which they felt contained by the therapy relationship.

**Sub-theme 4: Feeling uncontained**

Feeling uncontained described the experience of most of the participants of a sense of vulnerability, of being left to cope on their own in the therapy. Until any kind of therapeutic relationship developed, the participants found it difficult to be in the room with a stranger; being with someone and yet feeling alone. Teresa recalls:

"Just being in the room with someone I didn’t know was… really scary and it was just, like, hard to… just stay there."

Anna felt she was left to cry by her therapist a lot of the time, which left her with the feeling that the therapy wasn't going anywhere:

"Erm… I used to sit and cry [surprised], ‘cos she’d ask me stuff and I were constantly upset, every time it would just trigger something off, and… half the time I were just sat crying."

Participants usually reported feeling uncontained only during a session, or part of a session, but sometimes it could last for longer periods of time. During this time, many participants reported not attending their sessions and often 'acting out' which was a term Dawn adopted from her therapist’s explanation of her behaviour. This included self-harm behaviour sometimes. Dawn described her experience in many of her therapy sessions:

"Often I’d just feel like I’ve got no clothes on! I felt so raw and vulnerable and fragile a lot of the time. It was a very difficult time for me."
It could occur at any time within the duration of therapy; Carol had begun to trust her therapist, but suddenly felt it had become untenable when the issue of ending came to the fore:

"[W]e’d spent all this time unpicking everything and, and [clears throat] laying everything bare and then I didn’t feel she was gonna see it through."

Most participants not only experienced periods of feeling uncontained within therapy relationships which they viewed as negative or unhelpful, but also at times with the therapists by whom they felt contained by much of the time. During these times, it was as though the therapist changed from caring and accepting to cold and judgemental.

**Master theme 2: Perceptions of therapist**

Perceptions of the therapist within the therapy relationship were fluid and fluctuating. On occasion, particularly when triggered by either the content of the therapy; perceived demands by the therapist; or the participant's concern that their own behaviour had been damaging, the therapist appeared to change. The fluidity of perceptions of the therapist was also experienced as part of the process of therapy and the development of the therapy relationship.

**Sub-theme 1: Shifting perceptions**

The shifting nature of how the therapist was perceived was often described as sudden and unpredictable. Often the shift could be quite extreme. Dawn described feeling as though she didn't know who her therapist was a lot of the time:

"Sometimes I’d love her, sometimes I’d, I’d hate her, sometimes I’d completely distrust her, think she was a manipulator and playing mind games, and other times she was the best thing since sliced bread."

It is interesting to note that ‘manipulator’ is a common pejorative term used to describe clients with BPD. This raises the question of when clients with BPD experience their relationships with therapists as manipulative; does it correlate with the times when the therapist may feel ‘manipulated’?
Other participants thought that their therapists may feel very strongly about them, even hate them. Jane found herself wondering if her therapist was ending the therapy because she suddenly wanted to get rid of her:

"I was like, ‘Oh, maybe she hates me [worryingly],’ [chuckles]. And I thought, ‘Oh, am I bothering her [worryingly]?’"

There were links here also to the experience of being accepted; the experience of not pleasing/disappointing/angering the therapist was often associated with perceptions of the therapist as changing from being caring to being disappointed/not pleased/angry. For Carol, it was as though she would become somebody else, although not just any other, but somebody else that took on the characteristics of others Carol felt had let her down; it was as though it provided proof that things were bad and were not going to change.:

"She just became another... person that had let me down; just somebody that didn’t, didn’t care, couldn’t be bothered."

Mandy experienced a similar pattern:

"[W]hereas other days made me feel like she didn’t care and that she’s... you know, fed up with... having to see me rather than... feeling like she wanted to see me."

She went on to describe what she felt was her therapist's disappointment in her was difficult to cope with because it was what the 'entire world' felt about her. However, she found she was able to use this possible misrepresentation of her therapist's feelings about her, with her relationships with others outside of therapy, to test whether she really was a disappointment to others.

**Sub-theme 2: Ideal therapist**

Some participants recalled initially having hopes, and sometimes expectations of their therapists, which were later seen as unrealistic. Mandy reported that she was:
"[...] looking for was a mother figure who was going to support me emotionally."

The fantasy of the ideal therapist seemed to be in contrast to the low expectations participants also had of the therapy relationship in relation to being understood and accepted by their therapist. However, it was possible they were two sides of the same coin. Carol experienced both when she felt that the person she had high expectations let her down. She described her therapist as:

"[T]his person that I’d, I’d put on this, this pedestal of being a helper."

When she felt let down by her therapist it seemed to confirm the position on the other side of the coin; her therapist became 'the same' as everybody who had let her down. It was as though there was no other way for her to relate to her therapist; she was either on a pedestal or just like everybody else who had let her down.

There was some variation between the interviews, meaning that for some of the participants the therapist was experienced more like a role model. Dawn's therapist modelled mature adult behaviour:

"I learnt a lot from her, from her responses, from what I saw as an emotionally whole, grown up, mature adult."

In Teresa's account, there was a convergence of the two – the ideal therapist and therapist as role model – which she seemed to find confusing:

"[S]he was very much like just really comfy in herself [...] 'I’m not going to worry about what anyone’s thinking of me,' [chuckles]. And I just, I’d love to be like that [chuckles]. I don’t know, it’s a bit fucked up. So I kind of wanted her to mother me [chuckles], but I was, I kind of wanted to be her [chuckles]."

Teresa's description of her experience gave the impression that she felt divided between the needs of the child in her to be mothered and the adult who needed guidance on how to be grown up. For Hannah, it was more straightforward; she felt that she and her therapist had 'clicked' at the beginning and that they just worked well together:
"I just thought he was brilliant [enthusiastically]."

She mentioned that therapy probably wouldn't have 'worked as well' with somebody else and that she attributed its success to him. In her account, there was a lot of praise for him although occasionally she recognised that she worked 'really hard' and that she was highly motivated from the start. It seemed that they were a good 'fit', but it was difficult to be sure exactly how much of that success was due to them as individuals with particular personalities and how much was perhaps due to a good working relationship.

**Sub-theme 3: Wanting to please**

During periods in which participants felt anxious about disclosing difficult material, many developed strategies to protect themselves which involved trying to pleasing their therapist. In this sense, there was no fixed idea of what the therapist was like, rather participants had to develop strategies to work out what would be the correct course of action to ensure they did not evoke the therapist's displeasure. Mandy was concerned that if she revealed too much of herself and her emotional intensity, she would be rejected for being too much to cope with:

"[I] 'd give them the answers that I thought they wanted to know and not the answers that I wanted to give them."

For Dawn her desire to please her therapist was intricately tied to her wish to be 'good' in the eyes of her therapist. In order to achieve this, she would not challenge her therapist and would consequently feel constrained by this experience:

"I think that, in some ways,... I wanted to be like the good girl and I would be compliant."

Oftentimes this meant that she would find herself becoming the 'rebellious teenager' and becoming angry at her therapist or not attending sessions for a period of time. Teresa described her need to please her therapist as not particularly 'healthy', but she felt that over time it enabled her to become self-compassionate. She states:
"[S]ometimes I feel like I deserve... at least OK things, if not good things [chuckles].
Yeah. So maybe she just, like,... you know, got me to that point, even if it was via,
'I just want your approval because you're a nice therapist lady.'"

At first Teresa wasn't able to want goodness for herself, but she found that wanting it in order to please her therapist allowed her to begin to believe that she did deserve it.

**Sub-theme 4: Authentic**

It was really important to the all participants that they felt that their therapist was being authentic or genuine. For Anna, it meant she did not have to spend all her time in the session trying to 'second guess' her therapist's intentions; she was stating them openly. Anna recalled:

"She came across as really genuine, so I relaxed."

Genuineness provided proof of the therapist's care for the participants. Mandy felt it was particularly evident when she told her therapist about positive things that she had experienced between sessions and her therapist expressed pleasure. This proved to her that it meant more to her therapist than just the successful completion of a therapy task. Mandy remembered:

"[S]he would ask, you know, 'How are you? How was the week?' and, when... I told her that things had been good, she was... genuinely pleased..."

This sub-theme is linked to evidence of care and the importance of concrete manifestations of care by the therapist. In this sub-theme therapist honesty/authenticity/congruence suggested that they are able to be affected by the participants. Jane interpreted her therapist's shocked responses as a sign that she cared:

"[Y]ou could bring things to her that were really bad and she might look shocked, but, at the same time she'd go, 'OK, we can work with this [normalising],'
[chuckles]."
Whilst having an impact on the therapist was viewed positively, it was important for the therapist not to become overwhelmed. Jane's therapist was able to take on board the difficult material Jane brought and let her know that it was something she could help her with. For Hannah, this was crucial; she wanted her therapist to be himself when she brought matters of an extremely distressing nature to him, however, it was important to her that he was strong enough to cope with it and therefore be able to help her to cope with it:

"He was concerned but he was himself... and that was very important to me. ... He wasn’t, sort of, shock, horror..."

Sometimes therapist authenticity was experienced as a demonstration of a person to person relationship, rather than purely client to therapist. Teresa found that this helped her to open up to her therapist because she wasn't afraid of 'letting her guard down':

"[I] felt like she was willing to relate to me as a human being, as like, like, she’s like, ‘Well, I get nervous about stuff too sometimes.’"

Perceptions of the therapist were multi-faceted, fluid and subject to shift suddenly. Tangible expressions of authenticity provided evidence of care and recognition of them as fellow humans.

**Master theme 3: Issues of control**

Control – or a lack of it – in the therapy relationship was central to the participants' experience. Control was spoken about as belonging to either the therapist, the participant or shared between them. As with the other themes in this study, this theme represents the experience of control as a fluid continuum with positive and negative experienced at different times within the therapy relationship. Some participants made comparisons between different therapists in terms of where the control lay and others reflected on fluctuations in experiences of control within a given therapy relationship.
Sub-theme 1: Empowerment

Situated at one end of the continuum, empowerment encapsulated the experience of being in control of therapy and making decisions about the direction to take. Participants spoke about this as a positive experience. Hannah reported that she felt she was given control of her therapy before she had even started, when her therapist asked her to write a list of 'what she had problems with and the things she wanted to work with':

"[I]t kinda... gave me control over the therapy in the way that... and I had to think about what... I wanted to do."

Control was passed to the participants by their therapists. For Anna, this compared favourably to other therapy experiences where she had little say in what happened in the therapy:

"[Q]uite a lot of it was about handing it over to you, wasn’t it, so like what you can do for yourself and your life, rather than someone sat there who... who knows best for you."

The giving of control was also seen as an indication of the therapists' trust in the participants. Mandy felt that her therapist's trust in her enabled her to find solutions to her own problems. Furthermore, these solutions were more likely to 'stick' than if her therapist had instructed her to try them:

"[S]he’d ask the question and I’d answer it rather than... me kind of questioning things and her coming up with the answers."

Control was also seen as something that could be taken. Dawn felt it was empowering to be able to tell her therapist how she felt about their relationship:

"[T]hat was really good for me to be able to say that, to tell her exactly that’s what it feels like sitting with you – it feels cold and clinical, no warmth."

In the context of this therapy relationship, Dawn spoke of taking back control because she felt that she was in a very powerless position within the relationship.
**Sub-theme 2: Collaboration**

Working collaboratively implied that a dialogue was established between therapist and participant. Control was situated between the participant and therapist. Although the dialogue was usually led by the therapist, the emphasis was on working together. Hannah described the process as one in which each person had input:

"He asked me, sort of, what worked for me and... he said he would show me, erm... techniques"

The dialogue was often about how the therapy was being experienced, and what changes could be made. Carol found it valuable to have the chance to give her opinion on the therapy process:

"But she also made sure that I had... opportunity to... erm, say how it was for me and how it was going."

Collaboration also involved therapist and patient working together to try to understand events outside the sessions. Jane found that the process of breaking down the various elements which constituted an event useful:

"He'd go, ‘Was this helpful?’ ‘No.’ ‘How did you feel afterwards? How can we change this in future?’ in some ways, you felt like a kid, but breaking it down into little, little steps really helped."

Breaking down the tasks in therapy was, for Teresa an indication that her therapist was listening to her when she found something too difficult and a willingness on the part of her therapist to really work with her and give her some control over choices:

"He'd be like, 'Well,... I get why these things are hard, but I think you can do this part of it, actually [positively].'"
Collaboration implied an emphasis on the 'we'; both parties working together. It was welcomed by Dawn who experienced it as one of the more positive aspects of her therapy relationship:

"[If I'd struggled with anybody or a situation, we'd talk about it in therapy, and I suppose it was almost like she'd go through it with a, a fine-toothed comb with me."

Working together on the process, tasks and content of therapy was experienced by the participants as a constructive component of the therapy relationship. Control was felt by the participants to be more balanced between them.

**Sub-theme 3: Control of ending**

Endings were talked about at length by all the participants, with most mentioning the ending as soon as they began to reflect on their therapy relationship experience. Perhaps this was the first thing they remembered because it was the last contact they would have had with their therapist. However, endings also seemed salient for giving rise to feelings of distress and fears of rejection and abandonment. Many of the participants had experienced endings in the past which felt premature and/or uncontainable. Having some control over aspects of the ending appeared to mitigate the worst aspects of these experiences.

In Dawn's account, she recalled having the realization that there was not going to be an ending which would be satisfying for her, therefore taking control of when it occurred lessened the distress associated with the end of the therapy relationship:

"I keep running back to this wire monkey and I don't think it's actually serving a purpose for me anymore."

Mandy took control of the end of her relationship with her therapist by physically leaving before the end of the therapy:

“Easier to be the one to leave than the one to be left behind.”
In circumstances where the ending was determined by service policy, therapists seemed able to helpfully facilitate the transition to the ending of therapy by giving advanced warning and providing methods for coping with it. Jane found it 'terrifying' when her therapist announced that therapy was ending, but the prospect became more manageable when she offered her practical methods to use:

"'OK, we're gonna start preparing you not to have therapy.' And I was like, 'Whoa, whoa, whoa [worryingly], 'you know. And she, and then we started talking about tools.'"

Hannah's therapist had extended her therapy, however, when she was nearing the end of that period she felt she was ready and ended it early:

"I think I'm good to go."

Hannah seemed to take control of her ending and did not have any real doubt about whether she was ready. However, most of the participants experienced some ambivalence towards ending the relationships with their therapists. Carol felt that although she had some control over how and to some degree, when to end, she didn't feel she had enough control to not allow the ending to take place at all:

"'Go on, you, you can, you can do it, you can swim, you, you’ll be OK, you can do, you can reach the other side.' And you’re holding on, you’re thinking, '[Sighs] Maybe I can, maybe I can’t, 'and you do let go, but you don’t want to, do you?"

Although none of the participants felt they had complete control of the ending, most managed to find ways of ending the relationship with their therapist which they could cope with and was in some way meaningful to them.

Sub-theme 4: Doing to
'Doing to' represents the experience of participants when they did not have control within the therapy relationship. As the phrase suggests it was associated with feeling disempowered; therapy being done to them rather than with them. Mandy reported that she
was instructed to carry out tasks between the sessions without any discussion about their nature:

"[S]he was more, kind of, like, ‘OK, so this is your homework for next week and you’re going to do X, Y, Z.'"

Often the therapist's style of questioning was experienced as something which was done to the participants, particularly if there was not reason given as to why they were asking the questions. Carol recalled:

"She’d kind of write it down and, erm... I, I think, this was early on and when she was, kind of, trying to decide... I don’t know what she was trying to decide... how mad I was [speculating]?"

For Dawn the experience of having therapy done to her was characterised by the therapist controlling the agenda. In her account, Dawn described being in sessions where she felt the therapist was only addressing what they believed to be important, not her:

"[I]f you were late or if you missed a session, such a big thing would be made of it [unbelievably], such a long, drawn out thing that that sort of kept me quite compliant."

‘Doing to’ represented the negative aspects of the therapy relationship for participants.

Discussion

Participants experienced the therapy relationship, as fluid and changeable. On the whole, it was felt to be containing; within it they felt understood, safe and accepted. However, periods of feeling uncontained were also reported. The therapist was experienced at different times, variously, as ideal; genuine; or someone one needed to please and was often subject to change suddenly, usually from a caring to negative figure. Within the relationship, control was experienced as being with either the therapist, the participant or located between them. Issues of trust permeated the themes.
What emerged from the analysis was the importance for participants to feel contained. Whilst this may be true for all clients, it may be more so for clients with BPD. A key component of containment was feeling understood. Feeling misunderstood by others is recognized in the literature on BPD to be one of the subjective markers for meeting the criteria (Linehan, 1993b). It is therefore of great value to the client with BPD to feel understood, particularly if it is experienced as attunement with the therapist. Many of the accounts contained examples of this; the sense that the therapist was aware of aspects of the participant that they themselves were not aware of. Attunement in the therapy relationship is theorized about across modalities. BPD is thought to develop, in part, as the result of a developmental deficit concerning early caregivers' ability to be attuned to the infants' inner state. In psychodynamic theory, Winnicott, refers to the 'maternal reverie' of the caregiver, providing the infant with a sense of continuity for the nascent self (Winnicott, 1988). In attachment theory-based MBT, attunement is thought to continue at a later stage in the form of mirroring; here the infant is able to use the caregiver as a mirror, enabling them to internalize the maternal responses and come to experience them as their own (Bateman & Fonagy, 2004). In DBT the process of validation, could also be seen as a form of attunement to the infant or child's feelings or thoughts (Linehan, 1993b). Therefore, in the therapy relationship attunement is thought to have a reparative effect. There is, however, also the danger of idealisation of the therapist, which was evidenced in the superlative terms used, such as, 'so clever' and 'brilliant' to describe their therapists when they went beyond the expectations of the participants.

