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**EXPLORING CLINICIANS' EXPERIENCES OF WORKING WITH PEOPLE  
DIAGNOSED WITH BORDERLINE PERSONALITY DISORDER**

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**COMPULSORY DECLARATION**

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work(s) of other people has been attributed, and has been cited and referenced.

## ABSTRACT

Borderline Personality Disorder (BPD) was only recognized in the DSM III in the 1980s as a diagnostic category, yet it has been an area of interest in the field of psychology for more than 40 years. Literature suggests that clinicians may find treating and working with people with BPD to be a difficult and frustrating experience, as the therapist is frequently worried about manipulative behaviour, lack of boundaries on the part of the patient and the patient's inability to set limits or monitor his/her own emotional state. Furthermore, self-destructive behaviours commonly displayed by people with BPD seem to contribute to problems in the therapeutic relationship and complicate therapeutic tasks, both of which are related to low treatment success. This study uses an explorative, qualitative design to sketch an understanding of clinicians' experiences of working with BPD, including their instrumental knowledge of the disorder, their personal experiences of working with people diagnosed with BPD and the impact of the apparent stigmatisation of BPD on the participants' conceptualisation of the disorder and on the therapeutic relationship with a BPD patient. Nine clinicians, who have had direct experience of working with BPD patients were interviewed using semi-structured interviews. The data collected from the interviews was analysed using content analysis and the findings suggest that the participants are aware of the stigma associated with the disorder and do find BPD patients to be difficult for a number of reasons. The findings also suggest that a number of factors mediate the perception of clinicians that BPD patients are difficult including access to support, prior experience and the manner in which BPD is conceptualised by the clinician.

**KEYWORDS:** Borderline Personality Disorder; Personality Disorders; Stigmatization

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## CHAPTER 1: INTRODUCTION

Despite the fact that Borderline Personality Disorder (BPD) was a diagnostic latecomer to the Diagnostic and Statistical Manual of Mental Disorders (DSM), only appearing in the DSM-III in 1980 (Clarkin, Hull, Cantor & Sanderson, 1993), it has been a popular topic for psychological research for more than 40 years (Grinker, Werble, & Drye, 1968; Gunderson & Singer, 1975; Kernberg, 1967 & 1975; Mahler, 1971). Since then there has been a considerable quantity of research done on the disorder. There are numerous peer reviewed journal articles published on BPD and its associating factors, such as the aetiology of BPD (e.g. Landecker, 1992; Swift, 2009a; Trull, 2001; Wastell, 1992), and the comorbidity of BPD with Axis I disorders (e.g. Gunderson, Paris & Weinberg, 2007; Morgenstern, Langenbucher, Labouvie & Miller, 1997; Shea, Klein, & Widiger, 1992), and Axis II disorders (e.g. Sasone & Levitt, 2005; Sasone, Levitt & Sasone, 2005; Zanarini et al., 1998; Zanarini et al., 2004). Other studies have researched the most effective treatment methods for BPD (e.g. Livesley, 2005; Nysaeter & Nordahl, 2008; Paris, 2004b; Paris, 2005b; Robins & Chapman, 2004; Zanarini, Frankenburg, Khera, & Bleichmar, 2001) and the expected prognosis of those with BPD (e.g. Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004).

Compared to the large number of quantitative studies done on BPD, there have been fewer qualitative studies published on BPD. Such studies include Hodgetts, Wright and Gough, (2007) and Steinmetz and Tabenkin (2001). Of the qualitative studies done on BPD only a small number have focused on developing a contextual understanding of BPD from the perspective of the clinicians working with patients diagnosed with this disorder. Such studies include Ma, Shih, Hsiao, Shih and Hayter (2008), Nehls (1994) and Woollaston and Hixenbaugh (2008). This is in spite of the fact that patients who have been diagnosed with BPD have a reputation for being one of the most difficult and challenging sub-groups of people to work with across various cultures and care settings (Bland & Rossen, 2005; Book,

Sadavoy & Silver, 1978; Gross et al., 2002; Maltzberger & Buie, 1974; Schafer & Nowlis, 1998; Steinmetz & Tabenkin, 2001; Ward, 2004).

People with BPD have been labelled as difficult and challenging patients because they tend to make emotional demands upon clinical staff and require that staff work closely and intensely with them (Clarkin & Posner, 2005; Paris, 2005a; Piccinino, 1990). People diagnosed with BPD often attempt to create relationships that cross professional boundaries and which place clinical staff in difficult or compromising positions. This leads to clinicians experiencing strong emotional reactions to these patients (Ma, et al., 2008). Manipulative behaviour, lack of boundaries on the part of the patient, and an inability to set limits or monitor their own emotional state have been cited as reasons for why clinicians find it difficult to work with people who have BPD (Ward, 2004).

The interpersonal relationships that are typically seen in an individual with BPD are characterized by instability, intense feelings, and recurrent crises. People with this disorder have difficulty being alone and may try to avoid real or imagined abandonment by hanging on to relationships, even after having alienated other people. As a result of this behaviour, clinicians often struggle with balancing the needs and demands of the patient with BPD with the other non-BPD patients' needs. Self-destructive behaviours commonly displayed by people with BPD contribute to problems in the therapeutic relationship and complicate therapeutic tasks. (Schafer & Nowlis, 1998).

As a result clinical staff interacting with people diagnosed with BPD have at times expressed feeling emotionally and physically drained and frustrated (Cleary, Siegfried & Walter, 2002). Many of the behavioural problems associated with BPD have been linked to problems with emotion processing (Bland, 2003; Levine, Marziali & Hood, 1997; Stein, 1996). When intense affect is not processed adequately, unstable moods frequently occur. Impulsive behaviour such as the inability to control inappropriate and intense affect may lead



to displays of anger or physical fights. When a person diagnosed with BPD displays intense anger, the clinician may feel personally attacked, angry, helpless, frustrated, or fearful for their safety and the safety of the other patients. This behaviour may be seen as deliberate and bad rather than a behavioural symptom of the illness. As a result, clinical staff may become less empathic and withdraw, distancing themselves emotionally from the patient (Fraser & Gallop, 1993; Gallop, Lancee & Garfinkel, 1989).

### **1.1 Aims and Objectives of the Study**

Literature suggests that clinicians encounter serious problems when working with clients who have BPD, including counter-transference hatred (Maltzberger & Buie, 1974) and negative therapeutic reactions towards the patient (Kernberg, 1977). Research suggests that BPD is a difficult and complex form of psychopathology and that for mental health professionals, working with people diagnosed with BPD can be an extremely challenging and at times frustrating, process (Ma, et al., 2008). The attitude and feelings of the therapist towards the client has an impact upon the therapeutic relationship or alliance (Gabbard & Horowitz, 2009; Hinojosa Ayala, 2005). The therapeutic alliance can be defined as the quality of involvement between the therapist and the patient (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). A wide range of evidence indicates that the therapeutic relationship is an important predictor of therapy outcome and is associated with positive outcomes across different forms of psychotherapy (Horvath & Greenberg, 1994; Ligiero & Gelso, 2002; Martin, Gaske, Davis, 2000; Spinhoven et al., 2007). Considering the evidence which suggests that health care professionals find it difficult to work with people diagnosed with BPD (Bland & Rossen, 2005; Gross et al., 2002; Paris, 1994; Steinmetz & Tabenkin, 2001; Ward, 2004), it is surprising that there has not been more exploration into understanding how clinicians feel about working with people who have BPD and how their feelings impact upon the therapeutic relationship and the efficacy of treatment.