Participants experienced the therapist at times as ideal, they were 'on a pedestal', then shift quite suddenly into hateful, uncaring people who would let them down. In object relation theory, this process is known as 'splitting'. According to Klein's concept of early infancy the infant is only able to cope with entirely 'good' or 'bad' experiences; the 'paranoid-schizoid position'. Good is introjected and bad projected out. However, as a result of projecting the bad out, the world can then feel like a persecutory place, good may then also be projected out. As development continues the infant is able to achieve some integration of this split internal state, known as the 'depressive position' (Clarkin, Yeomans, & Kernberg, 2006). Due to problems in the infant caregiver dyadic relationship, clients with BPD, are not as able to integrate these internal states and are often functioning, psychologically, in the paranoid-schizoid position. As such, others are either idealized (all good), or devalued (all bad). Often the particular form the devaluation will take with
another person is what the individual with BPD projects into them. For the participants in this study it was, for example, one of the participant's sense of being a disappointment which appeared to be projected onto her therapist. Participants, therefore, seemed to find it difficult to hold a coherent image of their therapist in mind. Research suggests that BPD clients have more difficulty than individuals with other types of personality difficulties in creating a ‘benign image’ of therapists (Bender et al., 2003).

Other possible explanations for this level of seemingly distorted thinking have been investigated and the evidence is mixed and full of contradictions (Allen & Whitson, 2004). One theory with empirical support is that ‘invalidating environments’ – constantly being discredited and denigrated and having inner states mislabelled – in childhood may cause individuals to develop a lack of certainty about their own thoughts and feelings. This is compounded by the reactions of caregivers to the child’s emotional states which are often punitive, which may mean clients have learnt to hide their true thoughts and feelings well. This is thought to lead to ambiguous communications which have a variety of meanings, even contradictory ones. (Linehan, 1993a). In a similar vein, Veen and Arntz (2000) propose that the B&W or dichotomous thinking, which is thought to arise from intrapsychic splitting may actually be a form of multidimensional thinking in extreme form. This may in part explain the varied nature of the perceptions; manipulative; disappointed, not pleased; hating; and angry. Whilst they are all negative, there are more shades of grey apparent, than just pure ‘bad’. They suggest it is possible that therapists may be overgeneralizing the sudden switching evaluations clients make of them and that clients are viewing them as ‘all good’ or ‘all bad’.

The way the participant perceived the therapist was linked also to the participant’s need for tangible or concrete ‘evidence’ of the therapists' feelings towards them. There was no expectation that the therapist would automatically care for them. The participants therefore noticed, and were often surprised, by caring behaviour towards them. Similarly, for therapist authenticity; participants greatly valued it; however they did not initially trust that their therapist would be honest and genuine with them. Participants seemed to need constant reminders; it was difficult for them to assimilate all the different behaviours of the therapist and interpret their momentary affective states or behaviours as part of a coherent whole (Clarkin et al., 2006).
Interestingly, the relationship was not explicitly discussed by the participants. Perhaps it was difficult to find the right discourse to talk about relationships given that those in common usage pertain to romantic, family or friendship relationships. Therefore, much of what was talked about was therapists' behaviour; what they did and said, rather than who they were in themselves and how they related. This could also be due to the modalities of therapy which he participants were engaged in. All except one had a strong emphasis on action – doing rather than talking – and practical life skills components. However, it is perhaps difficult to separate out therapy from 'the relationship' which has all the aspects of being with/doing to/teaching/leading by example/containing/holding. According to much leading research on the common factors in therapy outcomes, techniques and theory-driven practice are less important factors compared to the therapy relationship (Norcross, 2011; Wampold, 2001). This supports idea that ‘active ingredients’ in therapy relationship are more difficult to determine because the relationship permeates all aspects of therapy.

Bordin’s (1979) 'pan-theoretical’ theory of what he terms, the ‘working alliance’ provides a useful way of conceptualizing the therapy relationship, which resonates with the experience of the participants in this study. The working alliance is divided into ‘agreement on ‘goals’, ‘tasks’ and ‘bonds’. Goals are an agreement on what the client is trying to achieve. Tasks refer to what is expected of the therapist and client in the process, and moving therapy towards the agreed goal, which is dependent on the ability of the therapist to link the task with the client’s understanding of their difficulties and desire to change. Bonds describe the attachment and trust which is developed in the relationship (Bordin, 1979). This speaks to the participant's positive experiences of 'doing with' in the therapy relationship; a sense of collaboration and joint venture. Bonds were more problematic, as attachment was often experienced as untrustworthy and bringing to the fore the issues of abandonment and rejection.

In terms of the themes on control, the analysis resonated with pan-theoretical evidence on the concept of self-agency as part of a common strategy for creating a positive therapy relationships with BPD clients (Clarkin et al., 2015; Links, 2015). Central to the definition of self-agency is the ability to change the environment as a result of one’s actions and intentions (J. Knox, 2011). The participants in this study spoke of the need to control the aspects of the relationship with their therapists, in particular, to have some control over the endings where they felt their actions could have an impact on the way the ending transpired,
even if it was to leave before the therapy was due to end, in the case. Even in Carol’s case where she didn’t necessarily want the therapy to end, the fact that she stuck it out and left on her terms, i.e., with ambivalence, by recognising that was what she was doing, she did leave on her terms in a way.

Collaboration was the participant’s preferred form of control, that is, between themselves and the therapist. This is probably the most well evidenced concept in the BPD therapeutic relationship literature (Clarkin et al., 2015; Linehan, 1993a; Markowitz, Skodol, & Bleiberg, 2006). It is seen as a core part of the alliance and engenders a sense of joint nature of the enterprise of therapy; that the client and therapist each brings different types of knowledge which they can then use to work together. This is demonstrated in Hannah’s comment that her therapist asked her what she already knew worked for her and then offered to show her some other techniques.

**Conclusion**

This IPA study has provided an in-depth account of the experiences of the therapy relationship for clients with BPD. Participants experienced the therapy relationship, as fluid and changeable. Difficulties around holding a coherent mental image of the therapist were reported. Positive experiences discussed by participants were the containing quality of the relationship and working collaboratively with their therapists.

**Limitations of the study**

One of the limitations of this study was that the participants were possibly not representative of the majority of individuals who meet the criteria for BPD. They were very self-motivated individuals who volunteered to take part after seeing recruitment notices on social media. They wanted to tell their story in order to help others with BPD. Their experience will not necessarily be replicated in other studies. Another limitation is in regards to the variety of therapy types the participants had been engaged in. It was difficult to determine how much of their understanding of their relationship with their therapist was formed by the mode of therapy being practiced.
Implications for clinical application and further study

One potential outcome of this study is that it will contribute to a greater understanding of the subjective experience of the therapy relationship for clients with BPD which will be of value to counselling psychologists working with this client group. By providing therapists with an in-depth analysis, detail and richness from client point of view an understanding of the particular behaviours and patterns of relating in session, therapists may be better able to be better understand the internal states of their clients. This type of research enables a different way of engaging with the material; it is not concerned with finding factors which clinicians may then be able to apply to their practice in the form of techniques or attitudes. Instead, it provides an alternative way of understanding the phenomena which may not be strictly technically applicable, but has the potential to engender a more direct empathic understanding which can influence clinical practice with this client group through a deeper understanding of their subjective experience of the therapeutic relationship. It is hoped that therapists of all persuasions, including counselling psychologists, will be able to gain some insight into the subjective experience of the client with BPD; to be able interpret their behaviour differently, perhaps even empathize with some of the more ‘extreme’ behaviour. It may also provide a very tentative guide on the use of self for therapists in terms of what the participants in this study found helpful.

It has been argued that experienced practitioners don’t only base their therapeutic work on the use of explicit protocols or singular models, but also develop particular context-dependent conceptualizations which allow therapists to respond with flexibility in the process of therapy (Fishman, 2005; McLeod & Elliott, 2011; Polkinghorne, 1992). Clinicians are just as likely to engage with ‘practice-based research’ (PBR) as with ‘evidence-based practices’ (EBP) which are based mainly on efficacy studies, involving randomized control trials (RCTs) of particular protocol driven therapy models. In this sense the current study can be thought of as contributing to a PBR knowledge-base (Henton, 2012). The types of studies which fall under this category are often characterized as outcome oriented and usually consist of case studies, process research and effectiveness research which attempts to capture all the variations and context specificity of everyday life, as opposed to efficacy research which tries to control for difference and generalize effects (Barkham, Hardy, & Mellor-Clark, 2010). Because of this focus on variations in care and human processes PBR can claim to reflect everyday clinical practice. Therefore, a broader definition of PBR is able to encompass the contribution a phenomenological
approach can make, either in terms of stand-alone studies using methods such as IPA, or as part of systematic case study research (Bager-Charleson, 2014; Flyvbjerg, 2006; McLeod & Elliott, 2011; Reeves, 2011). For example, case-studies might aim to address outcome questions directly or to test and/or construct theories but more phenomenologically, they may also aim to describe experience (Flyvbjerg, 2006). Barkham (2010) suggests that PBR enables individual practitioners to participate in building an evidence base, using methods such as case-study, single-case, and qualitative approaches, in what he terms a ‘bottom up’ approach. It can be viewed as an extension of ‘everyday’ research that practitioners engage in as part of their practice and as situated knowledge, or ‘insider’ research that involves practitioners engaging in an evaluation of their own and others’ practice (Bager-Charleson, 2014). It can be argued that research and practice come closer together in PBR than in other forms of research (McLeod & Elliott, 2011). Moreover, PBR together with EBP can provide a comprehensive picture of psychotherapy which is of value to all clinicians, including counselling psychologists (Barkham et al., 2010).

This study reinforces the notion of humanistic values underpinning tasks and goals as an integral part of the therapeutic relationship (Ashley, 2010). The relational aspects of therapy were thought and felt to permeate all aspects of the process, by the participants in this study. Central to this was the experience of ‘doing this with’ the therapist as opposed to the negative experience of having therapy ‘done to’ them. This is very much in line with Counselling Psychology’s ethos (Ashley, 2010; Hill, 2010; Steffen, 2013). Steffen (2013) demonstrates how integration of humanistic values in contemporary practice for BPD can be framed. Using the example of DBT, she posits that ‘validation’, resonates with client-centred relational values; of ‘being with’ and ‘change’, taps into the humanistic endeavour to foster growth and may involve taking a more active role, similar to a life coach; ‘doing to’ (Steffen, 2013). The current research emphasises the integration of these aspects of the therapeutic relationship and goes even further than adopting a both/and approach to propose it is a ‘doing with’ relationship.

Furthermore, the findings from this study can also build awareness for counselling psychologists that working with this client group may require a slightly different way of conceptualizing the therapeutic relationship to working with other groups of clients. Counselling psychology as a distinct division within applied psychology is predicated on the values of a client-centred humanistic practice with the therapeutic relationship at its
core. These values are based on Rogers’ (1957/2007) concept of the conditions deemed necessary and sufficient for meaningful therapeutic change to occur. The three ‘core’ conditions are:

1. The therapist experiences unconditional positive regard for the client.
2. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
3. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (Rogers, 1957/2007, p. 240)

Therapist behaviours associated with a client-centred practice can be summed up as active listening, which comprises; attending, reflecting, clarifying, paraphrasing, summarizing, and avoiding questioning. Communication is often non-verbal and can be minimal depending on the stage of the therapy process with an individual client (Mearns, 2003; Rogers, 1951). For example in Knox’s (2008) study of the experience of ‘relational depth’ – a state of profound contact between two people – in person-centred therapy, clients’ descriptions of the relationship involved an emphasis on “mutuality, intimacy, openness, a sense of wellbeing, and a co-reflectivity beyond words” (R. Knox, 2008, p. 182). The focus is predominantly on who the therapist is, how congruent they are within themselves, and how they embody the core conditions (Moon, 2005; Tangen & Cashwell, 2016).

By contrast, this study found that for this population, the relationship was experienced in less nuanced and subtle ways. There was a much greater emphasis on concrete, or tangible demonstrations of care from the therapist. The therapist was not experienced as a consistent figure which seemed to render the participants’ ability to perceive the therapists’ unconditional positive regard (UPR) and empathy as problematic and not reliable. Whilst it may not represent the current discourse on the therapeutic relationship, particularly as understood within counselling psychology, it is a particular version of it. For this client group, their experience of relationship is of a concrete manifestation of the therapists’ intentions towards them and feelings about them; the therapists’ behaviour is at the forefront. This however does not mean that the humanistic value base has been undermined, it just requires a slightly different reading of the core conditions with an emphasis on how they are communicated. Rogers (1957/2007) advocated that the therapist experiences UPR
for and an empathic understanding of the client. They ‘endeavour’ to communicate this to the client, and that this communication be to a ‘minimal degree achieved’. From a person-centred perspective, the key method for communicating UPR is the therapist’s dedication to empathic understanding and often manifests itself as an interactive process wherein the therapist, follows the client and sometimes checks with the client to see if the therapist is indeed accurately understanding what the client is saying (Moon, 2005). The findings from this study suggest that the communication of UPR and empathy perhaps needs to be more overtly expressed within the relationship with clients with BPD and achieved to a greater degree than Rogers suggests.

The implications for counselling psychologists working with clients with a diagnosis of BPD, based on the findings of this study, are that it is important not to presume what the therapeutic relationship is like for them. The therapist’s subjective experience of the relationship may not be experienced by the client in the same way. These findings may also be helpful with regards to other client groups, such as those who do not respond well to overly empathic therapists and those with a fear of compassion (Cooper, 2008; Gilbert, McEwan, Matos, & Rivis, 2011) Undoubtedly additional research needs to be carried out with this participant group to gradually build the knowledge base. Further studies could compare clients without BPD diagnosis to see if their subjective experience differs and in what ways. Research comparing client experiences of the therapeutic relationship within different types of therapy could be useful in terms of determining how much the relationship is shaped by the mode of therapy, particularly the varying emphasis on ‘doing’ tasks in the therapy. It would also be useful to conduct similar studies with therapists who work with this client group, which may provide a deeper understanding of differences in perception of what is happening in the relationship. One related, under-researched area is the effects of stigma on perceptions of BPD clients by therapists (Aviram, Brodsky, & Stanley, 2006). Research into this area could help determine what role stigma plays in therapists’ perceptions of their clients and how this may affect, say, their capacity for empathy.
References


Rizq, R. (2012). 'There's always this sense of failure': An interpretative phenomenological analysis of primary care counsellors' experiences of working with the borderline


Appendix A

Hannah interview

R: So, I saw from your email you had, erm,… been diagnosed, did you say 2008?

P: Yes.

R: And, erm, and you saw a therapist for eight months [questioning]? Is that right?

P: Yes.

R: Yeah.

P: Yeah, that was in 2011.

R: Hmm mmm [understanding], OK. Erm… so I don’t know if you just want to talk a bit about, sort of,… perhaps how you became to be diagnosed and how that… sort of,…

P: Erm, well… I was… first time, I, I know, knew I was sick in my teenage years, but I didn’t get, actually get my first diagnosis until I was 23, and then… that was just depression. But I kept getting iller,… worse and, erm, I completely lost it around 2008 and, er… [pause]… erm, yeah, how did that happen again [thinking] ‘cos I got really drunk and I insisted that my, er, husband at the time helped me, and, er… find somewhere to go, because I knew I couldn’t cope anymore and I knew that… he couldn’t help me. Er, so, erm… [pause]… I thought, you know, wer, I couldn’t, I couldn’t do this anymore and I would kill myself if it kept going like this.

He got an appointment with, erm… [pause]… it’s a bit hazy exactly how it happened, you see. We saw… the on-call doctor and he sent us over to the acute… ward and we had a chat with the acute ward. And the next day I got… because I was still drunk at that time, the next day… I had to come back and continue talking with them and they let me… come and stay for a while. So I stayed for a week, I think, the first time. And then they… I spoke to psychiatrist. He was awful! Erm…

R: Can you say more about that? What makes it awful?

P: Erm, well I didn’t feel he was listening to me and he dragged three or four students with him and he had somebody who was always writing for him. He always had someone to come with him to write. And I told him I couldn’t cope with all these people and I didn’t want to talk to all these people, and he said… ‘There was nothing I can do about it,’ basically. And, er… erm… [pause]… well, I talked to him and my husband was with me at the time, and… [pause]… I lost it at one point and left the room, and then I got, came back in again.