## EXLPORING CLINICIANS' EXPERIENCES OF WORKING WITH BPD

This study aims to explore the experiences and perceptions of clinicians working with people diagnosed with BPD, using semi-structured interviews. By analyzing the data collected in the interviews using thematic analysis, I hope to gain insight into how clinicians understand the disorder and attempt to treat it, their personal feelings about working with people who have BPD and how they feel and think about the stigma that is associated with BPD patients.

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## CHAPTER 2: LITERATURE REVIEW

The literature review begins with a synopsis of the clinical presentation of BPD. I then discuss the epidemiology, comorbidity, aetiology, treatment and prognosis of BPD in accordance with research findings on each topic. Finally the literature review covers the stigmatisation of people with BPD as these patients have a reputation for being difficult and difficult to treat.

### 1.2 BPD Characteristics

The current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR: American Psychiatric Association, APA, 2000) defines Personality Disorders (PDs) as pervasive, inflexible and enduring characteristics that are present from early childhood and cause significant distress and impairment in one's daily functioning. PDs are classified under three clusters: Cluster A (odd/eccentric) includes Paranoid, Schizoid and Schizotypal PDs; Cluster B (dramatic/emotional) includes Borderline, Antisocial, Histrionic and Narcissistic PDs; and Cluster C (anxious/fearful) includes the remaining, Avoidant, Dependent and Obsessive-compulsive PDs.

BPD is associated with pervasive, widespread dysfunction across emotional, behavioural, cognitive and interpersonal domains (Bender et al., 2001). Research shows that BPD has a characteristic clinical presentation that allows it to be distinguished from other disorders (Zanarini, Gunderson, Frankenburg & Chauncey, 1990). In the DSM-IV TR, BPD is described as "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (DSM-IV TR, APA, 2000, p. 710). BPD manifests in severe problems in sustaining close interpersonal relationships, with dramatic shifts from idealization to devaluation. Self-destructive behaviours, associated with impulsiveness are common and include: sexual

promiscuity, self-mutilation, and suicide ideation and attempts. People with BPD also experience intense, volatile feelings and moods and identity disturbance, and at times their thinking can be grandiose, with distorted versions of reality. The communication style seen in people with BPD can be tangential, and over-personalized (Bland, 2003; Sable, 1997). Research also shows BPD to be specifically connected to enduring generalized distress, interpersonal problems, problems with affect regulation, and impaired coping (Johnson et al., 2003).

The most commonly used tools for diagnosing BPD are the DSM-IV TR (APA, 2000) and the Diagnostic Interview for Borderlines (Gunderson & Kolb, 1978; Gunderson, Kolb & Austin, 1981; Zanarini, Gunderson, Frankenburg & Chauncey, 1989). Both these diagnostic tools describe BPD as having a marked problem with the regulation of emotion, cognition and behaviour.

### ***Emotional Dysregulation***

Emotional dysregulation is considered to be a central defining feature of BPD (Gunderson, 2001; Linehan, 1993; Skodol et al., 2002). Emotional dysregulation in people with BPD is characterised by low emotional awareness and clarity, and a fear of negative emotions (Leible & Snell, 2004). Emotional patterns seen in those with BPD include the tendency for their emotions to spiral out of control; to become irrational when strong emotions are stirred; to catastrophise by seeing problems as disastrous and insolvable; and to have difficulty with self-soothing (Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2009). People with BPD often display emotional responses that are reactive, and they tend to struggle with episodic depression, anxiety, irritability and anger and may experience a lack of positive emotions (Gunderson, 2001). People with this disorder are likely to become overly dependent on others to help regulate their affect. Because people who have BPD are likely to fear abandonment and not trust others easily they struggle with relating appropriately to others and may display

a hostile and suspicious approach to others' feelings of warmth and caring (Bland, Tudor, McNeil Whitehouse, 2007).

### ***Behavioural Dysregulation***

People with BPD exhibit behavioural dysregulation which can be understood as a difficulty in regulating and controlling one's own behaviour. In people with BPD behavioural dysregulation often results in extreme and impulsive behaviour such as substance abuse, self-harming, parasuicide and completed suicide (Horsfall, 1999). In particular self-mutilation, parasuicide and completed suicide are symptomatic of BPD, as people with this disorder have a tendency to direct destructive behaviours towards themselves (Zanarini & Frankenburg, 2007). The most common methods of self-mutilation reported by patients with BPD are cutting themselves, punching themselves, punching walls, and head-banging (Barlow, 1993). The most common methods of suicide attempts reported are overdosing and cutting. About 72% of patients with BPD reported having a lifetime history of using multiple methods of self-mutilation and about 31% reported having a lifetime history of using multiple methods of attempting suicide (Zanarini et al., 2008).

### ***Cognitive Dysregulation***

People with BPD may show signs of cognitive dysregulation that include chronic thoughts of distrust and suspiciousness, ideas of reference and dissociation, paranoid ideation, a lack of goal directedness and perseverance in reaching goals, dissociative symptoms including depersonalization and derealisation and identity disturbances created by an unstable sense of self or self image (Clarkin et al., 1993; Zanarini, Ruser, Frankenburg, & Hennen, 2000).

People with BPD may also experience further cognitive symptoms which can be described as *quasi-psychotic* in nature and include reality-based delusions or hallucinations (Lieb et al.,

2004). One study found that as many as 40% of the sample who were diagnosed with BPD exhibited *quasi-psychotic* thoughts (Zanarini, Gunderson & Frankenburg, 1990).

### **1.3 Epidemiology**

BPD occurs in approximately 1 to 2% of the general population, however prevalence rates increase substantially in outpatient and inpatient populations, rising to 10 and 20% respectively (Lieb et al., 2004; Moran, 2002). This may be due to the fact that individuals with BPD typically access medical and psychiatric health care services at a disproportionately greater rate than individuals with other mental disorders (Bender et al., 2001; Jackson & Burgess, 2004; Linehan, 1993). BPD is typically associated with lower social class and lower levels of education (Paris, 2005a). From a broader perspective BPD is more likely to be encountered in Western cultures (Paris, 1996).

The diagnosis of BPD is more common among women than men, with women making up 70 to 77% of the BPD population (Kraus & Reynolds, 2001). A number of hypotheses have been proposed to explain why historically more women than men have been diagnosed with BPD (Gibson, 1991; Simmons, 1992). These hypotheses generally fall within two streams of thinking, the first of which is that there is a tendency towards gender stereotyping in regards to particular psychopathologies such as BPD. An example of gender stereotyping in the diagnosis of BPD is that women who appear as angry and promiscuous are more likely to receive a diagnosis of BPD, whereas men are more likely to be diagnosed with Antisocial Personality Disorder. The second stream refers to early theorising around the development of BPD. The authors of the initial theories of BPD (Mahler, 1971; Masterson & Rinsley, 1975) proposed that it arose from a developmental arrest that occurred during the process of separation-individuation. In the rapprochement phase of separation-individuation, people with BPD were thought to have been rewarded for dependent behaviour and punished for efforts to be autonomous. At the time this theory was proposed it was usually the female

child in the family who would have less autonomy and be more dependent on parental figures. Furthermore, although the role of both parents was addressed, this theory focused on inadequate mothering as the genesis of BPD. Masterson (1976) suggested that the mother of a person with BPD was herself a borderline and as such responsible in some way for the development of borderline tendencies in the child. This particular theoretical perspective suggests that women are predisposed to BPD in a way that men are not because of the cultural contexts in which girl children develop.

#### **1.4 Comorbidity of BPD with other Axis I and Axis II Disorders**

Research shows that people diagnosed with BPD often present with comorbid Axis I disorders (Gunderson, Paris & Weinberg, 2007; Morgenstern, Langenbucher, Labouvie & Miller, 1997; Shea, Klein, & Widiger, 1992), and Axis II disorders (Sasone & Levitt, 2005; Sasone, Levitt & Sasone, 2005; Zanarini et al., 1998; Zanarini et al., 2004). Gunderson (2001) suggests that the Axis I disorders most frequently found in BPD patient samples are: Dysthymic Disorder, Major Depressive Disorder, Substance Abuse, Posttraumatic Stress Disorder and Eating Disorders. Research shows that while people with PDs are prone to a comorbid presentation of an Eating Disorder, of all the PDs it is BPD that is that most commonly linked to individuals with clinically significant eating pathology such as Anorexia Nervosa; Binge-eating Purging Type and Bulimia Nervosa (Sansone & Levitt, 2005; Sansone, Levitt & Sansone, 2005). Theories on why this is so propose that there is a high component of impulsivity in both of these eating disorders as exemplified by the behaviours of bingeing and purging. People with BPD are prone to engaging in such behaviour due to their lack of impulse control (Sasone & Levitt, 2005).

While BPD has been found to have high rates of comorbidity with virtually all Axis II disorders (Gunderson, 2001), there is some debate about which PDs share the highest

diagnostic overlap with BPD. Zanarini et al., (2004) found the most commonly occurring comorbid Axis II presentations seen with BPD are Paranoid, Avoidant, and Dependent Personality Disorders. Whereas Gunderson (2001) suggested that Histrionic and Avoidant Personality Disorders share the highest overlap with BPD. Other studies show that up to 75% of people diagnosed with BPD meet the requirements for a Cluster C PD such as Avoidant or Dependent Personality Disorder (Zanarini et al., 1998; Zanarini et al., 2004). Research suggests that there is also a high degree of overlap between BPD and Paranoid Personality Disorder, with up to one third of people with BPD meeting the DSM III-R criteria for Paranoid Personality Disorder (Nurnberg, et al., 1991; Zanarini et al., 1998).

### **1.5 Aetiology of BPD**

Evidence on the aetiology of BPD is conflicting. Some of the studies investigating the aetiology of BPD have found support for a biological basis for the disorder (Coccaro, 2001; Feigenbaum, 2007; Miller, 2006; Nehls, 1998), while other theories propose that environmental factors such as childhood sexual abuse and early trauma are linked to the development of BPD (Minzenberg, Poole & Vinogradov, 2006). The rate of childhood sexual abuse has been estimated to be as high as 75% among people with BPD (Battles et al., 2004), and because of this it has been suggested that it may be an aetiological factor in the development of BPD (Guzder, Paris, Zelkowitz & Feldman, 1999; Zanarini, Ruser, Frakenburg, Hennen & Gunderson, 2000). More recent research suggests that anywhere from 25% - 71% of people with BPD experienced some form of physical or sexual abuse in childhood (Bland et al., 2007; Gunderson, 2008; Paris 2005a). In addition to abuse, rates of maltreatment, in childhood, in the BPD population have been proposed to be as high as 90% (Zanarini, et al., 2000).



Another factor linked to the development of BPD is insecure attachment styles between infant and primary caregivers (Levy, 2005). A review of studies addressing the link between insecure attachment styles and BPD consistently found that people with BPD displayed fearful or disorganised patterns of attachment (Fonagy, Gergely, Jurist, & Target, 2002; Agrawal, Gunderson, Holmes & Lyons-Ruth, 2004). Some research suggests that rather than BPD being attributed to purely biological or environmental factors it is more likely the result of the interplay between biological factors and adverse environmental experiences (Linehan, 1993; Shearin & Linehan, 1994).

### **1.6 Treatment of BPD**

Currently there are a number of treatment options available for working with people diagnosed with BPD. Here the most common methods used to treat BPD will be briefly touched upon.

#### ***Dialectical Behaviour Therapy (DBT)***

DBT was developed by Marsha Linehan (1993) and is currently one of the most widely studied and disseminated forms of therapy used for treating BPD (Levendusky, 2000; Sneed, Balestri, & Belfi, 2003; Swenson, 2000; Swenson, Sanderson, Dulit, & Linehan, 2001), and there is evidence to suggest that it is highly effective in treating people with BPD (Livesley, 2005; Paris, 2005b). DBT evolved from Cognitive Behavioural Therapy (CBT) as a specific treatment for BPD to address the symptoms of emotional dysregulation, suicidal and self-injurious behaviour that are commonly seen in patients with BPD. DBT is typically conducted over a 12 month period and involves weekly individual therapy, skills training, telephonic skills training and a therapist consultation team.

Based on an affect regulation model, DBT works on the assumption that impulsive and self-destructive behaviours are the result of a deficit in one's ability to regulate emotions

effectively. DBT teaches people how to identify accurately and describe their emotions, then adopt a non-judgmental and non-reactive attitude towards their feeling states. Through DBT people learn about the adaptive nature of their emotions and gain the capacity to recognize and change certain emotional triggers that lead to self-destructive behaviours. While DBT is specifically designed to address suicidal and self-injurious behaviours it also targets the mood instability commonly seen in patients with BPD by emphasizing empathic responses to distress that provide validation for the patient's inner experience.

### ***Psychodynamic Therapy***

Transference Focused Therapy (TFT) is a form of psychodynamic psychotherapy specifically modified to treat patients with personality disorders such as BPD. It is based on Kernberg's object relations model of BPD (Kernberg, 1975, 1984) and emphasises three primary factors as important in therapy: interpretation, maintenance of technical neutrality and transference analysis (Yeomans, 2004). The focus of TFT is on the exposure and resolution of the intrapsychic conflict experienced by the patient. The aim of treatment is to increase impulse control, anxiety tolerance and the ability to modulate affect. It also works towards the development of more stable interpersonal relationships (Clarkin, Yeomans & Kernberg, 2006).

Studies on the efficacy of TFT in treating people with BPD are conflicting. One study suggests that the data supporting the efficacy of TFT in treating BPD is inconclusive (Clarkin, et al., 1993), whereas another study found TFT to be more effective than DBT and supportive psychotherapy in significantly reducing suicidality and anger in patients with BPD (Clarkin, Levy, Lenzenweger & Kernberg, 2007). Furthermore, this study also found TFT to be just as effective in reducing symptoms of depression and anxiety and in improving global functioning and social adjustment in people with BPD as DBT and supportive psychotherapy.