And, er… at the end of the meeting he told me I had a mood disorder… but they never exactly told me I had borderline, and I didn’t find that out until they sent a letter to the GP, because I, I ticked the box where you say that you get all the… letters are sent to the GP are all sent to you. And that’s where it said my diagnosis was…

R: Not to you but to the GP…

P: Yeah.

R: … you got copied in, OK.

P: So…

R: What was that like?
P: Erm, I thought that was quite bad because I felt that I needed to know exactly what it was, because, if I didn’t know exactly what I was dealing with, I didn’t know, I couldn’t…
know how to cope with it and, er, get better. And, erm… so I was quite disappointed at that because, as a mood disorder, I expected to… that they meant, er, border, erm, bipolar.

R: Mmm, mmm [understanding].

P: So… erm… [pause]… so that’s what we told the children at first, until, and then, when that letter came a couple of weeks later, I had to sit them down again and explain.

R: How old were they?

P: Erm, 2008 [thinking], that’s… [pause] seven years ago [uncertain]? My oldest would’ve been 14, 15… and W was… two years younger, so he was about 12, and the youngest… [thinking]… 11 [half-laugh] [coughs]. So they’d grown up with me being quite ill. You know, I had good periods and bad periods, but… it wasn’t very good for them. … But that was, sort of, the beginning of me being really bad… and, erm…

R: Can you say a little bit more about it? Just…

P: Yeah, erm, I had my first therapist, but that was from the voluntary service locally. That was talking, erm, therapy… and… it didn’t really work and I kept… [pause]… I did all sorts of crazy things [half-laugh]. You know, erm… [pause]… I’d be depressed and just stay in bed for ages and then I’d go out and party and be wild and not think about what I was doing at all. And I cut myself, erm, kids… so, my oldest… er, it was late at night, usually, because I didn’t want the kids to see, but she’d walk in on me and catch me out doing it. … And I was in and out of hospital a few times. I think I’ve been in, in there about six times altogether. Erm… [long pause]… and then I want… then I stopped seeing that therapist and then a… a while after, I went into hospital again.

R: So, while you were seeing this therapist, there was all of this going on at the same time.

P: Yeah.

R: You were having, you being admitted and…

P: Yeah.

R: And was that…

P: Erm, I wasn’t admitted so many times right the beginning. Sort of, from 2008 to 2012 I’ve been admitted about six times.

R: Hmm mmm [understanding].

P: Er, but I was still doing things I shouldn’t be doing, erm… you know, and… I got, erm, a social worker assigned to me from, erm, from the hospital, er, from the recovery team, and she was wonderful. She… er, she… saw me every two weeks… and she supported me and…

R: You said she was wonderful.

P: Yeah, she’s, she’s been great [enthusiastically].

R: Yeah. So in what way exactly?

P: Erm… she would listen to me and she understood and she would always try and find ways of helping me.
## Appendix B
### Master table of themes for the group

<table>
<thead>
<tr>
<th><strong>Contained/uncontained</strong></th>
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<th><strong>Being understood on a deeper level</strong></th>
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<tr>
<th>Anna: &quot;[T]here’s more, there’s more she knew, she said, ‘I don’t know,’ she said, ‘but I think there’s more to this than, than just depression,’ she said&quot;.</th>
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<tr>
<td>Mandy: &quot;Erm… she knew that I hadn’t really tried even if I didn’t&quot;.</td>
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<tr>
<td>Dawn: &quot;And she said to me, ‘You’ve just told me all of that as if you’re reading out a shopping list [surprised].’ And I began to realise that my emotional doors were locked firmly&quot;.</td>
</tr>
<tr>
<td>Hannah: &quot;[W]e talked about it, we didn’t do quite so much of that homework […] but, erm, he, he… listened to me, […]. And not, and not at one point did they say, ‘No, you mustn’t do it,’ you know?&quot;</td>
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<tr>
<td>Teresa: &quot;[I]’ve always just been really, like,… I don’t know, just really flippant, especially about my dad and stuff. And… [pause]… you know, she totally just… called me on it, basically [chuckles].&quot;</td>
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<td>Carol: &quot;I don’t know how she did it, but she did. She just seemed to know when, when it was right to say, ‘No, come on [encouragingly], you know, we can… you know, have a think about it and talk about it and…’ And then other times she’d say, ‘OK, well, we’ll come back to that another time.’&quot;</td>
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<tr>
<td>Jane: &quot;[I] think because she knows… I always get down that hill… before I can’t get out, before I’ll ask for help,… rather than slipping a bit, calling somebody and saying, ‘Actually, I’m not OK.’&quot;</td>
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<tr>
<th><strong>Bad aspects of self accepted</strong></th>
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| Mandy: "[I] started letting… little bits of information out and they weren’t sort of pounced upon as being… the end of the world". |

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<td>262-3</td>
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</table>
Hannah: "There was somewhere where I could go when I was feeling... really low and it was safe to talk about it and safe to feel that bad".

Teresa: "[W]hen I eventually could say some things, she was, like... [pause] very matter of fact about it, but also very much like... [pause], ‘Well, this wasn’t your fault,’ so...

Dawn: "If I felt angry at her, I’d always be scared that she wouldn’t want me anymore. She’d always say, you know, ‘You’re welcome here whatever your feelings. Whatever you bring, you’re welcome,’"

Jane: "[I]t was hard because there’s an element of shame... And you’d come out and you’d say, ‘Oh, I don’t know why I said it,’ and she said, ‘Well, it’s good that you can admit it,’ and she never made me feel terrible about it."

**Evidence of care**

Teresa: "[S]he, like, put my boots and my wet socks on the, on her radiator, and it was just really, like, a little sweet, like, weird thing to do."

Hannah: "[H]aving [...] him on my side, erm... it really worked [enthusiastically]. Erm... and... [pause]... I’m sure that they had to argue for me to be able to stay there for longer."

Carol: "She’d pull stuff out sometimes and I’d think, ‘Well, I told you that about... you know, two months ago [surprised]. How can you remember that now [impressed]?’

Anna: "[S]he really listened and really wanted to help, ‘cos she’d, like, improvise, possibly, erm, and, and work things out, you know, it’s, like tailored that to me."

Mandy: "So,... yeah, I trusted her more because she was correct [chuckles]."

**Feeling uncontained**

Dawn: "[O]ften I’d just feel like I’ve got no clothes on! I felt so raw and vulnerable and fragile a lot of the time. It was a very difficult time for me."
Anna: "Erm… I used to sit and cry [surprised], ‘cos she’d ask me stuff and I were constantly upset, every time it would just trigger something off, and… half the time I were just sat crying."

Teresa: "Just being in the room with someone I didn’t know was… really scary and it was just, like, hard to… just stay there."

Carol: "[W]e’d spent all this time unpicking everything and, and [clears throat] laying everything bare and then I didn’t feel she was gonna see it through."

Perceptions of therapist

Shifting perceptions

Carol: "She just became another… person that had let me down; just somebody that didn’t, didn’t care, couldn’t be bothered."

Mandy: "[W]hereas other days made me feel like she didn’t care and that she's… you know, fed up with… having to see me rather than… feeling like she wanted to see me."

Dawn: " Sometimes I'd love her, sometimes I’d, I’d hate her, sometimes I’d completely distrust her, think she was a manipulator and playing mind games, and other times she was the best thing since sliced bread."

Jane: "I was like, ‘Oh, maybe she hates me [worryingly],’ [chuckles]. And I thought, ‘Oh, am I bothering her [worryingly]?’"

Teresa: "I guess I felt like she didn’t care… about me or like she thought I wasn’t trying sometimes. … Erm, but, yeah, so, like, but she just thought, yeah, that she thought negative things about me."

Ideal therapist

Teresa: "[S]he was very much like just really comfy in herself […] I’m not going to worry about what anyone’s thinking of me,’ [chuckles]. And I just, I’d love to be like that [chuckles]. I don’t know, it’s a bit fucked up."
So I kind of wanted her to mother me [chuckles], but I was, I kind of wanted to be her [chuckles]."

Dawn: "I learnt a lot from her, from her responses, from what I saw as an emotionally whole, grown up, mature adult."

Carol: "[T]his person that I’d, I’d put on this, this pedestal of being a helper."

Mandy: "I was looking for was a mother figure who was going to support me emotionally."

Anna: "[M]y first experience with that counsellor was, was so good, the rest of them, actually, have a bit more to live up to.

Hannah: "I just thought he was brilliant [enthusiastically]."

Wanting to please

Dawn: "I think that, in some ways,… I wanted to be like the good girl and I would be compliant."

Mandy: "[I]’d give them the answers that I thought they wanted to know and not the answers that I wanted to give them."

Hannah: "I liked him, you know, as a person and as a therapist, so I did want to do my best."

Teresa: "[S]ometimes I feel like I deserve… at least OK things, if not good things [chuckles]. Yeah. So maybe she just, like,… you know, got me to that point, even if it was via, ‘I just want your approval because you’re a nice therapist lady.’"

Authentic

Dawn: "[S]ometimes she’d be very humble and she’d talk about some of the mistakes and say, ‘Let’s work on repairing the rupture.’"

Carol: "I did feel that she genuinely was interested and genuinely cared and genuinely wanted to help."
Jane: "[Y]ou could bring things to her that were really bad and she might look shocked, but, at the same time she’d go, ‘OK, we can work with this [normalising],’ [chuckles]."

Teresa: "[I] felt like she was willing to relate to me as a human being, as like, like, she’s like, ‘Well, I get nervous about stuff too sometimes.’"

Hannah: "He was concerned but he was himself… and that was very important to me. … He wasn’t, sort of, shock, horror…"

Mandy: "[S]he would ask, you know, ‘How are you? How was the week?’ and, when… I told her that things had been good, she was… genuinely pleased…"

Anna: "She came across as really genuine, so I relaxed."

**Issues of control**

**Empowerment**

Hannah: "[I]t kinda… gave me control over the therapy in the way that… and I had to think about what… I wanted to do."

Mandy: "[S]he’d ask the question and I’d answer it rather than… me kind of questioning things and her coming up with the answers."

Jane: "[S]he found that people can train themselves out of it […] So, engage in therapy […] and she said, ‘The more you put in, the more you’ll get out,’ and I never, sort of, thought of it that way."

Dawn: "[T]hat was really good for me to be able to say that, to tell her exactly that’s what it feels like sitting with you – it feels cold and clinical, no warmth."

Anna: "[Q]uite a lot of it was about handing it over to you, wasn’t it, so like what you can do for yourself and your life, rather than someone sat there who… who knows best for you."

**Collaboration**
Carol: "But she also made sure that I had… opportunity to… erm, say how it was for me and how it was going."

Hannah: "He asked me, sort of, what worked for me and… he said he would show me, erm… techniques"

Jane: "He’d go, ‘Was this helpful?’ ‘No.’ ‘How did you feel afterwards? How can we change this in future?’ n some ways, you felt like a kid, but breaking it down into little, little steps really helped."

Dawn: "If I’d struggled with anybody or a situation, we’d talk about it in therapy, and I suppose it was almost like she’d go through it with a, a fine-toothed comb with me."

Teresa: "He’d be like, ‘Well,… I get why these things are hard, but I think you can do this part of it, actually [positively],’"

Control of ending

Dawn: "I keep running back to this wire monkey and I don't think it's actually serving a purpose for me anymore."

Hannah: "I think I'm good to go."

Carol: "‘Go on, you, you can, you can do it, you can swim, you, you’ll be OK, you can do, you can reach the other side.’ And you’re holding on, you’re thinking, ‘[Sighs] Maybe I can, maybe I can’t,’ and you do let go, but you don’t want to, do you?"

Teresa: "I mean, if she decided when it ended, I think I would have felt more abandoned."

Jane: "‘OK, we’re gonna start preparing you not to have therapy.’ And I was like, ‘Whoa, whoa, whoa [worryingly],’ you know. And she, and then we started talking about tools."

Mandy: “Easier to be the one to leave than the one to be left behind.”

Doing to

Mandy: "He was more, kind of, like, ‘OK, so this is your homework for next week and you’re going to do X, Y, Z.’"
Carol: "She’d kind of write it down and, erm… I, I think, this was early on and when she was, kind of, trying to decide… I don’t know what she was trying to decide… how mad I was [speculating]?"

Dawn: "[I]f you were late or if you missed a session, such a big thing would be made of it [unbelievably], such a long, drawn out thing that that sort of kept me quite compliant."

| Carol: "She’d kind of write it down and, erm… I, I think, this was early on and when she was, kind of, trying to decide… I don’t know what she was trying to decide… how mad I was [speculating]?

Dawn: "[I]f you were late or if you missed a session, such a big thing would be made of it [unbelievably], such a long, drawn out thing that that sort of kept me quite compliant." | 227-30

| Dawn: "[I]f you were late or if you missed a session, such a big thing would be made of it [unbelievably], such a long, drawn out thing that that sort of kept me quite compliant." | 120-3 |
### Appendix C

**Master table of themes and sub-themes for the group**

<table>
<thead>
<tr>
<th>Theme / sub theme</th>
<th>Anna</th>
<th>Teresa</th>
<th>Mandy</th>
<th>Hannah</th>
<th>Carol</th>
<th>Dawn</th>
<th>Jane</th>
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<tbody>
<tr>
<td><strong>Contained / uncontained</strong></td>
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<td>658-62</td>
<td>85-88</td>
<td>770-3</td>
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<tr>
<td>Bad aspects of self accepted</td>
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<td>680-3</td>
<td>507-10</td>
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<td>521-2</td>
<td>185-6</td>
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<td>1042-5</td>
<td>836-7</td>
<td>1051-4</td>
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<td><strong>Doing to</strong></td>
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Appendix D

Ethical approval

Chair's Action

Proposal Ref: 1083-PSY-15
Name of Student/Trainee: SAMANTHA DEWHURST
Title of Project: How do clients who meet the criteria for Borderline Personality Disorder experience the therapeutic relationship? An Interpretative Phenomenological Analysis.
Supervisor: Dr Ben Rumble
Date of submission: 20th January 2015
Date of confirmation:

The above Research Project has been submitted to the FAHS Ethics Committee and has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee with minor conditions. Confirmation has been received that the conditions stipulated after ethical review have now been addressed and compliance with these conditions has been documented.

The final list of documents reviewed by the Committee is as follows:

Protocol Cover sheet
Summary of the project
Detailed protocol for the project
Participant Information sheet
Consent Form

This documentation should be retained by the student/trainee in case this project is audited by the Faculty Ethics Committee.

Signed and Dated: Professor Bertram Opitz
Chair

Please note:
If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.
Information sheet

How do clients who meet the criteria for Borderline Personality Disorder experience the therapeutic relationship?

Thank you for agreeing to receive this information and considering taking part in this study. My name is Samantha Dewhurst and I am conducting this research as a trainee counselling psychologist as part of the Doctorate in Counselling Psychology at the University of Surrey. This is your information sheet to keep and I hope it will provide enough information for you to decide if you would like to take part.

What is the study about?

This study hopes to learn more about how you found your relationships with your personal therapist. I am interested in your experience of this therapeutic relationship. Through hearing your views and feedback, psychologists and other professionals can better understand and develop supportive services.

You are eligible to take part in the study if:

You have been diagnosed with Borderline Personality Disorder or emotionally unstable personality disorder, or you self-identify with the condition and feel you meet the criteria.

You have had a therapeutic relationship with a psychotherapist, counsellor or psychologist in the past five years but are not currently in therapy.

You would be willing to spare up to two hours of your time to tell me about your experiences at any time before the end of May 2015.

Do I have to take part?

No. It is completely up to you to decide whether or not you would like to take part. If you do decide to join the study, you can withdraw at any point. The information you provide in your interview will not be used in the analysis if you withdraw your involvement within two weeks of meeting with me.

What will I be asked to do if I take part?

The meeting will last approximately 60 minutes, depending upon how much you would like to say. I will audio record our meeting with a digital voice recorder. You do not need to bring anything along to our meeting or prepare beforehand. However, if you would like to bring anything with you such as a diary, drawing or notes you kept at the time or have written since you are very welcome to do so.
Will my data be anonymous?

The information you provide will be anonymised to all apart from me and my research supervisor. The data collected for this study will be stored securely and only the investigator and research supervisor, Ben Rumble will have access to this data.

Audio recordings will be deleted after they have been electronically transcribed, anonymised and checked.

The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.

The transcriptions will be anonymised by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study. However, your name will not be attached to them.

There are some limits to confidentiality: if what is said in the meeting makes me think that you, or someone else, may be at significant risk of harm I will have to speak to a colleague about this. Wherever possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported for the purpose of a research report as part of my doctoral studies. A shorter version may be submitted for publication in an academic or professional journal. You will also be given a copy of the report when it is completed.

Are there any risks?

It is not anticipated that joining the study to discuss your experiences would cause significant emotional distress. However, if you feel as though you would like to discuss how you are feeling you can contact your GP or an independent source of support through the contacts such as those at the end of this information.

Although it is unlikely that you would require emergency emotional support, we would recommend you have an emergency contact person and telephone number with you before our discussion as a precaution.

Are there any benefits to taking part?

Although I hope you may find participating interesting, there are no direct benefits in taking part. However, by sharing your thoughts and experiences you are helping our understanding as professionals in this field, which may in time, further the development of services.

Who has reviewed the project?

This study has been reviewed by the University of Surrey Faculty of Arts and Human Sciences Ethics Committee and granted favourable ethical approval.
Where can I obtain further information about the study if I need it?

If you have any questions about the study, please speak to myself, the principal investigator, Samantha Dewhurst at s.dewhurst@surrey.ac.uk.

Expenses

Although I will travel to meet you at a convenient place, you may also incur some travel expenses. The maximum amount you would be able to claim for attending your interview in total is £10.00, even if your travel expenses are more than this amount. If you are travelling by car, please provide the calculations of the mileage travelled on the basis of 25p/mile. If you are travelling by public transport, please provide your receipts in order to claim your expenses. If you can book your transport before the interview and provide an exact cost and payment confirmation, I will be able to bring your expenses and a receipt for you to sign to your interview.

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact the department Head of Research:

Dr. Dora Brown  
School of Psychology  
Faculty of Arts and Human Sciences  
University of Surrey  
Guildford GU2 7XH  
Email: dora.brown@surrey.ac.uk  
Phone: Work: 01483 68 3979

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

Your therapist or GP

The Samaritans - www.samaritans.org or tel. 08457 909090

Family Lives confidential helpline and substantial website - http://familylives.org.uk/how-we-can-help or tel. 0808 800 2222 or skype also on 0808 800 2222

Thank you for taking the time to read this information sheet.
Appendix F

Consent Form

How do clients who meet the criteria for Borderline Personality Disorder experience the therapeutic relationship?

I the undersigned voluntarily agree to take part in the study on ………………..

I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any risk to my well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I agree to engage to the best of my ability with the researcher in the informal interview process. I shall inform them immediately if I suffer any deterioration of any kind in my health or well-being, or experience any unexpected or unusual symptoms.

I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation.

Name of volunteer (BLOCK CAPITALS) ........................................................
Signed ........................................................................................................
Date ..............................................................................................................

Name of researcher (BLOCK CAPITALS) ..................................................
Signed ........................................................................................................
Date ..............................................................................................................
Appendix G

Interview Schedule

**BPD diagnosis**
How did the diagnosis come about?
Can you tell me a bit about what your life was like before?
What was going on for you at the time?
What does BPD mean to you?

**Therapy**
How did you come to be having therapy?
Was it as a result of diagnosis?
Did anything change because of diagnosis?
What was the therapy like?

**Therapist**
Could you describe your relationship with your therapist?
Could you go into more detail?
Did the relationship change?
What did your relationship with your therapist mean to you?
How did the relationship compare to other relationships in your life?
Appendix H

Submitting articles to CPR

Introduction

Counselling Psychology Review is the Division of Counselling Psychology’s quarterly peer reviewed research publication. It brings together high quality research pertinent to the work of Counselling Psychologists. It primarily focuses upon work being undertaken in the UK but it is also likely to be of interest to international colleagues and those in related therapeutic disciplines. The content is pluralist in nature, with its focus being on excellent work rather than methodological or paradigmatic preference, and submissions are invited in the following areas:

• papers reporting original empirical investigations (qualitative, quantitative or mixed methods);
• case studies, provided these are presented within a research frame;
• theoretical papers, provided that these provide original insights that are rigorously based in the empirical and/or theoretical literature;
• systematic review articles;
• methodological papers.

Notes for Contributors

1. Length:

Papers should normally be no more than 5000 words (including abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

2. Manuscript requirements:

• The front page (which will be removed prior to anonymous review) should give the author(s)’s name, current professional/ training affiliation and contact details. One author should be identified as the author responsible for correspondence. A statement should be included to state that the paper has not been published elsewhere and is not under consideration elsewhere. Contact details will be published if the paper is accepted.
• Apart from the front page, the document should be free of information identifying the author(s).
• Authors should follow the Society’s guidelines for the use of non-sexist language and all references must be presented in the Society’s style, which is similar to APA style (the Style Guide, available from the Society, or downloadable from http://www.bps.org.uk/publications/submission-guidelines/).
• For articles containing original research, a structured abstract of up to 250 words should be included with the headings: Background/Aims/Objectives, Methodology/Methods, Results/Findings, Discussion/Conclusions. Review articles should use these headings: Purpose, Methods, Results/Findings, Discussion/Conclusions.
• Approximately five key words should be provided for each paper.
• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
• Graphs, diagrams, etc., must have titles.
• Submissions should be sent as e-mail attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add ‘CPR Submission’ in the e-mail subject bar. Please expect an e-mail acknowledgment of your submission.
• Proofs of accepted papers will be sent to authors as e-mail attachments for minor corrections only. These will need to be returned promptly.
“Setting out on an expedition together as a fellow adventurer”: A Foucauldian discourse analysis of the construction of the therapeutic relationship with clients who meet the diagnostic criteria for borderline personality disorder

Abstract
Dominant discourses on borderline personality disorder (BPD) construct the notion of a client who is difficult, un-likeable, manipulative, attention-seeking; even dangerous. Their pejorative nature has been a major factor in the pessimism about treatment effectiveness with this client group. This has begun to shift, however, partly with the development of specific treatment programs, such as dialectical behaviour therapy (DBT) which emphasise clients’ subjective distress. The present research focused on the therapeutic relationship as an important factor in this perceptual shift. In DBT, specific therapist-oriented strategies for tackling pejorative perceptions of BPD are generated to facilitate the formation of a strong therapeutic alliance. This research study investigated the potential role of the therapeutic relationship in DBT in the development of counter-discourses which may disrupt the dominant pejorative discourses on BPD. A Foucauldian discourse analysis (FDA) was carried out in order to investigate how the therapeutic relationship with clients who meet the criteria for BPD was constructed, the discourses drawn upon, and the discursive strategies employed in the talk of DBT therapists. Interviews were conducted with DBT therapists and an analysis of their transcripts carried out according to FDA guidelines. Three distinct discursive constructions were identified; ‘working with a diagnosis’, ‘collaborative and equal’, and ‘interpersonal and supportive’, located within wider, biomedical, collegial, and intimacy discourses, respectively. Certain subject positions were made available to therapists; ‘expert’, ‘collaborator’ and ‘confidant’, which afforded particular actions; ‘being distant from the client’, ‘journeying together with the client’ and ‘being able to be affected by the client’. The therapeutic relationship was not constructed as a negative one, and therefore not located in pejorative discourses about BPD. It was postulated the therapeutic relationship could therefore be viewed as a site of resistance to the discourses which ‘other’ and pathologize the client who meets the criteria for BPD.

Key words: Borderline Personality Disorder; BPD; therapeutic relationship; Foucauldian Discourse Analysis; FDA; Dialectical behaviour therapy; DBT
Introduction
Dominant discourses on borderline personality disorder (BPD), arguably construct the notion of a client who is difficult, un-likeable, manipulative, attention-seeking, adolescent, and sometimes even dangerous (Becker, 2000; Jimenez, 1997; Linehan, 1993; 2015b; Ussher, 2013; Wirth-Cauchon, 2001). Their pejorative nature has been a major factor in the pessimism and hopelessness about treatment effectiveness with this client group, who were deemed ‘untreatable’ by the mental health profession (Becker, 2000; Linehan, Cochran, Mar, Levensky, & Comtois, 2000; Sulzer, 2015a). This has begun to shift, however, partly with the development of specific treatment programs, with robust evidence bases which emphasise the subjective distress of those diagnosed, such as dialectical behavioural therapy (DBT) (Pickersgill, 2013). The therapeutic relationship has been defined in BPD research as a common factor in therapy which predicts good clinical outcomes (Bedics, Atkins, Harned, & Linehan, 2015; Clarkin, 2012; Goldman & Gregory, 2010; Livesley, 2012). Aspects of the relationship such as therapist empathy, providing a containing presence and managing countertransference are rendered difficult to achieve in the context of prevailing negative discourses on BPD. However, DBT attempts to tackle pejorative perceptions of BPD with specific therapist-oriented strategies generated to facilitate the formation of a strong therapeutic alliance (Linehan, 1993; Rizvi, 2011; Robins & Koons, 2000; Swales & Heard, 2007).

The present research investigated the potential role of the therapeutic relationship in DBT in the development of counter-discourses which may disrupt the dominant pejorative discourses on BPD, by adopting a Foucauldian discourse analysis (FDA) approach, based on the work of post-structuralist, Michel Foucault. From this perspective, discourses are “practices which form the objects of which they speak.” (Foucault, 1972, p. 49). A discourse refers to a set of meanings around a particular phenomenon, such as the therapeutic relationship, which represents it in certain ways; various, competing discourses construct this object by bringing different aspects to the fore, with different implications for what can be said and done (Burr, 2003). In the Foucauldian sense, a counter-discourse is a discourse against power, or taken-for-granted ways of perceiving social phenomena. BPD, by this formulation can be understood in part, as a product of psychiatric discourses which have created the object, with diagnostic criteria, which became the dominant way people who experience certain kinds of distress were understood. Other discourses were rendered less powerful and the dominant discourse took on a ‘truth’ status (Foucault, 1980).
Definition of BPD

BPD is a diagnosis given to individuals who experience a range of affect and interpersonal difficulties which they find debilitating (Krawitz & Jackson, 2008). According to the fifth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5), BPD involves a prevalent pattern of unstable relationships and self-image as well as increased impulsivity, with onset usually in early adulthood (American Psychiatric Association, 2013). A diagnosis can be made if the client presents with at least five of the nine criteria for BPD which include: fear of abandonment; black and white thinking, particularly in relation to others, i.e. idealisation and devaluation of others; identity disturbance; impulsiveness such as binge eating or substance abuse; suicidal, para-suicidal and self-harm behaviours; affective instability, or extreme mood swings; chronic feelings of emptiness and paranoid ideation and/or dissociation (American Psychiatric Association, 2013). It is thought to effect between 2 and 6% of the population and around 70% with a diagnosis of BPD are women (Grant et al., 2008). There is also a high instance of co-morbidity with other mental health problems such as depression and anxiety. However, diagnosis is not simple, as Bender (2011) points out; there are 256 ways to meet the criteria for BPD because the categories are broad and open to interpretation.

BPD is a highly contentious diagnosis with confusion and disagreement about its validity and reliability as a distinct disorder, stimulating debate regarding its usefulness within psychology psychoanalysis and psychiatry (NICE, 2009). It has been described as a ‘wastebasket’ diagnosis with no conceptual clarity between the conflicting ideas derived from disparate psychological, psychoanalytic, biological and genetic theories (Aronson, 1985). These debates refer to the legitimacy of the diagnosis as a concept from within a biomedical discourse, however, others have sought to challenge these ontological assumptions and provide a socio-historical perspective to understand BPD as a product of particular views on personhood, gender, and mental illness specific to the post-enlightenment era. Furthermore, they are able to shed some light on why this diagnosis has such negative connotations. (Allen, 2004; L. S. Brown, 1992; Wirth-Cauchon, 2001).

Deconstructing BPD

BPD is perceived as a character pathology, compared with a non-blaming diagnosis such as PTSD: ‘bad girl’ vs ‘good girl’ (Becker, 2000). Brown and Crawford (2007) propose
that the notion of the BPD client as ‘untreatable’ can be traced to concepts of ‘moral insanity’ in the 19th century. Moral insanity was used to describe individuals who were not delusional, but behaved in an anti-social manner and seemed to be in control of their behaviour. This resonates with modern perceptions of BPD where suicidal behaviour is viewed as deliberate attempts to manipulative others and beliefs that clients with a diagnosis are unlikely to comply with recommendations for treatment (B. J. Brown & Crawford, 2007).

Some feminist writers have also suggested BPD is also a product of the notion of a feminine selfhood as fluid, interpersonal and emotional; the antithesis of the unitary, rational and independent individual (Wirth-Cauchon, 2001). She compares BPD to ‘hysteria’ – the 19th century ‘woman’s malady’ – which is now understood as a diagnosis based on assumptions about women’s social roles and psychological disposition at that time. The ‘fragmented self’ in BPD expresses the conflicting representations of contemporary womanhood. The oscillation between these ways of being can be conceptualized as the individual taking up different subject positions within the opposing discursive fields and not necessarily indicative of an underlying pathology (Wirth-Cauchon, 2001). Subject positions provide the individual with ‘subjective experience’ as they take up or reject the various options available to them within the various discursive practices they engage in (Davies & Harré, 1990; Edley, 2001). In her discourse analysis of the DSM-IV diagnostic criteria for BPD, Allen (2004) reveals the assumptions made about selfhood, gender roles, and adulthood which value the notion of a, “stable, highly autonomous individual oriented towards self-control and persistent goal-directed behaviour.” (Allen, 2004, p. 132). These manifestations of distress as instability – of self-concept, in interpersonal relationships and in mood – have contributed to the labelling of individuals with BPD as ‘difficult women’ (Ussher, 2013). Women’s anger is further pathologized and women dubbed ‘dangerous’ (Jimenez, 1997).

The ‘symptomology’ of BPD can be thought of as intelligible responses to gender construction as well as childhood trauma resulting from neglect and abuse (Sabo, 1997; Wirth-Cauchon, 2001). In particular the high rates of childhood sexual abuse which have prompted some to suggest that BPD can be understood as a, “normative, if not frankly normal response to abnormal events.” (L. S. Brown, 1992, p. 213). By this account, BPD is viewed not as an illness which was ‘discovered’, but as a way of problematizing the emotional, inter-relational and fluid experiences of the ‘feminine’ self, and treating it as an
illness is stigmatizing women for their supposed inherent ‘femininity’, in the same way ‘hysteria’ did in the 19th century (Ussher, 2013). This also has implications for how men who are diagnosed with BPD are viewed and treated (Wirth-Cauchon, 2001).

Attributions of blame and control are central to the negative, often judgemental discourse on BPD. Nehls (1999) study found clients experienced the BPD diagnosis as more of a pejorative label than a diagnosis and felt blamed for it. Similarly, staff experienced less sympathy for, felt more negative about, and attributed more control over negative events to those with a diagnosis of BPD, compared with those with a diagnosis of either schizophrenia or depression in Markham and Trower’s (2003) study.

The effects of stigma on therapists working with BPD clients may negatively impact on the therapy. People tend to distance themselves from stigmatised populations and therapists may emotionally distance themselves from their clients which may set off a cycle of therapist and client reactivity, contributing to high attrition rates and poor therapy outcomes (Aviram, Brodsky, & Stanley, 2006). However, this is an under-researched area and little is known about the effects of stigma as an independent factor in therapy. The effect of stigma regarding BPD on the therapeutic relationship seems a natural place to start as it involves exploring therapists’ understanding of their clients and their consequent manner of relating to them. More can then be understood about how that might impact on the processes and outcomes of therapy.

**BPD and the therapeutic relationship**

The difficulties with interpersonal relationships, experienced by individuals with BPD, are usually replicated in some way in the context of therapy, inhibiting the formation of close collaborative alliances and creating impaired personal boundaries between therapist and client (Bateman, 2012; Livesley, 2012). Therefore establishing a therapeutic relationship is believed to be problematic and aspects of the relationship such as therapist empathy, providing a containing presence and managing countertransference are difficult to achieve (Clarkin, 2012; Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). This is due in part to the prevailing negative discourses on BPD, such as, viewing the client as hostile (Linehan, 1993). However, DBT explicitly attempts to address such pejorative perceptions of BPD with therapist-oriented strategies that facilitate the formation of a strong therapeutic alliance (Linehan, 1993; Rizvi, 2011; Robins & Koons, 2000; Swales & Heard, 2007).
**DBT and the therapeutic relationship**

Marsha Linehan (1993) originally developed DBT as an alternative to cognitive behavioural therapy (CBT) for working with parasuicidal clients with BPD. She introduced the concept of dialectics, particularly that of acceptance, from Zen Buddhism, and change, to the change-oriented CBT methods. DBT is a behavioural therapy based on a biosocial theory that places particular emphasis on the aetiology of BPD resulting from the interaction of a genetic pre-disposition of emotional sensitivity with an invalidating environment. Mindfulness is a core component to help clients become more aware of emotional states, as well as distress tolerance, emotion regulation, interpersonal effectiveness and self-management being actively taught. The year-long program consists of a weekly skills acquisition group and weekly individual therapy with phone coaching with the therapist at pre-determined times. The therapists take part in a weekly group consultation meeting where they aim to be non-judgemental, provide support and offer strategies to each other (Linehan, 1993).