### ***Mentalization Based Therapy***

The term mentalization was coined by Peter Fonagy and his colleagues to describe the capacity to reflect on one's own experiences in order to make inferences about behaviour in oneself or in others (Fonagy 1991; Fonagy, et al., 2002; Fonagy & Target, 1996). The ability to mentalize is a developmental achievement aided by the existence of secure attachment relationships with primary caregivers (Levy et al., 2006). Mentalization Based Therapy (MBT) was developed (Bateman & Fonagy, 2004) as a treatment for BPD, with the view that the aetiology of BPD has its roots in the experience of insecure attachment relationships with primary caregivers which inhibits one's capacity to mentalise. MBT is based on the belief that people with BPD struggle to mentalize as adults as a result of having experienced insecure attachment relationships with their primary caregivers in childhood (Fonagy, et al., 2002). The focus of MBT is on relationship patterns and the unconscious factors that inhibit change. Treatment entails bringing the patient's mental experiences into conscious awareness and facilitating a more complete and integrated sense of mental agency (Bateman & Fonagy, 1999).

### ***Group Therapy***

Group therapy has been used as both a primary method of treatment for BPD as well as an adjunct to other treatments. Despite the general view that group therapy is useful in helping to treat people with BPD up until recently there has only been one controlled trial done on the effectiveness of group therapy as a BPD intervention (Munroe-Blum & Marziali, 1995). The outcome of this study was compared with individual therapy only and both methods achieved similar results. Part of the reason that there has not been more research into the efficacy of

group therapy in treating BPD is the difficulty in getting patients diagnosed with BPD to remain in group therapy for an extended period of time. Group work tends to be more successful in inpatient settings, such as substance abuse treatment centres where participation is mandatory. In such settings patients with BPD seem optimistic about the role of group therapy in their treatment (Gunderson, 1984). The presence of peers in a group may allow for confrontations regarding maladaptive or impulsive patterns to occur without the patient being threatened by the feedback coming from a source of authority or perceived power.

### ***Pharmacotherapy***

While an in-depth analysis of the successes and pitfalls of using pharmacotherapy to treat BPD are beyond the scope of this literature review, a brief outline of pharmacotherapy for BPD will be discussed. Low-dose neuroleptics have been used as a means of addressing impulse control issues in BPD (Soloff, 2000). Selective Serotonin Reuptake Inhibitors (SSRIs) have also been widely used to treat BPD, usually with the aim of targeting the prominent depressive symptoms seen in this population. While some research suggests that SSRIs do reduce mood disturbance (Rinne, van den Brink, Wouters & van Dyck 2002; Salzman, et al., 1995; Zanarini, Frankenburg & Parachini, 2004), the results fail to match the efficacy of antidepressants in classical depression. Other studies suggest that SSRIs effective in reducing anger and impulsivity in BPD patients. (Coccaro & Kavoussi, 1997). Thus the evidence for the use of antidepressants to treat mood disturbances in people with BPD remains equivocal.

Lieb et al (2004) suggests that the calming effect of drugs enables patients to reflect before acting. However, the benefits of using antidepressants must be balanced against the high risk of overdose. Furthermore, although improvement in the behavioural symptoms associated with BPD have been noted following pharmacological treatment none of the

medication used for BPD produces clinical remission (Paris, 2005b). Clinicians' failure to recognize the limitations of pharmacologic interventions in BPD often leads to the prescription of additional medication, even if they are likely to have the same therapeutic effect (and limitations) as the first drug. This leads to polypharmacy, or 'cocktail therapy', a practice that is not evidence-based and one that makes it more likely that people will suffer from side effects. Research shows that typically patients with BPD are often taking up to four or five different medications, with at least one drug from each major group of medications (Zanarini et al., 2001).

### ***Schema Focused Therapy***

Schema Focused Therapy (SFT: Young, Klosko, & Weishaar, 2003) draws on cognitive-behavioural, attachment, psychodynamic, and emotion-focused theories in treating people with BPD. SFT conceptualises patients with BPD as being under the sway of particular modes or aspects of the self. The goal of therapy is to then reorganise this inner structure. There are four core mechanisms of change that are used in SFT: (1) limited re-parenting, (2) experiential imagery and dialogue work, (3) cognitive restructuring and education, and (4) behavioural pattern breaking. These interventions are used during three phases of treatment: (1) bonding and emotional regulation, (2) schema mode change, and (3) development of autonomy. The main objective of SFT is to enable the patient to cope with their various schema modes through encouragement and the learning of self-help skills which are modelled by the therapist. SFT for people with BPD emphasises the collaborative and working relationship between the patient and therapist. The basic framework of SFT for the treatment of BPD involves the following steps; assessing the symptoms and personality patterns of the patient, assessment and education around schemas and schema modes, establishing treatment goals, negotiating limits of therapist's availability, coping with schemas or schema modes,

learning new interpersonal skills and termination and relapse prevention (Nysaeter & Nordahl, 2008).

Studies researching the most effective method for treating BPD differ somewhat but the therapeutic modalities mentioned above have all been cited as effective ways of treating the symptoms commonly associated with a diagnosis of BPD (Swift, 2009b). Literature suggests that using one of the therapeutic methods mentioned above rather than another type of therapy may significantly improve the prognosis of a person with BPD (Bateman & Tyrer, 2004).

### **1.7 Prognosis**

Some studies suggest a poor prognosis for people with BPD (Nehls, 1998; Woollaston & Hixenbaugh, 2008), showing that they have high rates of premature termination of treatment and display an on-going dependence on mental health care systems. However, other studies indicate that borderline symptoms decline with age (Bateman & Fonagy, 2006; Johnson et al., 2000; Lenzenweger, Johnson, & Willett, 2004; Livesley, 2005; Paris, 2004b), and that about 75% of people with BPD will regain close to normal functioning by the age of 35 to 40 years, and 90% will recover by the age of 50 (Paris 2005b). While approximately 1 in 10 people with BPD completes suicide, as many as 90% of people with BPD improve despite threats to end their lives (Paris, 2005b).

A number of factors have been identified as having a negative impact on prognosis, these include affective instability, increased length of hospitalisations, presence of dysphoria, family history of mental illness and early onset of BPD. A number of factors have also been linked to a more positive prognosis, these include high IQ, absence of parental divorce and narcissistic entitlement (Lieb, et al., 2004). There is evidence to suggest that the treatment

methodology employed in treating people with BPD can have a significant impact on prognosis (Bateman & Tyrer, 2004; Gunderson, 2009).

### **1.8 The Stigmatisation of BPD**

Literature indicates that there is a stigma associated with BPD that goes beyond those associated with other mental disorders (Aviram, Brodsky & Stanley, 2006; Cauwels, 1992; Nehls, 1998; Schafer & Nowlis, 1998; Simmons, 1992). The stigma attached to the diagnosis of BPD is the result of the reputation that people with the disorder have for being difficult, manipulative, demanding and treatment-resistant patients and that these characteristics are viewed as the inherent nature of the individual rather than the nature of the pathology (Aviram, Brodsky & Stanley, 2006). Gallop, Lancee and Garfinkel (1989), found that the label of BPD was enough to change the behaviour of treatment providers towards patients with the disorder. Such changes include a reduction in sympathy and empathy for the patient and a tendency to see their behaviour as manipulative and attention-seeking (Fraser & Gallop, 1993).