Although the therapeutic relationship is an integral part of DBT, it is not seen as a mechanism of change in therapy, rather it is viewed as a crucial vehicle for facilitating client improvement. These include techniques for relating to clients to facilitate a strong alliance with a particular focus on therapy interfering behaviours which often present as relational difficulties between therapist and client (Linehan, 1993). The relationship is guided by particular assumptions about the client group which also operate to counter negative perceptions and minimise the impact of difficult client behaviour. Clients are seen to be doing the best they can, wanting to improve and not able to fail in therapy (Linehan, 1993). These assumptions form the basis of a therapist stance which encourages acceptance of clients’ self-damaging behaviour as an understandable response to their distress and make it possible to find something to validate in that behaviour, by viewing the client with compassion (McMain & Wiebe, 2013; Rizvi, 2011).

**Previous research**

In order to test these theoretical assumption, previous research on DBT and the therapeutic relationship has focused on therapist perceptions of the clients and the effect on clients. The first study measured the effect of reducing therapist stress by shifting perceptions of the client from hostile to friendly. Therapist ratings that were consistent with non-pejorative...
conceptualization were associated with better therapy outcomes (Shearin & Linehan, 1992). Further studies have supported these findings (Bedics et al., 2015). Another theory-driven study, tested four hypotheses of the therapeutic relationship and patient introject in DBT. The authors surmised from their findings that therapists, balancing autonomy and control, maintaining a nonpejorative stance toward the patient, and the use of warmth and autonomy was a contingency for “improved intrapsychic outcome” (Bedics, Atkins, Comtois, & Linehan, 2012, pp. 237-238). However, in her longitudinal investigation into the therapeutic relationship in DBT, Little (2011) found that patterns of therapeutic alliance across time did not predict therapy outcome and suggested that more qualitative research was required to better understand the quality of the relationship.

There are relatively few qualitative studies which directly investigate these aspects of the relationship in DBT. However, there are a number of studies which make reference to the therapeutic relationship in their findings. For example, Hodgetts et al., (2007), explored clients’ experiences of DBT and found that the therapeutic relationship was, “consistently identified within participant’s accounts as being important” (Hodgetts et al., 2007, p. 176). In her doctoral thesis on the client’s experience of ‘recovery’ from BPD in DBT, Tsakopoulou (2009) identified ‘resilient therapeutic relationship’ as an important theme, which one participant highlighted in this way: “I like the way people don’t give up on you and they persist and push you” (Tsakopoulou, 2009, p. 73). In her study of the efficacy of individual treatment components of DBT, Araminta (2000) found that clients who reported to have most benefited from the program, placed high importance on the therapeutic relationship, particularly the non-judgemental and validating qualities of their therapist.

Only one study was identified which directly focused on the therapeutic relationship. It explored the aspect of negative affect in the relationship in DBT in case studies of two clients with different therapy outcomes, which they attributed to therapist response to the clients’ initial hostility and attacks (Burckell & McMain, 2011). These qualitative studies on therapy with clients with a diagnosis of BPD identified aspects of the therapeutic relationship within their themes. Other studies highlighted DBT’s perceived ability to change therapists’ attitudes and improve the therapeutic relationship. For example, Rossiter’s study on DBT therapists’ clinical experience found reduced pessimism and a “heightened sense of moral responsibility that further strengthened the capacity for therapeutic intimacy.” (Rossiter, 2008, p. 140). She suggests these findings can in part be
explained by DBT’s incorporation of explicit principles and techniques to facilitate therapists in transforming pejorative perceptions of their clients (Linehan, 1993; Rizvi, 2011; Robins & Koons, 2000; Swales & Heard, 2007). Of particular relevance to the present study, a New Zealand-based study of DBT theory and practice utilized a discourse analysis which enabled the researcher to give prominence to the power of language to encourage change and to resist dominant discourses such as those of stigma and illness (M. Simons, 2010).

The present research
The present study explores this further by focusing explicitly on the therapeutic relationship in DBT and its potential role in the development of counter-discourses which may have the potential to disrupt the dominant pejorative discourses on BPD. It attempts to answer the question of whether such pejorative discourses are challenged by the discursive process of constructing the therapeutic relationship. By adopting a social constructionist approach, this research viewed language as constitutive of our understanding of the world, as opposed to just descriptive, or reflective of an inner reality. In this approach, the therapeutic relationship is ‘brought into being’ through discursive practices. This highlights the situated-ness of knowledge about the therapeutic relationship and BPD, historically and culturally (Burr, 2003). It also has implications for ways of being as a DBT therapist; what options they have to construct the meaning of the therapeutic relationship within a particular time and place (Madill, 2005). Safran and Muran (2006) attribute the popularity of ‘therapy relationship’ in recent research to a paradigm shift across different modalities to focus on the relational aspects of therapy which suggests that the discourses and discursive practices that the psychotherapeutic profession and community produce and adopt make possible for therapists different ways of being with clients that shift and change.

Aims
The aims of this study were to gain an understanding of the ways in which the therapeutic relationship was constructed in the talk of DBT therapists, how particular ‘ways-of-seeing’ the world and ‘ways-of-being’ in the world were afforded in order to investigate the potential role of the therapeutic relationship in the production of non-pejorative counter-discourses on BPD.
In addition, it aimed to be useful in terms of providing information to enable therapists to increase their understanding of the therapeutic relationship in order to provide effective therapy, particularly with clients who meet the criteria of BPD. The therapeutic relationship is the cornerstone of counselling psychology practice, but it is important to be prepared to step outside the prevailing discourses to ask questions about how we have come to think about it in the way we have. A social constructionist approach is relevant to counselling psychology practice as it entails engaging in critique and not taking things for granted as part of a pluralistic ethos. Clinical practice arising out of epistemological and ontological understandings of theoretical positions and modes of clinical practice enabling counselling psychologists to apply to clinical practice interventions and techniques which are applicable for a particular client for a particular reason at a particular time (Draghi-Lorenz, 2010).

**Method**

A Foucauldian discourse analysis (FDA) was employed for this study because it facilitated the investigation of the potential role of the therapeutic relationship in the production of non-pejorative counter-discourses about BPD, by analysing DBT therapists’ talk. The therapists’ descriptions of their experiences were not viewed as a window into their thoughts and feelings, rather their ‘experiences’ were understood as constructed and sustained by discursive practices which offered subject positions which were taken up or rejected (Harper, 2011). Therefore the aim was not to discover the ‘truth’ of the therapeutic relationship with clients who met the criteria for BPD, but to provide a ‘version’ which would be unavoidably partial as it could be interpreted in manifold ways (Taylor, 2001). Willig’s (2008) six-stage guidelines were utilized to conduct the analysis.

**Participants**

Three participants were recruited, using a purposive homogenous sampling method. That is, as DBT therapists, they were deemed to be knowledgeable about the therapeutic relationship in DBT and to have experience of it. The participants were two female, and one male white Europeans, aged between 35 and 45. They were practicing individual DBT therapists who worked within the context of DBT specialist services; two were provided by the NHS and one operated privately.
Only a small number were required because in this type of discourse analysis study they are viewed as 'specimens of their kind'; that is, their interviews will not be testimonies or reflections of an outer (or inner) reality, but an 'instance' of a class, in this case, DBT therapists talking about the therapeutic relationship with clients who meet the criteria for BPD (ten Have, 2007). They were recruited based on being 'typical' of their group rather than representing the group as a whole. The small sample can be justified on the basis that the patterns revealed in the data will be indicative of the shared knowledge and skills within their 'culture', and therefore representative of other members of that culture (Taylor, 2001).

The participants were recruited via a number of methods. The first participant was recruited in person as a visiting lecturer on DBT on my course. The second participant was recruited via a ‘snowballing’ method by the first participant. The third was recruited from a twitter advertisement; one of many posted on a range of social media sites: DBT twitter feeds; counselling psychology UK Facebook group; London counselling psychology blog; DBT groups on Facebook. Other approaches which were not fruitful involved contacting private DBT services and training providers.

**Procedure**

Semi-structured interviews were conducted with each participant separately over Skype. There is some debate about whether Skype is an appropriate medium for conducting research interviews (Lo Iacono, Symonds, & Brown, 2016). Skype was chosen for this study as an interview medium as it was preferred by the participants and I had used it before and felt comfortable with it. Each interview was approximately one hour in length and was audio recorded. In an attempt to be non-directive, and for the interview to be as open as possible, an interview agenda of non-leading questions was used as a guide to be used flexibly to allow the participant to lead the conversation and share their experience.

The interviews were transcribed verbatim to a line numbered transcript with only the words spoken, obvious pauses and non-verbal utterances such as laughter. This was sufficient information, as FDA does not involve a micro analysis of the text in the way other discourse analysis methods do. After transcribing the interviews a process of reading and re-reading them as ‘texts’ to begin to get an idea of ways in which the therapeutic relationship was constructed. The process involved the analysing each transcript individually, before
looking for similarities across the transcripts in terms of how the relationship was discursively constructed. The steps were as follows:

1. **Discursive constructions**
   Identifying the different ways the discursive object – the therapeutic relationship with clients who meet the criteria for BPD – was constructed within the texts. This involved highlighting all the references to the object, even when it was not explicitly named, and focusing on how they are referred to in the text and how they construct the object in multiple ways.

2. **Discourses**
   Locating the different discursive constructions within wider societal discourses. By discerning the various ways the therapeutic relationship was constructed it became apparent that different discourses were being utilized to enable this process but also limit what could be said and done.

3. **Action orientation**
   Examining the 'action orientation' of the object within the text; asking what the function or intention is (which the speaker may not be aware of), such as, what might be gained from constructing the object in a particular way at that particular place in the text. This also refers to the interaction with the interviewer asking specific questions, and the extent to which a particular discourse fulfils a purpose such as promoting one version of events over another.

4. **Positionings**
   Intrinsically linked to the action orientation of the talk are the 'subject positions' the discourses offer. Subject positioning involves power relations by determining whether a person is permitted to speak, what can be said and whether those accounts are listened to. This allowed me to examine the ways in which the DBT therapist was positioned in relation to the wider discourses about the therapeutic relationship and BPD and in relation to the client.
5. Practice
Examining the possibilities for action facilitated by the particular construction of the object; the ways they limit what can be said and done. This involved asking what practices are constructed as legitimate ways of being or experiences for the DBT therapist.

6. Subjectivity
Lastly, considering the consequences for subjective experience of taking up these particular subject positions. This was an inherently speculative exercise and inferences could not be made regarding what therapists felt or thought about. However, it was possible to outline what was permitted to be thought about and felt about. (Willig, 2008).

Once all the interviews were analysed, commonalities were sought across the data set. After a process of deciding which discursive constructions could be subsumed within others and which were particular to the individual interview, a set of three distinct discursive constructs were decided on which seemed to best represent the data as a whole.

Ethical considerations
The present research project received favourable ethical opinion from University of Surrey Faculty of Health and Medical Sciences Ethics Committee, Ref: FT-PSY-170-15 [Please see letter of approval: appendix E].

The participants for this study were not considered to be a vulnerable group. However, talking about potentially upsetting and difficult issues during the interview may have caused some distress for participants. I prioritized the welfare and wellbeing of the research participants at all times. After the interview participants were debriefed to ascertain whether they need further information or support. Informed consent was obtained from participants just prior to the interview after they had read the information sheet provided approximately two weeks before and was followed up after the interview during debrief and just before the two week deadline for withdrawal from the study. (Information sheet appendix B, consent form appendix C).
As a trainee counselling psychologist, I abided by the principles set out in the ethical policies of the professional bodies, the British Psychological Society (2014) and the Health and Care Professions Council (2016). Yardley’s (2000) criteria for ensuring quality in the present study was adopted because incorporated these principles and offered guidelines for establishing the credibility and validity of the research in a rigorous manner which in itself is an ethical concern (Madill & Gough, 2016).

‘Sensitivity to context’. This ensured I was familiar with the existing literature both on the topic and the method of research. The chosen method of analysis showed sensitivity to the data, in that it was an in-depth analysis of in-depth interviews of the participants’ personal experience. I showed sensitivity to the participants by the nature of my enquiry – wanting to learn from them – and also the manner in which the research was carried out, including the aim to maintain anonymity for the participants and the clients they were talking about. However, due to the nature of the analysis, the question of deception could be raised – not that it would be considered overt – but the way in which the interviews were treated as ‘texts’ to be analysed discursively was not discussed at length with the participants. Therefore, their understanding of how the data would be analysed may not have been totally clear to them, such as how the meanings for the participants in what they were trying to understand themselves and convey would be understood as discursive constructs and not reflections of their inner states. Furthermore, as FDA is interpretative and the view of participants is that they are shaped by discourses they are not aware of, it would have been difficult to ask for participant validation of ‘their’ story (Harper, 2003; Josselson, 2011).

‘Commitment, rigour, transparency and coherence’ refers to the thoroughness of the research concerning the process of data collection and analysis. The research was rigorous and showed transparency in discussions of the rationale for the study, the method adopted and the detailed, in-depth analysis of the data. Although this discourse analysis was an interpretative exercise, I was not free to make any interpretations I wished. This analysis takes into account my training as a counselling psychologist, my knowledge of the existing work on the research topic and my ‘personal’ (albeit socially constructed) views and assumptions. Being transparent about these ‘biases’ renders this research responsible, and open to evaluation. In order to assess the validity of the research process, a 'mini-audit' was conducted by the research supervisor. The purpose of this audit was to check the information produced was credible, not whether it represented 'the truth' (Harper, 2003).
My research supervisor checked the annotations on two example transcripts for validity in relation to the text and offered insights on the process of carrying out the six steps of analysis. The main concern was that the data was produced with transparency and rigor and a discernible 'paper trail' was evident.

‘Impact and importance’. The current study aimed to have importance in terms of providing information to enable therapists to increase awareness of the role of the therapeutic relationship with BPD clients. This is of particular relevance to Counselling Psychology, which places relationship at the centre of the therapeutic work. More specifically it can bring awareness to the use of language in generating different ways of relating to clients, in particular the use of pejorative language which may shape the way BPD clients are viewed and related to, and how the therapeutic relationship may be constructed by discourses which counter these pejorative discourses. This adds to the large evidence base on the therapeutic value of the relationship between client and therapist.

In terms of data protection, I abided by the regulations concerning data protection stipulated by the Information Compliance Unit at the University of Surrey. They summarised as follows: data will be kept locked in my home for three years and stored electronically for ten years at the University of Surrey before being destroyed.

**Analysis**

In the interview transcripts, the discursive object, ‘the therapeutic relationship with clients who meet the criteria for BPD’ was constructed in at least three distinct ways: ‘working with a diagnosis’; ‘collaborative and equal’; and ‘interpersonal and supportive’. The following section outlines the three main discursive constructions, locates them within wider discourses and discusses the implications for action orientation; subject positions; practice; subjectivity and power relations. The findings are presented in this form with examples of the text to “illustrate and support the analysis” (Burr, 2003, p. 174). An example of action orientation is presented separately as a larger excerpt was required to demonstrate the interactional and functional aspects of the talk.
Working with a diagnosis

The therapeutic relationship involved working with a group of clients defined by having a diagnosis of BPD. It also involved working with the concept of diagnosis. The diagnosis of a ‘mental disorder’ is the basis of the biomedical model and one which constitutes a dominant discourse within the field of mental health. Notions of ‘treating illness’ and pathology are associated with this discourse. Pathology in this context can also refer to behaviours which are deemed extreme or ‘abnormal’ by societal values (Vanheule & Devisch, 2014). The use of this discourse rendered clients as fundamentally different from therapists. It refers to a client not primarily as a person in distress, but as a collection of symptoms which need fixing. This had implications for the therapeutic relationship. The use of a biomedical discourse in the texts was not straightforward; the participants uttered seemingly contradictory statements such as this:

Natalia (lines 22-29):

N: […] Er, I don’t want to use the word ‘disorder’, because I don’t really [chuckles], you know, believe that much in diagnosis. But, erm…
S: Can you say a bit more about that, why you don’t want to use ‘disorder’?
N: Well, I mean do believe in, in diagnosis, but it’s, erm, in a way, you know, it’s all [sighs], sometimes, erm, you know, it can be helpful, er, mostly for… communication purposes and just to give you, like a general sense of, er… what, like the, the client’s issues are. Er… but sometimes, you know, if, erm… it can be misleading as well.

The subject position offered by this construction is one of constant tension; of having to constantly negotiate the pros and cons of the relevance of diagnosis with regards to the relationship with the client. This involves positioning the client in relation to the therapist – as having a ‘disorder’ or not – and it seems to imply there might be potential problems if the diagnosis is not seen as ‘helpful’. The possibilities for practice are that the therapist can be an ‘expert’ and hold (and share) knowledge about the client pertaining to the diagnosis, but also risks ‘getting it wrong’ when the diagnosis is ‘misleading’. The subjective experience that may be available, by an ambivalence towards the value of diagnosis could be ‘felt’ in different ways: as anxiety, due to the lack of certainty; as freedom from the constraints of diagnosis; or perhaps as security in the knowledge it can be referred to when
needed. As made apparent by this first analysis, ‘identifying’ the ‘subjective reality’ of participants is inherently speculative.

The ‘working with a diagnosis’ discursive construction was referred to in talk about clients’ having a diagnosis.