Research suggests there is a relationship between the stigma surrounding BPD and the emotional reactivity of clinicians working with such patients. Clinicians are more likely to distance themselves from patients with BPD than they would do with other mentally ill patients (Fraser & Gallop, 1993). This is partly because clinicians consistently find that during certain periods of treatment with an individual who has BPD, the patient will be emotionally demanding and exhibit an intense range of emotions that are often directed towards the clinician (Aviram, Brodsky & Stanley, 2006). Being the recipient of intense emotions and behavioural 'acting out' results in clinicians developing negative countertransference towards patients with BPD (Schafer & Nowlis, 1998), which may manifest as anger, dislike, fear or dread (Wheelis & Gunderson, 1998). For many clinicians

the process of connecting with patients who have BPD is impeded by an underlying fear of being manipulated (Nehls, 1998) This often results in clinicians emotionally distancing themselves from such patients. Literature indicates that clinicians experience a range of difficult countertransference experiences in response to patients with BPD. Negative countertransference has been theorised to affect the therapeutic relationship (Ligiero & Gelso, 2002), which in turn negatively impacts upon treatment outcomes (Horvath & Greenberg, 1994; Martin, Gaske, Davis, 2000). Therefore, it would be useful to conduct further research to explore the specific nature of the feelings clinicians generally experience when working with BPD patients, in order to assess the impact of such feelings on treatment outcomes for BPD patients.

This literature review has highlighted some of the current research findings related to the clinical presentation, epidemiology, comorbidity, aetiology, treatment and prognosis of BPD. In addition literature shows that there is a stigma attached to the diagnosis of BPD and that many clinicians experience patients with BPD as being difficult, manipulative, demanding and attention-seeking. This often results in clinicians developing negative feelings towards the patient. This study aims to get a better understanding of how clinicians conceptualise BPD, whether or not they are influenced in any way by the stigma associated with BPD and what their personal experiences of working with such people are.



## CHAPTER 2: METHODOLOGY

### 2.1 Using a Qualitative Research Design

The purpose of this study is threefold. The first purpose is to explore the participants' conceptual understanding of BPD, this includes their thoughts on the aetiology, clinical presentation, treatment and prognosis of the disorder. The second aim is to understand their personal experiences of working with people diagnosed with BPD and the feelings that they experience in response to BPD patients. Finally the third aim is to assess the impact of the apparent stigmatisation of BPD on the participants' conceptualisation of the disorder and on the therapeutic relationship with a BPD patient.

A methodology is a specific philosophical and ethical approach to developing knowledge that includes a theory of how research proceed given the nature of the issue it seeks to address (Nicholls, 2009). Given the aims of the study there is a need to conduct an in-depth exploration of clinicians' experiences of working with those diagnosed with BPD. This presupposes a descriptive and exploratory qualitative design. Qualitative research allows for the collection and analysis of data that is rich in detail and contextually embedded (Denzin & Lincoln, 2000). It therefore provides a useful framework that does justice to the complexity of the topic without losing the nuances that come from the data being removed from a real-life context.

Given the nature of the study design and aims proposed, the interview material was analysed using content analysis. According to Hsieh and Shannon (2005), qualitative content analysis is a research method that allows for the interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns. Thus, themes were elicited from the interview transcripts through the coding of the material in the transcripts. A more detailed description of the analysis process will be discussed in analysis section.

## 2.2 Participants

A sample of nine mental health professionals were interviewed. Six of the participants are women and three are men. The ages of the participants in the study range between 33 and 52 years of age. Of these nine participants' three are addiction counsellors, two of whom work in an inpatient setting while the other works in private practice. One participant is a social worker specialising in the field of addiction. He previously worked in an inpatient setting and is currently in private practice. Four of the participants are psychologists, one of whom works in a psychiatric hospital and the other three in private practice. The remaining participant is a psychiatrist working in private practice. All participants are first language English speakers.

Initially participants were recruited via professional networking and once this avenue was exhausted convenience sampling was used to identify further participants for the study. All participants met the criteria of having worked in their chosen field for at least two years and having worked with at least three patients who had been diagnosed with BPD. All of the participants were willing to take part in the study and while no monetary compensation was provided an effort was made to reduce the inconvenience and time taken away from work to participate in the study by conducting the interviews at a location and time chosen by the participant. When quoting the participants in the analysis and discussion they will be referred to by the first letter of their name to ensure anonymity. Table 1 below provides a list of each participant and the field in which they work.

Table 1

<b>Participant</b>	<b>Professional Field</b>
Participant A	Clinical psychologist working in private practice
Participant G	Psychiatrist working in private practice
Participant T	Social worker working in private practice, specialising in field of substance

	abuse
Participant J	Clinical psychologist working in private practice
Participant E	Addictions counsellor working in private practice
Participant M	Clinical psychologist working in private practice
Participant P	Addictions counsellor working in inpatient facility
Participant R	Addictions counsellor working in inpatient facility
Participant S	Clinical psychologist working in a psychiatric hospital

### 2.3 Data Collection and Method of Analysis

Each of the nine participants were interviewed and the interviews were then transcribed verbatim so that the material could be analysed. In order to aid the collection of rich and meaningful data the interviews were semi-structured. Thus while a number of questions relating to topics of interest surrounding working with people who have BPD were prepared prior to the interview, the interview schedule was not rigidly held to and an attempt was made to allow the interviews to take on an individual quality directed by the nature of the information shared by each participant. A main source of concern regarding the interviews was to allow each participant to share their personal experience of working with people diagnosed with BPD without any imposed agenda. This meant using open-ended questions that did not 'lead' the participant to give a particular response. The interview schedule was used as a means of highlighting particular areas of interest with regards to working with people with BPD that I as the researcher had identified. The interviews were voice-recorded so that they could be transcribed verbatim once complete. Quotations included in the analysis of the interview material have been cleared of repetitions and unnecessary words such as 'um' and 'er' as they do not add significantly to the analysis of the interview material. Interviews were conducted in the chosen setting of the interviewee and each interview lasted between 40 to 60 minutes (See Addendum A for interview questions).

The method of analysis used in the study was content analysis, which is a research method that allows for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns (Moretti, 2011). When doing content analysis one may use either inductive content analysis, which is the conventional style of content analysis, or deductive content analysis. In inductive content analysis coding categories are derived directly and inductively from the raw data. Thus one avoids using preconceived categories, allowing the categories and names for categories to 'flow from the data' instead. The advantage of the conventional approach of content analysis is that direct information is gained from the study participants without preconceived theoretical perspectives having been imposed. Deductive content analysis is based on previously formulated, theoretically derived categories and the initial coding starts with a theory or relevant research findings. Using existing theory or prior research, one begins by identifying key concepts or variables as initial coding categories of analysis, bringing them in connection with the data. This study relied on both inductive and deductive content analysis. Inductive content analysis was required in order to gather data on areas where current existing research and literature on BPD is limited. This includes most notably qualitative research on clinicians' personal experiences of working with people who have BPD. Deductive content analysis was also used to help validate and extend the theoretical frameworks already existing relating to BPD (Elo & Kyngas, 2008).

In terms of the inductive content analysis, the first step of the analysis process involved the repeated reading of interview transcripts in order to gain a sense of phrases that appeared to capture the themes connected with the research question. Following this, notes were taken of the content area to which the highlighted phrases referred. Then the content areas expressing similar concepts were grouped into mutually exclusive categories and giving a first label, e.g. stigmatization of BPD. In this manner the major themes elicited in each

interview transcript were highlighted and compared with the themes elicited in the other interview transcripts. Thus the inductive content analysis allowed for the discovery of themes that were consistent across the interview transcripts.

The deductive content analysis was guided by the themes chosen prior to the analysis of the material. Thus a major theme relating to the research question was the notion of people with BPD being 'difficult patients.' As with the inductive content analysis the process of analysing the material began with the repeated reading of the interview transcripts in order to establish a familiarity with the material. The identification of material related to the chosen theme was identified by highlighting phrases and words that were felt to be indicative of the theme.