Jacquie (lines 11-12):

 [...] clients [...] who had a diagnosis of borderline personality disorder.

Whilst it positions the therapist as ‘expert’, this particular reference to working with ‘clients with a diagnosis of BPD’, as opposed to say, ‘having BPD’ or ‘being borderline’, enables the therapist to view their client as a fellow human being with a set of symptoms, which may mean that subjectively they are able to feel empathic, although perhaps also feel at a distance because the client is different – ‘other’ – even if not fundamentally so.

The discursive construction ‘working with a diagnosis’ was also referred to as a tool therapists use with their clients to help explain their experiences. This is what one of the participants described saying to his clients:

Marko (lines 23-24):

 [...] this is a tool that we use to understand you a little bit more, it’s not an ultimate statement on who you are as a person.

There is an immediate qualification in this statement about the usefulness of the tool. The diagnosis is something the clients ‘have’, what they come to the therapy with and therapists seem to need to address this in some way, but by speaking of it as not having major implications for the clients; it doesn’t have to define them. The subject position made available is that of ‘expert’, and therefore in a more powerful position, but one who doesn’t know everything about the client, only that defined by the criteria of diagnosis. This means there is more scope to see the client as an individual whilst holding (and sharing) knowledge about ‘BPD’.
Further constructing the therapeutic relationship as ‘working with a diagnosis’ are the references to it as working with ‘particular groups’, i.e., those with a diagnosis of BPD, such as in the following statement:

Jacquie (lines 21-22):

I probably like all people, if I’m honest [chuckles]. I like people. Erm, but they’re still a particular group

This contradictory statement constructs clients part of ‘all people’, however, they are a separate ‘group’, which seems to construct them as one of ‘them’, where they have more in common with each other than those outside the group. The therapist, therefore, would be positioned as outside this group, and whilst being able to show and feel regard within the relationship, the experience made available by this may be that however much they ‘like’ their client, they are not like them. However, by constructing the group as likeable, thereby subverting one of the prevalent discourses regarding BPD, that of the difficult, potentially un-likeable patient, the participant is positioned by an interpersonal discursive construction rather than the group as defined by diagnosis and difference (Lewis & Appleby, 1988). This seems to be a strategy, as far as agency is possible within this framework, for participants to talk about the group in positive ways to counter the negative discourses around BPD. That is, accepting the group construction and being positioned by a ‘both/and’ construction; and as such, diagnosis does not need to be pathologizing.

Within the group, those with a diagnosis of BDP, are clients who are described as unique:

Marko (lines 11-12):

One thing they have all in common is the diagnosis […] but under all that they are still unique people and present in different ways.

This constructs a version of the group as inherently contradictory. Therefore another subject position offered by this discursive construction is to take a critical stance with regards to the DBT model, in the belief that it can’t ‘fit everyone’ with a diagnosis. One of the possibilities for action from this position is to not have expectations about what the model can do by attempting to make it fit all clients. Otherwise, feelings of disappointment or inadequacy as a therapist could be experienced by trying to adhere uncritically to the model.
It was difficult for speakers to refer to an object which had already been constructed along similar lines as the topic they were talking about, albeit phrased slightly differently; ‘meet the criteria for’, rather than ‘with a diagnosis of’ BPD; it seemed inescapable. However, the participants spoke about this in different ways. Some of the text refers to aspects of ‘working with a diagnosis’ fairly uncritically, speaking about symptoms and inclusion criteria as givens, such as this statement demonstrates:

Natalia (lines 255-258):

[…] yeah, but you will get some kind of rigid thinking from the client, and, and, somehow, er, when that happens, so, when I say ‘rigid’, I mean… erm, engaging in black, black, black or white, black and white, erm… er, thinking, erm, thinking in extreme ways, let’s say.

This positions the client as a ‘particular type’ with ‘typical’ characteristics common to other clients who meet the criteria for BPD, which would have implications for the relationship. Other parts of the texts read as a subversion of the construction, or at least its more negative aspects, for example describing clients as ‘against type’ by such strategies as mentioning:

Jacquie (lines 425-426):

I haven’t had that sort of… erm… I haven’t had somebody come in and… and be that, erm, be that negative about the therapy. But, I mean, it does happen, but I haven’t experienced it.

This reference assumes a ‘sort’ or ‘type’ of person which a therapist might expect to be working with within this ‘client group’. By minimising the prevalence of this type of client – they exist, but not in the participant’s experience – the therapist is positioned as perhaps more similar to the client and the possibilities for action may be to be less self-protective in the therapy work and feel closer to the client and more empathic.

The references which construct the therapeutic relationship as ‘working with a diagnosis’ refer to the clients within the relationship as, a ‘particular group’, or ‘type’ of client ‘with a diagnosis of BPD’, who could be defined by certain behaviours (explicitly or by inference) which would be expected of this group. Furthermore, ‘working with a disorder’
also involved working with clients who were ‘more than’ their diagnosis. ‘Working with a diagnosis’ was located within the wider biomedical discourse with its connotations of pathology and treating illness. Subject positions offered by this discursive construction were of the ‘expert’ holding knowledge about the ‘client group’ and positioning the client as fundamentally different from them. However, there were qualifying statements made whenever an utterance referring to ‘working with a diagnosis’ was made, which suggests a both/and construction whereby diagnosis is seen as inescapable, but other constructions such as ‘interpersonal and supportive’ operate alongside it much of the time in the texts, which offer the possibility of positioning the client as an individual. The possibilities for action include: accepting the possibility not all clients with a diagnosis will ‘fit’ the model; working with uncertainty; and holding and sharing knowledge regarding the diagnosis. The subjective experiences which may be made available to therapists by constructions of the therapeutic relationship as ‘working with a diagnosis’ are diverse and include: feeling separate from the client; feeling secure because of the knowledge held regarding the diagnosis; and feeling empathy and regard for the client when the diagnosis is subverted.

This construction of the object was inherently contradictory. There were virtually no references to ‘working with a diagnosis’ that did not contain tension within the same utterance; they could not be separated out. The most useful way to understand it was as a both/and construction, rather than either/or. Moreover, it was not easily subsumed under the other discursive constructions of the therapeutic relationship in these texts. The possible implications of this is that this discursive construction and the biomedical discourse it resonates with is perhaps not sufficient to take into account the interactional nature of the therapists’ work with their clients. However, it is always present somehow because it is a given within the context of working within the DBT model, which is worth bearing in mind regarding the discursive constructions I will discuss next.

Collaborative and equal
At the most basic level, the therapeutic relationship was referred to as a relationship where the therapist ‘worked with’ the client – all participants used this terminology – in contrast to, ‘treating’ the patient, even though DBT itself was often referred to as a ‘treatment’. The construction of the therapeutic relationship as ‘collaborative and equal’ resonates with a
wider collegial discourse; notions of colleagues working together with a common purpose, shared responsibility and with power vested equally.

One of the ways the therapeutic relationship was constructed as ‘collaborative and equal’ was by reference to ‘normalising’ the client’s experience:

Natalia (lines 182-188):

[...] you don’t wanna… er… [pause]… risk them thinking that, erm, they’re defective or abnormal or different in, erm, in essential ways, in basic ways, erm, from, from you. So, yeah, so, typically, I mean, yeah, the relationship has to be… [pause] equal, let’s say. There needs to be a lot of, erm… focus on, on the relationship and, and… and part of the, er, and you achieve that sense of, er… erm, partly by… conveying the message that, you know, somehow, that… you know, that this is quite normal, it’s very normal for you to feel that way, or, erm, sometimes it’s very difficult for everyone to engage in skilful ways.

This positions the therapist as not essentially different from the client and the possibilities for action may include a collaborative style of working, including expectations that the client (positioned as ‘equal’) is capable of doing so. Power is more evenly distributed in the dyad by this construction. The adoption of a collaborative stance is advocated in many therapies for BPD because it enables the client to “experience the therapist as nonthreatening, thereby reducing emotional arousal and increasing tolerance of the therapist” (McMain, Boritz, & Leybman, 2015, p. 24).

Constructing the therapeutic relationship as ‘collaborative and equal’ were references to the expectations of clients to hold as much responsibility for the relationship as the therapist:

Jacquie (line 292):

[...] the client has to keep you in therapy as well as the other way round.

The therapist could be positioned as quite demanding by this, possibly with expectations of the client to ‘pull their weight’. Being motivated by the client could be experienced as more or less of a burden, in the sense that the therapist has the additional task of ensuring the
client is motivating them, but when the therapist does feel motivated by the client it may, for example, reduce the sense of responsibility the therapist feels for the client’s progress in therapy. Whilst this can be construed as ‘empowering’ the client, Brown and Crawford (2007) caution against taking this at face value and question whether it is always possible or necessarily desirable, and whether it prevents us from looking to wider societal structures to support such demands on clients; i.e. how to make it possible for them.

Further references include talk of demonstrating the therapist’s experiences as similar to the client’s within a style of working which involves the client playing an active role.

Marko (lines 69-72):

After I shared my experience, she says, ‘my god I thought you, I thought you are, are perfect at it… already’. And the idea that that my mind was also distracted, and that I had difficulties in bringing it back because it got caught up in something… was eye-opening for her.

A possible subject position offered by this is a ‘non-expert’, and it requires an openness of the therapist; a willingness to share (as the client does). The possibilities for trusting the client are made available from this position and the subjective experience of shared responsibility. In the following extract, the emphasis is on being different but equal. The participant utilizes the metaphor of an expedition to capture the notion of a joint enterprise with the client with powerful effect:

Jacquie (lines 932-938):

It’s, it’s like we’re, sort of, setting out on, on an expedition together […] and we both, we’ve got, we’ve got different maps: and I might have the terrain, and the, the other person might have a better understanding of the climate,…[…] which is maybe their experiences. So, but together we’re setting out. Erm… and, so, I would see it as a, sort of, fellow adventurer, really.

The implications for practice from the subject position of different but equal to the client is the possibility the therapist will be subject to and affected by the discoveries made, and also the hardships encountered along the way. The differences apply to what they are bringing
to the relationship, whereas the ‘fellow adventurer’ aspect implies a shared experience of sorts. The emphasis is on a shared experience of ‘journeying together’.

Further constructing the relationship as ‘collaborative and equal’ were references to what DBT therapy offers specifically, particularly the way it is ‘delivered’ as Marco elucidates:

Marko (lines 208-212):
A lot of the time they’ve had previous experience and they come to DBT and very often they are surprised by what we are offering and how we talk to them. This sort of hierarchy has gone.

Positioned as equal may enable the therapist to feel they are on the side of their client. However, maintaining boundaries and being able to challenge the client may be more difficult from this position. Clients with BPD are often described as wanting to push boundaries with their therapists (Kerr, 2004). Linehan (1993) argued that viewing BPD clients as a threat to boundaries is a misunderstanding of the behaviour which is usually the client responding to the intimacy of the therapy with its associations of early invalidating relationships.

The hierarchy is also absent in other ways; the client’s distress was described as something that can be understood by Jacquie:

Jacquie (lines 23-25):
[…] for me, it’s, sort of, very understandable why they have the distress they have, you know, and sort of think it’s, erm, you know, I, you know, you look back and you work out, with people, what their stories are […]

Positioning the client as a unique individual with ‘stories’ or narratives which make sense of their distress enables the therapist to understand them more easily. The subject position and actions offered by this discursive construction for the therapist is a listener of client’s stories, working alongside the client to help make sense of experience.

Constructing the therapeutic relationship as ‘collaborative and equal’, drawing on the language and meanings inherent in a discourse of collegiality facilitates and limits
particular ways of being with their clients for the participants as therapists. It may facilitate the therapist to feel less dissimilar from their clients, especially in fundamental ways. There seems to be more expectations of the client from this position, such as the requirement for them to motivate the therapist, as well as more involvement from the therapist to be alongside their client. The subjective experience of being with the client enabled by this construction is aptly conveyed by the expedition metaphor with each participant being equal, whilst holding different knowledge, and working together. However, Lowe (2003), drawing on Potter (1996), questions the equality status of the relationship and suggests discourses of collaboration can conceal the power of the therapist, a process of ‘mis-empowering’ the client and therefore shoring up therapists’ ‘rhetorical armoury’. The reality of the situation is that it is, in the end, the therapist who decides what the parameters are; including the tasks, goals and duration of therapy.

Interpersonal and supportive

The third discursive construction of the therapeutic relationship was as ‘interpersonal and supportive’. The texts referred to the therapist’s thoughts and feelings about the clients and the impact of the client on them. This seemed to resonate with the wider discourse of intimacy which is usually associated with close or warm friendship, familial, or personal relationships. For example, in this excerpt the participant describes how she felt towards her clients:

Jacquie (lines 12-13):

I just felt that I… [pause], you know, liked working with, with them, liked them… as a group of people.

Constructing the relationship as one involving the therapist liking, regarding favourably or feeling affection for the client undermines the notion of the client with BPD being “difficult to like” (Linehan, 1993, p. 383) The therapist is positioned as being capable of liking, they have ‘permission’ to act on that with a client who is positioned as likable and may therefore actually experience the affection for the client. The discursive construction of ‘interpersonal and supportive’ referred not only to the therapist’s feelings towards the client but also their perceived impact on the client and how they made use of themselves within the relationship to support the client, as the following account illustrates:
Natalia (lines 296-299):

So, I think that’s very important, to just stay there, as much as possible. I’m not saying that, you know, I, I would stay even, even if a client, let’s say, gets shouting at me, or something like that, but I do, I do try to… erm, stay with them, as much as possible, and help them understand their behaviour.

This construct positions the therapist as non-reactive, perhaps putting their own needs aside in order to be there for the client. It may be difficult to challenge the client’s behaviour from this position and may demand a lot from the therapist. It would be possible to experience empathy for the client and position them as comprehensible and to accept their behaviour.

The ‘interpersonal and supportive’ is also something that can be spoken about explicitly, as is demonstrated thus:

Marko (lines 133-135):

When a client’s behaviour has an impact on me I can also say it in a descriptive way: ‘You know when you do this or that, I’m noticing that my response is to want to pull away from you.’

Positioned as a person who is able to be affected by the client’s behaviour, and with permission to share feelings, the therapist may be enabled to model behaviour, such as being open about feelings, rather than just talk about it in the abstract. Therapist self-disclosure is a central tenet of the therapeutic relationship as conceptualised within DBT. It is conceived of as a two-fold strategy: one, to enable therapists to use examples from their own life to demonstrate their own difficulties of successes in various aspects of life skills, such as developing healthy interpersonal skills; and two, to enable the therapist to share their on-going reactions to the client in the spirit of openness and honesty within the relationship. However, the expectation to be open and honest entails the therapist bringing more of themselves to the relationship which may feel like it changes the focus from the client to the therapeutic relationship. Within DBT this is viewed as problematic because the focus is on client behavioural change, not therapy process, however Linehan (1993)
suggests process issues need to be addressed but they need to be timely and the therapist should not become side-tracked.

Some of the language used to construct the therapeutic relationship in this way is more often associated with a discourse of romantic intimacy, particularly when there are difficulties, such as in this excerpt:

Jacquie (lines 138-139):

   Look, this is going to be better for everything, if we did just either take a break, erm… or, you know, just recommit to this […].

Furthermore, if the relationship does ‘break down’, the two parties would engage in practices to try to resolve their difficulties which draw on the discourse of couples’ therapy, such as here:

Jacquie (lines 162-165):

   Almost like a, sort of, mediator, sort of, couples counselling type approach of what’s going on, who’s what. So, it wouldn’t be the question of… erm, the therapist has, has done something wrong or the clients have done something wrong. It’s like, what was the dynamic between the two […].

References to commitment and the possible need for breaks as well as the potential for the relationship to break down, indicates that both client and therapist are likely to be emotionally invested in the relationship. Each of them is taking responsibility for its ‘success’ and neither individual liable for its problems. The inability to attribute blame for relationship difficulties could have different implications for subjectivity, for example not being able to locate the ‘problem’ in the client or their condition. Moreover, locating the relationship difficulty within and between the therapeutic dyad and the necessity of external assistance to help resolve problems, may be subjectively experienced as incredibly supportive, but could also lead to feelings of incompetence, such as being perhaps dependent on others, like the client is. Whilst this could be constructed as ‘equality’ within the relationship, it may not have the same felt quality as the feeling of equality fostered by the relationship as constructed as ‘collaborative’ with its emphasis on ‘working together’; ‘doing with’ rather than ‘being with’.
Other ways the construct was referred to was as supportive or accepting, but only that part of the acceptance/change dialectic which is the underlying principal of DBT practice, as the following example shows:

Natalia (lines 339-341):

I try to place the therapeutic relationship first. And maybe that’s why I’m more at the, I tend to be… more at the, er, accepting part, er, end of the dialectic, when it comes to how I am with them.

This would appear to disrupt the ‘doing with’ aspects of collaborative construction. It positions the therapist as being alongside the client, but perhaps less able to encourage or motivate to them to change.

However, ‘interpersonal and supportive’ also denoted acceptance and change, as in this excerpt:

Marko (lines 182-186):

[…] this way of creating relationships where people feel accepted, where people feel challenged and where they know this guy is on my side – even when he’s saying something I don’t like he’s on my side […].

The therapeutic relationship embraces both acceptance and change in this example. It is closer to the ‘collaborative and equal’ discursive construct, whereby the therapist is an ally of the client’s. However, it refers to how the client is feeling and to something about the relationship which perhaps goes beyond what they are doing with the therapist in the therapy.

The following excerpt which describes two aspects of emotional regulation demonstrates the way the two discursive constructions are different but somehow interlinked.

340 M: [laughs] I think there are… I like to think about erm, emotions or sort of regulation
of emotions in two terms: there is the self-regulation which we teach in DBT, in terms
of, you take charge of your emotions and apply this skill and that skill. Then there
is
this interactive regulation too which actually is based on relationship; a baby cries,
mother gets distressed, runs to baby, they both calm down. So part of me wonders
to
what extent is it the skills and to what extent is it talking to me on the phone and
perhaps getting some validation and some interest.

The therapeutic relationship involves sharing skills and working in collaboration with the
client (lines 340-342). However, the interactive regulation requires (or permits) a response
from the therapist-mother who becomes distressed themselves by the client-baby’s distress
and facilitates the return to emotional equilibrium (lines 343-344). Whilst both are
constructed as aspects of the therapeutic relationship, the ‘interpersonal and supportive’
discursive construction draws from a discourse around relationships in a broader sense. In
the excerpt the actual example is of the mother infant dyadic relationship, however it could
pertain to any relationship where deeper, caring feelings are experienced.

Constructing the therapeutic relationship as ‘interpersonal and supportive’ seemed to
enable the participants to experience ‘genuine’ feelings for their clients, particularly
positive ones, such as, liking them. Furthermore, it seemed to permit greater ‘use of self’
for the therapist; they were allowed to bring more of themselves – their thoughts and
feelings about the client – into the relationship. It appeared to correspond with one aspect
of the dialectic, namely acceptance, but it was also referred to as creating the conditions for
client change. It has similarities with the discursive construction, ‘collaborative and equal’,
in that the therapist is positioned as non-expert, alongside or with the client. Whilst this
might make for a meaningful relationship, it may limit the extent to which the therapist can
maintain personal boundaries and not become emotionally affected by their client’s distress
to the detriment of their ability to continue to work productively with them.

Focus on action orientation and positioning
This section addresses what purpose the different constructions served in terms of the
participant’s interactional concerns in the context of the interview. By analysing a longer
excerpt with some dialogue with the interviewer the functions the constructions serve, in terms of the participant managing interests, or assigning responsibility, can be examined in more detail and provide more information about them. The following excerpt from Jacquie’s interview transcript serves to demonstrate how the different constructions of the therapeutic relationship are deployed within the texts:

Jacquie:
83 that. So, I like the fact that, in DBT, you are very warm and empathetic and…
84 understanding, but it doesn't mean to say you’re a pushover. You’re very clear on
85 what, you know, what clearly, what you need to achieve together. You know, I’m
86 [firmly]! Erm, so it’s very important that we do good work together,
87 as well as, as well as getting along.
88 R: Mmm, that’s important, it sounds. You’re, you’re not their mate.
89 P: No, so, that’s being able to hold that balance of being able to be understanding
90 and empathic, without being considered, erm… you know, too soft, not being
91 prepared to be the bad object, and all the rest of it. I’m quite prepared to be the bad
92 object, you know, in
93 pushing for change, if that’s needed, erm, but we don’t talk about that in DBT; erm, we just
94 say that it’s, you know, you need to be very careful that you’re not just cosying-up.
95 R: Mmm, hmm mmm [understanding].
96 P: Erm… but we do cosy-up when needed. You know, we do…
97 R: Yeah.
98 P: … have the heart-to-hearts and, erm… and have a lot of interpersonal, you know,
99 we, the, this weekend I’ve had, I’ve had, my clients have had access, I’ve talked to
100 them on the phone.
101 R: Hmm mmm [understanding].
102 P: Done coaching all weekend. So, you know, sometimes it is, you know, it is
103 lovely, and you get a text saying, ‘Thank you so much for being around this weekend.’

The text begins with the participant invoking the use of a construction of the therapeutic relationship as ‘interpersonal and supportive’ in order to emphasise their emotional involvement and possibly that the interpersonal and supportive qualities are located within the therapist (lines 83-84). Then seemingly unprompted, they counter it with the
construction ‘working with a diagnosis’, possibly to distance themselves from this (over)involvement, and the possible dangers of being seen as too intimate with this client group into the relative safety of the expert, more distant position where they are not seen as a ‘pushover’ (lines 83-84). Describing the therapist as not being a ‘pushover’, however, has implications for the way the client is positioned in relation to the therapist: pushover suggests there is someone who does the pushing. Perhaps in order to mitigate this negative depiction of the client, the participant draws on the discursive construction ‘collaborative and equal’ which emphasises their collegial togetherness (lines 84-85) before it is countered emphatically, even defensively, by the statement they are not the client’s ‘mate’ (line 85). Whilst this may not refer only to clients with a diagnosis of BPD, in this context it could be argued the participant was drawing on this particular construct to distance themselves from their client and perhaps position themselves as more of an expert within the relationship. In what could be seen as an attempt to mediate these incompatible constructions of the therapeutic relationship, the construction ‘collaborative and equal’ is used to stress the importance of working together, which can be accomplished while at the same time being emotionally involved to some extent (‘getting along’ lines 86-87). Lines (86-87) make use of a collegial as well as intimacy discourse; they are both utilized to describe different aspects of the therapeutic relationship which can co-exist, in this instance. The overall impression of this part of the excerpt is that the participant was concerned to not be thought of as either too lenient (and therefore possibly ineffectual) or too tough (and therefore possibly heartless).

In response to the questioning statement by the interviewer regarding the importance of ‘not being the client’s mate’ (line 88), the next two lines (89-99) refer to a ‘balance’ between ‘interpersonal and supportive’ – being empathic and understanding – and ‘working with a diagnosis’ – not being ‘too soft’ with clients who are constructed as capable of catalysing the therapist into being the ‘bad object’ (lines 90-92). The text refers to this term not being used within DBT – it is borrowed from psychoanalytic theory – however, the meaning is similar; i.e. the therapist is seen as ‘all bad’ and not helpful in the client’s eyes (line 92). This would make it impossible to construct the therapeutic relationship as ‘collaborative and equal’; the reader is reminded of the difference between therapist and client and by consequence the power differential. The therapist is positioned as expert with a client with a psychological problem common to others of their ‘type’. Not being ‘too soft’ is reiterated, this time in DBT parlance with the term ‘cosying up’ (line 93). It is difficult
to see how a ‘balance’ (line 89) can be maintained with the use of these contradictory discursive constructions; how ‘empathy and understanding’ would be limited by the othering and pathologizing of ‘working with a diagnosis’. However, that is not to say the therapist would be unable to care for the client or be supportive, the therapist may just invest less of themselves in the therapeutic relationship.

The last part of the excerpt (lines 95-102) seems to be uttered as though the participant was making an argument against the suggestion the therapeutic relationship was not ‘interpersonal and supportive’, albeit qualified by the notion it was when ‘needed’ (line 95). The references to clients having ‘access to’ the therapist (line 98) and the therapist being emotionally effected by the client, by stating it was ‘lovely’ (line 101) to receive a grateful text from them (line 102) are examples of the reciprocal nature of this construct of the therapeutic relationship. The participant, in this context, could be seen to be constructing the therapeutic relationship as ‘interpersonal and supportive’ to justify the sense of satisfaction and pleasure they derive from the work.

The ‘subjective experience’ of the therapist seems to be of juggling different subject positions afforded by the discursive construction: expert; collaborator; confidant. These subject positions sometimes overlap, as in the case of those offered by ‘working with a diagnosis’, which is often constructed as both/and, such as in lines (89-91), where expert and confidant are referred to as being able to be in balance. However, they mostly contradict each other. It gives the impression of a fine balancing act between these subject positions, resulting in the therapist being metaphorically kept on their toes. This toing and froing between the discursive constructions resonates with the concept of ‘back and forth’ communication and relating between client and therapist advocated within DBT (Linehan, 1993). Linehan describes the process of change in DBT as the client and therapist being on either end of a teeter-totter, or see-saw, and the goal is to each manage to get to the middle before moving up a notch and starting the process over again. As with a see-saw, the movement of one will impact the other and therefore a balance is required to prevent one or the other falling down. Acceptance and change is constantly being negotiated between therapist and client until they find a way of working which can foster both. What seems to be required of the therapist by this conceptualisation is a fluidity and focus which would enable them to experience, understand and respond to their client in constantly changing conditions, generated mainly by the client’s fluctuating needs, and to a lesser extent the
therapist’s. The toing and froing may therefore reflect the various subject positions, actions enacted and resultant subjectivity by the particular way the therapist practicing DBT negotiates the dialectic with their client between acceptance and change in the moment-by-moment co-construction of therapy relationship (Bedics et al., 2012; Swales & Heard, 2007).

**Discussion**

**Evaluation of discursive constructions**

The analysis suggested the therapeutic relationship for DBT therapists is constructed in (at least) three distinct ways: ‘Working with a diagnosis’; ‘collaborative and equal’; and ‘interpersonal and supportive’. Located in the discourses of ‘biomedicine’, ‘collegiality’ and ‘intimacy’, certain subject positions were made available to therapists, broadly defined as, ‘expert’, ‘collaborator’ and ‘confidant’ which afforded particular actions such as, ‘being distant from the client’, ‘journeying together with the client’ and ‘being able to be affected by the client’. These particular ways of seeing and being in the world made certain feelings and thoughts possible, however, their specific nature could only be speculated on. They included, ‘feeling separate from the client’, ‘feeling similar to the client’ and ‘liking the client’. ‘Working with a diagnosis’ was quite a weak construct in that therapists made pragmatic use of the terminology rather than ascribed to it, and so did not adopt a stable position. Power relations shifted constantly between positions, such as, the expert having more power than the client, to power shared more equally between therapist/client collaborators or those with mutual feelings for each other.

What was apparent from the entirety of the transcripts was the therapeutic relationship was not constructed as negative, and therefore not located in pejorative discourses about BPD. This is even despite instances where I asked potentially provocative questions regarding the behaviour of clients, motivated by my curiosity regarding findings from my previous study, which had identified ‘shifting perception of therapist’ as a theme (Dewhurst, 2015). Usually I was picking up on something the participant had said such as Marko referring to clients ‘behaving very differently from one context to the next’ [line 4] and querying him further [line 300]. In the interview with Natalia I pointedly asked her how it feels when what she does or says gets ‘taken the wrong way or assumptions [are] made by the clients’ [lines 250-1]. In these examples and more the participants took up the discourses identified in this study, which positioned them as equal and empathic with their clients.
Counter-discourses of the therapeutic relationship in DBT

One hypothesis for how negative discourses may have been ‘prevented’ from prevailing is the discursive practices of the therapeutic relationship in DBT acted to counter them with their emphasis on equality with and care for the client. Wirth-Cauchon (2001) predicted a change in the discourses on BPD due to the types of therapeutic interventions being developed in the 1990s. She highlighted DBT as one such therapy to re-orient to therapist, through dialectical acceptance, to take the client’s perspective seriously and on its own terms. Combined with an understanding of the socialization of women to be more dependent on others and therefore conceptualizing BPD difficulties arising, in part, from the “collision of a relational self with a society that recognizes and rewards only the individuated self.” (Linehan, 1993, p. 32). However this is not achieved by DBT therapists changing their attitudes to clients as a cognitive exercise performed in training by adopting a “non-judgemental and non-pejorative tone” with clients (Linehan, 1993, p. 18). A specific way of being with a client is advocated by DBT which encourages positive feelings, such as liking and holding hope for the client, but how is it ‘delivered’? Rossiter’s (2008) research on DBT therapists found their professional and personal identities were transformed by the impact on them of practicing DBT, which engendered a new found capacity to care about their clients and ‘rejoice’ in their successes despite experiencing great distress; they went from managing clients to treating them. This transformation was attributed to ‘relational factors’ within the conceptual framework of DBT. This was reflected in the present study; the discourses on the therapeutic relationship facilitated journeying together with the client and sharing in the client’s joy – and pain.

Change of attitude or ways of relating

In her dedication at the beginning of the DBT skills training manual Linehan (2015) reminds DBT therapists they can “choose whether to look out for themselves or to look out for their clients, but they cannot always do both. If they want to look out for themselves at a possible cost to their clients, I remind them they are in the wrong profession.” In DBT the therapeutic relationship is viewed as a vehicle for client change, necessary, but not sufficient. However, the therapist’s ‘use of self’ seems paramount in this dedication and is present in the discourses of intimacy and collegiality identified in the texts of the present study. Therapist ‘use of self’ is not really fleshed out in the literature, probably because it is located within a behavioural discourse which emphasises ‘relating behaviours’ to be adopted by the DBT therapist, such as, validation as a ‘strategy’ and identifying client
behaviours that ‘cross their limits’ (Swales & Heard, 2007). This discourse was not so present in the therapist talk in this study, other than to denote actual interventions in the therapy. Conceptualizing the therapeutic relationship as a discursive practice foregrounds the use of language in its moment by moment co-construction with the client. This sharing and shaping of ‘realities’ is done in dialogue, through connectedness; they are not the attributes of individuals, enacted through behaviours. Therefore as this dialogue is jointly produced, it cannot be totally controlled by either therapist or client, which suggests the relational is “greater than the sum of its parts” (Shotter, 1993a cited in Riikonen & Vataja, 1999, p. 178).

**Relational resistance**

This research falls short of being able to describe the ‘inner’ experiences of the participants as a Foucauldian analysis only shows possible ways certain subjectivities are permitted, not actually how participants feel and think (Willig, 2008). This creates difficulties for understanding why certain discourses are taken up and some not. Besley (2002) postulates the individual holds multiple possible positions in relation to dominant discourses such as those pejorative or negative discourses on BPD and different subjective possibilities for constructing our own distinctive narratives are therefore possible. Although the individual is not the foundation of the discursive field, it is an element within it, which means there is a space from which it is possible to speak. It is a necessity for discourse to exist (J. Simons, 2013). Although Bennett (1996) warns this ‘freedom to choose’ only exists in the outer edges of ‘subjectivity’ and cannot be completely separated from the discursive web of power/knowledge. Freedom, or human agency is posited to reside in the ethical pursuit of ‘care for the self’, a Foucauldian concept referring to the practice, in different forms throughout history, pertaining to understanding oneself and contemplating the values one wishes to live by. Foucault in his later works defined it as separate from moral codes and described people as not being merely subjugated by dominant discourses, but are also able to resist subjectivities and potentially disrupt normalised ways of being (Foucault, 1986, 1988). Furthermore, there is some suggestion this practice is inherently relational and provides a space to ‘care for the other’ (Kosmala & McKernan, 2011).

The therapeutic relationship could therefore be viewed as a site of resistance to the discourses which other and pathologize the client who meets the criteria for BPD. It has
opened up the possibilities for subject positions which are not fundamentally different from clients’; the basis for a continuum conception of BPD. In this account, therapists, as ethical subjects, are concerned to develop ways of being, borne out of a kind of self-awareness, which resonates with their values and by extension their responsiveness to the ‘other’ including their clients (Foucault, 1986).

**Limitations of the present study and areas for further research**

One fairly obvious limitation was the data did not capture process or change over time. This may render the contradictions between the discursive constructions less apparent because they may manifest at different times. Research into this aspect of the therapeutic relationship – how it changes in dialogue with clients and over time – would require analysis of individual therapy sessions and/or analysis of therapy over a course of treatment (Madill, 2005). The current research was only able to get a snapshot of the therapeutic relationship.

As mentioned earlier, the participants had undergone similar training: two as counselling psychologists and one in counselling and psychotherapy. It is likely therefore they chose that type of training in order to develop the relational aspects of their practice, and would therefore be more interested in talking about it – even promoting it. It is interesting I was not able to recruit any DBT therapists who had not trained as psychotherapists or counselling psychologists. One could speculate the notion of talking about the therapeutic relationship was not something they thought was important or were interested in, or perhaps felt able or qualified to? Further research could involve other professionals, such as social workers or nurses, who have trained as DBT therapists to investigate how they are positioned within the discursive practices of the relationship and whether they differ from psychotherapeutically trained DBT therapists?

**Implications and significance of this study**

This study has opened up a novel way of viewing therapeutic practice which may have come to be regarded as a ‘truth’ by psychotherapists and psychologists. It has the potential to generate an awareness that change is possible to improve services and care for clients who meet the criteria for BPD. However, it surmises that this is not the result of natural progression in the ways that interventions are thought about and introduced, with an
expectation that more client-centred and responsive therapies will automatically be developed. Rather, it is through the dynamic, interactive, on-going struggles at the micro level in the web of knowledge/power which constitutes DBT therapists and constrains how they can practice therapy, but also provides them with the possibility of resistance. If there is awareness of the dominant discourse, a counter-discourse is possible. Marsha Linehan’s development of DBT generated a discourse of resistance to the powerful negative discourses on BPD and this research helped to show that it was through the discourses on the therapeutic relationship which constructed it as ‘collaborative and equal’ and ‘interpersonal and supportive’, in particular, which helped to mitigate the effects of pejorative discourses on BPD.