## **2.4 Ethical Considerations**

In terms of ethical considerations the study followed general ethical guidelines which include informed consent, transparency, the right to withdraw at any time, optional debriefing and confidentiality (Willig, 2001). Before commencing with the data collection a proposal was submitted to the UCT Psychology Department Ethics Committee and consent was obtained to continue with the study.

Participants were provided with a consent form (Addendum B) to sign prior to the start of the interviews in which the aims and purpose of the research was explained as an exploration of their professional and personal experiences of working with people diagnosed with BPD. By providing participants with information as to the purpose and procedure of the study prior to beginning the interview, this allowed them to make an informed choice as to whether they would like to participate or not before beginning the interview. This ensured that standards of transparency were met as there was no deception of participants on any level because they knew beforehand the purpose of the study and how the data collection was to

proceed. In the consent form participants were informed that should they at any stage during or after the interview feel that wanted to withdraw from the study they had the right to do so without fear of being penalized in any way. Furthermore, participants were asked to sign an additional consent form agreeing to the interview being voice-recorded.

Confidentiality of participants was ensured regarding any information that was shared during the data collection process by ensuring the anonymity of all participants was upheld. All data collected during the interviews was by myself in a kept in a locked filing cabinet and destroyed at the end of the study to preserve confidentiality and anonymity of participants. Furthermore, the identity of any patients mentioned during the interviews was protected by changing names and details that might identify the patient. Although the topic of the interviews was not evocative in nature participants were offered an optional debriefing session once the interview was complete if they felt they needed it. As all participants were working professionals, every attempt was made to reduce the inconvenience of participating in the study.

### CHAPTER 3: ANALYSIS AND DISCUSSION

The analysis of the interview material is divided into two broad sections. The first section focuses on the participants' working knowledge of BPD. This includes knowledge pertaining to the clinical presentation, aetiology, treatment and prognosis of BPD. This then enables a preliminary assessment of whether or not the participants' understanding of BPD is in line with current theoretical knowledge of the disorder.

The second section of the analysis is concerned with the personal experiences of the participants in relation to working with people diagnosed with BPD, with a focus on the difficulties and challenges that arise in the therapeutic relationship and negative countertransference reactions towards BPD patients. The second section also explores the impact of the stigmatisation of BPD on the participants personal experiences of working with people who have BPD. In such cases where the participant refers to specific clients, names have been changed to ensure anonymity.

#### 3.1 Working knowledge related to BPD

##### *Symptoms and characteristics of BPD as noted by participants*

Participants were asked about what symptoms they commonly associated with a diagnosis of BPD. Table 2 provides a summary of the symptomatology that the participants felt was characteristic of BPD.

Table 2.

<b>BPD characteristics</b>	<b>Number of participants that identified the characteristic as a symptom of BPD</b>
Self-harm	8
Suicide ideation or suicide attempts (parasuicide)	5
Lack of impulse control	4
Emotional instability	7
Instability of Relationships	6

## EXPLORING CLINICIANS' EXPERIENCES OF WORKING WITH BPD

Fear of abandonment and subsequent 'neediness'	6
Idealisation and devaluation	5
Splitting	5
Promiscuity	4
Lack of boundaries	6
Substance abuse	8

Self-harm and substance abuse are the two characteristics that participants most commonly associated with BPD, whilst promiscuity and lack of impulse control were the two characteristics that fewest of the participants associated as a symptoms of BPD. Table 2 shows that clinical judgement concerning signifying markers of BPD differs between participants to some degree. One reason for this may be the differing contexts in which the participants are working. Four of the participants interviewed specialised in the field of substance abuse with two of them currently working in an inpatient setting, while the other two are currently working in private practice, but with previous employment as clinicians in an inpatient facility. These four participants spoke more to 'addictive' behaviours such as substance abuse, eating disorders and sexual promiscuity as signifying markers of BPD. In contrast the participants who are psychologists working in private practice typically identified instability in relationships and jobs and difficulty in establishing trust as key markers of a BPD diagnosis. What this suggests is that the context in which mental health professionals find themselves working may impact on the behavioural, emotional and cognitive factors that they associate with the diagnosis of BPD.

In addition to the common characteristics associated with BPD that are listed in Table 2 some of the participants highlighted other symptoms as being key markers of the disorder. For instance participants M, R and J spoke about a lack of identity and a feeling of being lost or empty as two symptoms that are key markers of borderline pathology.



*M: ...I see that its women who have extremely poor self-esteem, an extremely poor negative sense of self, they don't know who they are and... feel lost and ungrounded... Everything is their fault and they're never going to make it and they have these high expectations and everybody else has high expectations, but they feel that they'll never be able to meet them and they... sense that they can't... hold on to anything... there's no sense of foundation, there's no sense of security and they don't know who they are... and that they're lost.*

Participant M associated feeling lost and ungrounded with borderline pathology, while participant R spoke of emptiness and a lack of identity as indicative of BPD.

*I: If you were to be told that you'll be receiving a client who's been diagnosed with borderline personality disorder what would you immediately highlight in your head to look out for, what behavioural symptoms, what emotional issues would stand out for you that might be a concern as you work with them?*

*R: From an emotional point of view I would be aware of the emptiness and the lack of identity and just be very attuned to the tendency of their, of the borderline not to want any boundaries, of their desire for fusion as opposed to being individual. And I would be aware of a sense of the patient wanting to co-opt me into where they're at in order not to have to actually have to feel the separation and the abandonment depression.*

Participant J also refers to identity confusion as symptomatic of BPD, which she sees manifest through problems with sexual and gender identity formation.

*I: And in your experience of working with people who have BPD and from what you've learnt what symptoms do you commonly associate with the diagnosis?*

*J: So it would be gender-identity confusion is the one thing I would say that comes to mind, they don't know if they gay or straight and keep changing their minds about that.*

Participants also referred to different levels of severity of BPD and the impact this has on the manner in which a person presents with the disorder. The following excerpt taken from the interview with participant A speaks to his experience of this.

*They make very good initial impressions, they're often very insightful, very intelligent, quite vibrant, so in the first couple of sessions of therapy they often make a very good impression and they can read situations very well. You know I think one also needs to differentiate, you know the kind of borderlines you'll pick up in a hospital context which are so end of the line borderline. You know in private practice one doesn't really see that extreme, one does periodically, but one sees more the high functioning borderline who you know you might get some self-mutilation but it's quite occasional and it's not life-threatening and you know you*

*get acting out but it's not as extreme as like the really severe borderlines you pick up in the hospital context. So the high functioning borderline that I would see in a private practice context would you know remain high functioning and it's more the psychic borderline stuff that's where it's at, rather than physical enactments but still one gets, one does get enactments they just not as hectic.*

The DSM-IV TR does not differentiate between different levels of severity in the diagnosis of BPD. This is indicative of a binary approach to the diagnosis of BPD where an individual either does or does not meet the criteria for diagnosis. However, the excerpt from participant A suggests that there is continuum of borderline pathology and that patients diagnosed with BPD may present differently in terms of the level of functioning that they exhibit. Literature supports the finding that people with BPD exhibit varying levels of functioning and suggest that while some individuals with BPD are fairly high functioning in specific areas of daily living such as social or occupational functioning, others may show a markedly decreased level of functioning in specific areas (Jorgensen, et al., 2009; Mills, 2004).