The use of Foucauldian discourse analysis as a method facilitated the exploration of the dialogical nature of the relationship – its inherent relacionality. Other studies in the cognitive psychological tradition have managed to isolate various relational effects of the relationship as theorized in DBT, such as ‘therapist behaviour’ and ‘patient introject’, but are not able to capture the interaction (Bedics et al., 2012). This research was able to capture that to some extent, not in terms of the moment-by-moment communication of therapist and client in the therapeutic encounter, but through the discursive construction of the encounter as fundamentally relational. This seemed to be in large part due to the subject positions taken up by therapists as not being fundamentally different from clients. Given that the therapeutic relationship has been identified as a ‘common factor’ in therapy which transcends the various schools and modalities of therapy, the findings from the present research may also be applicable beyond DBT (Norcross, 2011; Wampold, 2001). That is to say, any form of therapy where there is the potential for improving and placing greater value on the therapeutic relationship as constructed in this research; ‘collaborative and equal’ and ‘interpersonal and supportive.’ That may not be applicable for certain types of therapy, such as Kleinian models which primarily utilize the transference relationship, but would apply to most other therapeutic perspectives which have developed specific ways of working with BPD. These either de-emphasise the role of transference in the relationship or work with transference in a safe and holding environment where negative affect can be contained (Clarkin, Yeomans, & Kernberg, 2006).

The therapeutic relationship is the cornerstone of Counselling Psychology. It is believed that forming a strong therapeutic relationship early is the best predictor of positive
treatment outcomes, and that the relationship is the foundation of change for the client. This research adds a further element by highlighting the role of the relationship in resisting and/or countering stigma attached to BPD. This may in part be due to the therapist’s use of self and what seems to be a real investment in the relationship. It would appear that the relational discourses identified in this study perhaps serve to prevent pejorative discourses being drawn on.
References


Appendix A

Jacquie interview

R: Erm, OK, so just, just to, sort of, get us started, erm, I just thought it… would be good if you could tell me a little bit about how you came to be working in the service and with this client group?

P: Erm… I did a placement, erm… when I was doing my training, erm… in a personality disorder service, erm… and I, I worked there for about two and a half years as, as my training, part-time.

R: Was there something that drew you to that, at that stage?

P: … Yeah [thinking], erm… I think it’s because, erm, I wanted to work in the third wave, erm, cognitive behavioural way, and I understood that dialectical behaviour therapy was third wave. Erm… and I also wanted to work, sort of, longer term… erm, but, also, I had worked with clients, erm, in a psychodynamic placement, who had a diagnosis of borderline personality disorder. And, you know, I just felt that I… [pause], you know, liked working with, with them, liked them… as a group of people, felt like I could understand them, erm… and thought that’s a good combination of being, of the sort of therapy I might like to work in… and the sort of people, erm… with the certain sorts of distresses I feel I can understand and, erm… yeah, that I, I like working with that client group. So, that’s why I, that’s why I, I applied for that particular… erm, placement, and then, when I got that placement, I didn’t go for the other interview with my other placement, ‘cos that’s the one I wanted. So… erm…

R: Can you tell me a bit more about, erm, about what you liked about, erm…

P: … Yeah, I just, I don’t see… it’s funny, because I haven’t worked, it’s, I probably like all people, if I’m honest [chuckles]. I like people. Erm, but they’re still a particular group, I think, well, it, for me, it’s, sort of, very understandable why they have the distress they have, you know, and sort of think it’s, erm, you know, I, you know, you look back and you work out, with people, what their stories are, erm… you know, it can be quite a clear, sort of, What’s going on? What’s happened? And, erm, what the possibilities are for reducing distress? Erm… so… I’d find it very, I find it very, I find it very … I think, probably, you know, if I was to put myself on a, sort of, non-emotional to emotional spectrum, I think I’d put myself towards the emotional end of the spectrum as well. Erm, so I can relate to them. Erm… you know, I have, luckily for me, I haven’t had very distressing things happen in my past, erm… so I haven’t had the, sort of, validation some people have had. So, although I can, I can relate to the emotionality, erm, I’m not, sort of, stuck in, sort of, over-identification. Erm… so I thought it was the right sort of balance for me, sort of, un, I understood, but not, I wasn’t exactly the same. I understand the emotionality, erm… [pause]… Yeah, I don’t know if that quite answers your question, actually [laughs].

R: No, no, yes, yeah. No, I mean, given that it’s quite, you know, often people with BPD talk about being misunderstood, so, I mean…

P: Yeah.

R: … that’s, yeah, it’s very personal.

P: Yeah, I feel I can, I can genuinely… [pause] [unclear], and I think that’s really important, with working [breaking up]…
R: J, you’re breaking up a little bit.
P: … OK.
R: I don’t know. That’s really annoying, isn’t it [annoyingly]? Erm, do you mean just repeating that?
P: I’ll just check my, I’ll change my [breaking up.
R: Gone again.
P: Yeah.
R: Yeah.
P: Sometimes my 4G’s better than my WIFI, so, if its ok, I’ll swap to 4G.
R: OK. Do you mind…
P: No, I just wondered if…
R: … repeating what you last said?
P: Yes, about hope.
R: OK, yeah [interestingly].
P: Erm, I feel like I can genuinely hold hope… and I think that’s very important.
R: Hmm mmm [understands]. So, do you think, erm… [pause]… so, I guess, you know, just thinking about all that, in the context of DBT, so you worked with a, erm… dia, people with diagnosis in psychodynamic, and then you, erm, sort of, ended up working in a DBT context. So how does that… erm… [pause]… I mean, what’s that like [half-laugh]? I’ll just leave it really open [half-laugh]. What’s that like being…
P: What’s it like coming from psychodynamic and going into…
R: Well, just like, thinking about how you, erm… how you feel towards your clients and how you relate how that, sort of, works in a DBT context, I guess.
P: Yeah, yeah. I much prefer the way… the therapeutic relationship is defined in DBT than it is in psychodynamic.
R: Hmm mmm [interestingly].
P: I mean, I worked in a Kleinian psychodynamic, so I can’t say how it would be in an attachment based or a Winnocottian styley, erm… because it’s very much, sort of, erm… a collaborative, equal relationship, erm, whereas I felt, erm, in psychodynamic, it was much more that I, sort of, knew about them,… I didn’t feel like I did know about them than they did, but that’s the sort of stance, if you like, erm… of sort of holding it altogether and then, you know, delivering like some, sort of,… baby, some, sort of, interpretation, erm… which I just felt, I just felt was not, not really helpful. Erm, you know, I, I mean, I was actually able, in the end, I, I, the clients I got referred to… they tend, they tended to be people for whom, you know, and my empathic stance was going to be helpful. So, that, that was good in my place that they recognised; I just couldn’t work in that non… in that very straight-faced sort of way.
R: Mmm [in agreement].
P: I just couldn’t do it. Erm, so, in the end, they ended up referring people, who needed a certain, gentler, empathic… stance, but, from my point of view, being empathic and
Appendix B

Information sheet

The construction of the therapeutic relationship with clients who meet the criteria for borderline personality disorder: A discourse analysis.

Thank you for agreeing to receive this information and considering taking part in this study. My name is Samantha Dewhurst and I am conducting this research as a trainee counselling psychologist as part of the Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. This is your information sheet to keep and I hope it will provide enough information for you to decide if you would like to take part.

What is the study about?

This study aims to learn more about how you as a therapist experience the therapeutic relationship with your clients who meet the criteria for BPD. The data will be subject to a discourse analysis with the intention of improving our understanding the discursive practices – professional and beyond – that therapists draw on to make sense of their experiences of the therapeutic relationship with clients who meet the criteria for BPD.

You are eligible to take part in the study if:

You are working or have recently worked as a Dialectical Behavioural Therapy (DBT) individual therapist.

You would be willing to spare one hour of your time, at your convenience, to tell me about your experiences sometime before the end of April 2016.

Do I have to take part?

No. It is completely up to you to decide whether or not you would like to take part. If you do decide to join the study, you can withdraw at any point. The information you provide in your interview will not be used in the analysis if you withdraw your involvement within two weeks of meeting with me.

What will I be asked to do if I take part?

The meeting will last approximately 60 minutes, depending upon how much you would like to say. I will audio record our meeting with a digital voice recorder. You do not need to bring anything along to our meeting or prepare beforehand. However, if you would like to bring anything with you such as notes you kept at the time or have written since you are very welcome to do so.

Will my data be anonymous?

The information you provide will be anonymised to all apart from me and my research supervisor. The data collected for this study will be stored securely and only the investigator and research supervisor, Ben Rumble will have access to this data.

Audio recordings will be deleted after they have been electronically transcribed, anonymised and checked.

The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
The transcriptions will be anonymised by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study. However, your name will not be attached to them.

**What will happen to the results?**

The results will be summarised and reported for the purpose of a research report as part of my doctoral studies. A shorter version may be submitted for publication in an academic or professional journal. You will also be given a copy of the report when it is completed.

**Are there any risks?**

It is not anticipated that joining the study to discuss your experiences would cause significant emotional distress. The researcher will at all times prioritize your welfare and wellbeing. This will involve offering to take a break or resume the interview at another time, or to end your participation in the study. After the interview, you will be de-briefed to ascertain whether you need further information or support.

**Are there any benefits to taking part?**

Although I hope you may find participating interesting, there are no direct benefits in taking part. However, by sharing your thoughts and experiences you are helping our understanding as professionals in this field, which may in time, further the development of services.

**Who has reviewed the project?**

This study has been reviewed by the School of Psychology Ethics Committee, Faculty of Health and Medical Sciences and granted favourable ethical approval (Ref: FT-PSY-170-15).

**Where can I obtain further information about the study if I need it?**

If you have any questions about the study, please speak to myself, the principal investigator, Samantha Dewhurst at s.dewhurst@surrey.ac.uk or my supervisor, Ben Rumble at b.p.rumble@surrey.ac.uk.

**Expenses**

Although I will endeavour to travel to meet you at a place of your convenience, you may also incur some travel expenses. I can reimburse you up to £10 for travel costs. Please let me know if you need to claim this.

**Complaints**

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact the programme director:

Dr. Elena Manafi  
Programme Director  
PsychD in Psychotherapeutic and Counselling Psychology  
School of Psychology  
Faculty of Human and Medical Sciences  
University of Surrey  
Guildford GU2 7XH  
Email: e.manafi@surrey.ac.uk  
Phone: 01483 683 637

Thank you for taking the time to read these information sheets.
Appendix C

Consent Form

The construction of the therapeutic relationship with clients who meet the criteria for borderline personality disorder: A discourse analysis.

I the undersigned voluntarily agree to take part in the study on ………………..

I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any risk to my well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I agree to engage to the best of my ability with the researcher in the informal interview process. I shall inform them immediately if I suffer any deterioration of any kind in my health or well-being, or experience any unexpected or unusual symptoms.

I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation.

Name of volunteer (BLOCK CAPITALS) ........................................................
Signed ............................................................................................... Date ........................................................

Name of researcher (BLOCK CAPITALS) ......................................................
Signed ............................................................................................... Date ........................................................
Appendix D

Interview Schedule

As this is a semi-structured interview this interview schedule was only used as a guide. The intent is to allow the participant to speak as freely as possible. Therefore, the questions needed to be open and as free of assumptions as possible. In order to elicit a rich detailed account, I employed prompts such as: Why? How? Can you tell me more about that? Tell me what you were thinking. How did you feel? The type of questions varied to encourage different kinds of responses, for example; descriptive, narrative or evaluative questions.

Questions:

- How did you come to be working in this service/with this client group?

- What is it like to work with your clients?

- What is your experience of the therapeutic relationship with your clients?

- What aspects do you find easy/difficult/enjoy/dislike etc?

- [If there are difficulties] how do you deal with them?

- What do you feel works/doesn't work?

- How do you think about the therapeutic relationship – what does it mean to you?
Appendix E

Ethical approval

Fast-Track ethics application Ref: FT-PSY-170-15 - Confirmation to proceed

Earl JE Mrs (FHMS Faculty Admin)

Tue 20/10/2015 17:28
To: Dewhurst SL Ms (PG/R - Psychology) <s.dewhurst@surrey.ac.uk>; Cc: Rumble BP Dr (Psychology) <b.p.rumble@surrey.ac.uk>;

Dear Samantha

Thank you for submitting your ethics proposal form to the School of Psychology Ethics Committee, Faculty of Health and Medical Sciences, via the Fast Track procedure. I am pleased to confirm that your proposal, as stated in your application, does not raise any issues that would necessitate a full review and you are therefore able to proceed with your study.

Please keep your original proposal with the reference given above together with a copy of this email, as no copies are kept by the ethics committee.

If there are any significant changes to your proposal which require further scrutiny, please contact the Ethics Committee before proceeding with your Project.

Many thanks

Kind Regards

Julie

Julie Earl
Administrator Ethics Committees (FHMS and School of Psychology)
Faculty of Health and Medical Sciences
Duke of Kent Building (16DK03)
University of Surrey
Tel: 01483 689175
Email: j.earl@surrey.ac.uk

PLEASE NOTE: I am now based in FHMS (16DK03). My working hours remain the same and are 9-5.30, (5.00 in vacation), Tues, Wed and Thurs.
Appendix F

Submitting articles to CPR

Introduction

Counselling Psychology Review is the Division of Counselling Psychology’s quarterly peer reviewed research publication. It brings together high quality research pertinent to the work of Counselling Psychologists. It primarily focuses upon work being undertaken in the UK but it is also likely to be of interest to international colleagues and those in related therapeutic disciplines. The content is pluralist in nature, with its focus being on excellent work rather than methodological or paradigmatic preference, and submissions are invited in the following areas:

• papers reporting original empirical investigations (qualitative, quantitative or mixed methods);
• case studies, provided these are presented within a research frame;
• theoretical papers, provided that these provide original insights that are rigorously based in the empirical and/or theoretical literature;
• systematic review articles;
• methodological papers.

Notes for Contributors

1. Length:

Papers should normally be no more than 5000 words (including abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

2. Manuscript requirements:

• The front page (which will be removed prior to anonymous review) should give the author(s)’s name, current professional/training affiliation and contact details. One author should be identified as the author responsible for correspondence. A statement should be included to state that the paper has not been published elsewhere and is not under consideration elsewhere. Contact details will be published if the paper is accepted.
• Apart from the front page, the document should be free of information identifying the author(s).
• Authors should follow the Society’s guidelines for the use of non-sexist language and all references must be presented in the Society’s style, which is similar to APA style (the Style Guide, available from the Society, or downloadable from http://www.bps.org.uk/publications/submission-guidelines/).
• For articles containing original research, a structured abstract of up to 250 words should be included with the headings: Background/Aims/Objectives, Methodology/Methods, Results/Findings, Discussion/Conclusions. Review articles
should use these headings: Purpose, Methods, Results/Findings, Discussion/Conclusions.

- Approximately five key words should be provided for each paper.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
- Graphs, diagrams, etc., must have titles.
- Submissions should be sent as e-mail attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add ‘CPR Submission’ in the e-mail subject bar. Please expect an e-mail acknowledgment of your submission.
- Proofs of accepted papers will be sent to authors as e-mail attachments for minor corrections only. These will need to be returned promptly.
Conference Paper

Poster presented at the Division of Counselling Psychology Conference July 2016

Abstract

Objectives: Borderline personality disorder (BPD) is associated with a range of difficulties affecting interpersonal relationships, which are usually replicated in some way in the context of therapy. This study aimed to explore how individuals who meet the criteria for BPD experience the therapeutic relationship.

Design: The aim of the study was to produce a meaningful account of the experience for the client with BPD. An interpretative phenomenological analysis (IPA) was deemed appropriate in order to elicit rich detailed accounts of the participants' experience.

Method: Interviews were conducted with seven participants and an analysis of their transcripts carried out according to IPA guidelines.

Results: Three master themes emerged from the analysis: 'contained/uncontained'; 'perceptions of therapist'; and 'issues of control'. Participants experienced the therapy relationship, as fluid and changeable. On the whole, it was felt to be containing; they felt understood, safe and accepted. However, feeling uncontained was also reported. The therapist was experienced at different times, variously, as ideal; genuine; or someone to please and was often subject to change suddenly, from a caring to negative figure. Control was experienced as being with either the therapist, the participant or located between them. Issues of trust permeated the themes.

Conclusions: The importance of the therapeutic relationship was exemplified and the findings were consistent with theoretical understandings of the therapy relationship with this client group. It is hoped this research may contribute to a greater understanding of the subjective experience of the therapy relationship for clients with BPD and inform clinical practice.