The context in which the participants worked and trained played a role in which symptoms they indicated as primary markers of BPD. For example participant G, who is a psychiatrist, referred to emotional dysregulation as the key symptom of BPD and shared her understanding that the behavioural symptoms associated with the disorder arise as a result of people with BPD trying to mediate their emotional responses.

*G: So a big hallmark feature for me in terms of managing a borderline is getting a handle on the emotional dysregulation because into the emotional dysregulation comes all the symptoms of borderline so it's the irritability, the impulsivity, the self-mutilation. Most of them self-mutilate when they either highly irritable because it's a reflection of anger or they self-mutilate when they desperately depressed because they want to feel something other than feeling completely dead. The boredom, the emptiness that they describe all these symptoms seem to lift when you, when you aggressively treat the emotional dysregulation with a cocktail of treatments.*

Participant G's conceptualisation of BPD as a disorder of emotional dysregulation that can be successfully treated with medication is indicative of the training she received as a medical doctor. Psychiatry is a specialised field of medicine and follows the general principles of the

medical model which approaches physical and psychological pathology with the aim of finding medical treatments for diagnosed symptoms.

In contrast participant M, who trained as a clinical psychologist, made reference to dysfunctional interpersonal relationships as a key determinant of a BPD diagnosis.

*M: Yes I think it does play out mainly in relationships, well many of them keep going into destructive relationships okay so they go into a relationship in which, subconsciously, they know they're going to be abused or which they know is going to turn out negatively.*

Relational functioning is often central to psychological intervention. The fact that participant M chose to highlight difficulties in interpersonal relationships as central to a diagnosis of BPD shows how her understanding of the disorder is shaped by her professional context, just as participant G is shaped by hers. This indicates that the training one receives plays a major role in how various mental health professionals, whether they are psychiatrists, psychologists or counsellors, conceptualise and treat BPD.

### ***Participants' understandings of the aetiology of BPD***

As mentioned in the literature review the evidence on the aetiology of BPD is conflicting. While some research supports a biological basis for the disorder, showing that BPD appears to be significantly heritable (Feigenbaum, 2007; Gunderson, 2009), other research findings suggest that adverse environmental and psychosocial factors, such as abuse and neglect, are the key determinants of BPD (Bland et al., 2007; Gunderson, 2008). Alternative research supports the theory that BPD arises from both biological irregularities and adverse environmental experiences (Shearin & Linehan, 1994; Skodal, et al., 2002). From the analysis of the interview material it appears that the participants are as divided in their thoughts on the aetiology of BPD as the literature is. Of all the participants, participant G the psychiatrist ascribed the most credit to a biological basis for the disorder.

*I: So for you the aetiology is biological?*

*G: Ya, it's genetic, you genetically inherit it just like you inherit bipolar mood disorder you inherit borderline personality disorder. I don't believe it's a personality disorder, primarily I believe it is a mood disorder that you've inherited. I actually think that most of my borderlines I can actually trace back to the onset of puberty. I think that's where it becomes most noticeable and I think that the hormonal dysregulation which is associated with puberty and normal adolescence, well normal adolescent mood swings and moodiness is because of emotional dysregulation, but the predisposition to developing an affective disorder or a mood dysregulation is triggered by the hormonal dysregulation round about puberty.*

Participant G suggests that not only is BPD a genetic disorder but that it is primarily a mood disorder. However, despite her understanding of the aetiology of BPD as a biological disorder she did speak to sexual abuse as being a factor that may play a role in the development of BPD.

*G: There is a massive correlation between borderlines being sexually abused and being borderline. Being sexually abused doesn't make you borderline but a lot of borderlines have been sexually abused. So I think that's something that needs to be just noted.*

Other participants such as participants R, E and J felt that relational and environmental factors such as sexual abuse and childhood trauma were more salient determinants in the aetiology of BPD.

*R: One of the things that I haven't yet spoken about is the high incidence of borderline injuries in people who have been sexually abused. For me I see, in terms of the work, that there's quite a strong correlation between abuse, sexual, physical and verbal and post-traumatic stress disorder and borderline characteristics and that's something that certainly informs my work as well.*

Participant R speaks about the correlation between different types of abuse experienced in childhood and the development of BPD. Participant J's comment mirrors this belief that a history of abuse can lead to the onset of BPD.

*I: I think maybe my last question is about aetiology and what factors you associate with, causal factors you associate with a borderline diagnosis?*

*J: Well I think there's very often deep trauma early on so it could be of a physical type, it could be you know physical abuse or sexual abuse or something deeply traumatic to the*

*psyche at a very young age and sometimes people have got no recollection of that at all so you've just got to work with what you can you know it's very difficult to try and uncover what the aetiology is. It may be more useful in some ways to deal with the here-and-now because it's all getting played out anyway in their dynamics with people so you know ya.*

Participant E shares a brief history of one of his clients to show the link between her experiences of abuse and her diagnosis of BPD.

*E: She's hectically borderline... she has a history of abusive relationships, she's 33 years old, and up till three years ago every man she ever hooked up with abused her in some way. One even raped her, one hit her on the head.*

This recognition of the link between abuse or trauma in childhood and the development of BPD falls in line with the finding that BPD is predominantly applied to survivors of childhood sexual abuse, particularly women (Shaw & Proctor, 2005). Research suggests that between 70 and 80 % of people diagnosed with BPD have experienced some form of abuse (Castillo, 2000). There is an argument that the diagnosis of BPD pathologises a natural response to the severe psychological distress that one experiences as the result of trauma and/or abuse (Herman, 1992). Shaw and Proctor (2005) argue that while some clinicians are making the link between BPD and sexual abuse many are still pathologising trauma because of a fundamental failure to locate and understand the distress responsible for BPD within its social context. Some argue that the diagnosis of BPD is an attempt to deny the extent and impact of childhood sexual abuse and that the symptoms of BPD can be better understood as an adaptive reaction to early relational traumas (Johnson, 2003; Kaehler & Freyd, 2009; Landecker, 1992; Wilkins & Warner, 2003). This critical understanding of BPD as a social construction that pathologises and individualises survivors of abuse and relational distress was not a focal theme addressed in this study.

### ***How participants felt about the prognosis of people with BPD***

Literature on the prognosis of BPD is conflictual, with different studies finding different prognostic outcomes for BPD patients. The participants' responses regarding prognosis

mirrored the split found in the literature as they differed significantly on their thoughts regarding the prognosis of someone with BPD. The following excerpts highlight the differences in thinking that the participants had around prognosis.

*T: I won't be as, not hopeful, but I'll be more subdued about their prognosis. I won't yeah, give as much hope.*

*I: Is that because of your previous experiences or because of something else?*

*T: Because of the borderline personality traits and how difficult it is for them to get over it, it's so hard for them to see it, it could take months for them to start working on those kinds of traits... Now borderline behaviours can be so extreme and so resistant that it can take you years to work through that kind of process, you need to have a lot of counselling and a lot of support to get through that and not many borderlines can stick through that kind of process, that's the nature of their illness.*

Participant T's response of not feeling hopeful about the prognosis of patients who have BPD is common among clinicians who regularly treat people with BPD (Swift, 2009b). Participant J shares this view on the prognosis of people with BPD.

*I: ...looking back on the clients you've worked with that do have a borderline diagnosis, prognostically how did it go? How did it end up?*

*J: Hmm, well (laughs) now that you ask that I have to say that I can't confidently tell you that they got better, so I would say almost all of them left before they got better.*

*I: What would you class as 'got better'?*

*J: Stable relationship, functioning well at work, staying in job for a long time, good connections with other people, you know mental health stable so they're not having wobbles and dips and ya.*

*I: So there's a tendency for them to leave therapy before they've reached that?*

*J: Yes I think it's often hard for them to pay for their therapy because they're often struggling to function at work and at some point if their therapy is being paid for by somebody else at some point that somebody else is going to get fed up and stop paying. So it's by nature of their diagnosis... in a way that they're probably not going to be able to sustain or pay for a long period of psychotherapy for many of them.*

Participant J's ideas on prognosis seem to have been at least partly determined by her past experiences of working with people diagnosed with BPD. Participant T and J's scepticism

regarding the prognosis of BPD is shared by some research findings that suggest the prognosis for patients with BPD is poor (Nehls, 1998; Woollaston & Hixenbaugh, 2008). In contrast, participants S and A reported feeling more optimistic about the prognosis BPD patients.

*I: What are your thoughts on the prognosis of somebody who's with this particular disorder?*

*S: Ya I'm influenced by a lot of the new work that's coming out, Anthony Bateman and Peter Fonagy and some other people have written some articles and that has a very positive view on prognosis. I quite like their work because it challenges the old stereotypes and the old facts that people think pertain to borderline personality disorder. So I think that if handled correctly the prognosis is much better than everybody thinks, but I also think that it means that as practitioners in whatever form we have to really think about the therapy that we do because what's come out is that sometimes the therapy that we do actually maintains the disturbances.*

Participant S's thoughts on prognosis are in line with the findings of some studies done on the prognostic outcomes of people with BPD (Bateman & Fonagy, 2006; Johnson et al., 2000; Lenzenweger, Johnson, & Willett, 2004; Livesley, 2005; Paris 2004), which suggest that the type of treatment methodology used by clinicians in treating BPD has an impact upon prognosis. Participant A shares this viewpoint.

*I: In terms of prognosis therapeutically for borderlines, what are your thoughts on this?*

*A: There's a lot of debate, I'm one of those who are more optimistic about borderlines because I think that invariably it's a structure that does come from distress and pain and I think given enough time, given the right recipe I think they do very well or they can do very well and I've seen borderlines mutate fantastically but it's a lot of PT and takes time and it's a lot of hard work. I think they can do very well, depending on two factors, one are they intelligent? They often are and two the nature of the acting out, for example if there's substance abuse involved it can be much more difficult. So if substance abuse isn't too serious and that's contained and it's a borderline with structure, you know a person who reasonably intelligent I think their prognosis can be good.*

As already mentioned research on the prognosis of BPD shows different findings. Some studies suggest a link between prognostic outcome and the type of treatment methodology used to treat BPD (Gunderson, 2009) and state that an unexpectedly good prognosis can be

expected if the right treatment methods are used in treating BPD. Participant S noted that the clinician's choice of treatment methodology impacted upon the prognosis of the client.

*I: So what you're saying is the prognosis is at least in part determined by the way the therapist works and the techniques that they choose too*

*S: Look I might even be guilty of that but this is what's been written about prognosis now in terms of some of the research that's coming out is that we need to be more vigilant about how we work with these patients because we might be part of the problem.*

In contrast Participant J felt that the type of treatment modality was less important than the qualities of the therapist in determining prognosis.

*I: Do you think that the type of treatment would make a difference in terms of prognosis?*

*J: Mm, well I think it's important that they are with somebody who's quite wise and astute in helping them to see their role in what they're doing as opposed to letting them see themselves as the victim and people are always doing bad things to them. Somebody who's very boundaried and very reliable and consistent I would say that what would be more important than the theoretical framework would be the kind of therapist, they would need to be very solid and not the kind of therapist who took long breaks but somebody who was pretty much there most of the time, ya.*

Participant J's remark that the theoretical framework is less important than the qualities of the therapist is not in line with the findings of current research on effective treatment methods for BPD which state that MBT and DBT are more effective in treating BPD than traditional psychodynamic psychotherapy (Livesley, 2005, Paris, 2005b). In comparing the responses given from participants S and J respectively it is useful to consider the context in which they work. Participant S works in a psychiatric hospital and regularly comes into contact with people diagnosed with BPD who exhibit low levels of functioning. Because of this she finds it crucial to keep up to date with current research on BPD. Participant J works in private practice and has not had a client with BPD for a number of years. Her field of practice has shifted to parenting and child-rearing and she does not keep up to date with current research on BPD because the knowledge is less pertinent to her work.



### ***What participants thought about treatment of BPD***

As discussed in the literature current research suggests that DBT, TFT and MBT are the most effective therapies for successfully treating BPD (Clarkin, et al., 2007; Fonagy & Bateman, 2006; Levy et al., 2006; Paris 2005b). However despite this widely recognised finding, in the analysis of the interview material I found that only participant S mentioned using DBT and MBT in treating patients with BPD and none of the participants mentioned TFT as a treatment option for BPD.

*S: I think the concept of mentalization, I discovered papers by Peter Fonagy and Mary Target... where they speak about psychic reality and the sort of developmental issues that are involved as to why certain people are unable to achieve mentalization or separation in that sense. And that helped a lot because it helped me understand how they were processing information and the difficulties that they would experience in terms of not being able to understand their own mental states as separate from or not the same as somebody else's. Or not being able to I suppose express that symbolically... and then on a more practical level... using something like dialectical behavioural therapy.*

Two of the participants felt that CBT was useful in treating BPD, in the excerpt below participant T describes his preference for using CBT to treat BPD patients.

*I: And in terms of choosing a particular type of therapy, have you found that certain types work better in dealing with borderlines than others?*

*T: Cognitive behavioural therapy is the one that I go with, and it's got to be long-term therapy where you can get them to look at how their thoughts affect their actions and their behaviours.*

Participant G also felt that CBT is useful in treating BPD, however, she uses it as an adjunct to pharmacotherapy.

*G: Put them on some Lithium, maybe a low dose antipsychotic and Bob's your uncle okay. It's a cocktail, always cocktail and the cocktail is usually a mood stabiliser, either one or two mood stabilisers and an antipsychotic and then maybe an antidepressant or not, each patient varies. So you optimise each patient's recovery by using a combination of biology and cognitive behavioural psychotherapy. It's got to be cognitive behavioural, in-depth psychoanalytical therapy is a no no with borderlines because they regress and unravel... it's about helping them to cope here and now, you know it's not going to help them to go examine what happened when they were four or five because it's actually irrelevant.*

While there is evidence to support the efficacy of using CBT to treat BPD (Linehan, 1993), there are now other treatment options which have been specifically designed for reducing the symptomatology associated with BPD. The fact that none of the participants except for one mentioned any of the treatment options currently shown to be most effective in treating BPD (Clarkin et al., 2007; Fonagy & Bateman, 2006; Paris, 2005b; Yeomans, 2004) suggests that there is a divide between research findings and clinical practice in terms of treatment of BPD. However, it should be noted that the one participant who is up to date with the latest treatment methods for BPD is the only participant working in a psychiatric hospital, a setting where she would encounter patients with severe forms of BPD far more regularly than any of the other participants. Thus it is imperative that she is up to date with current research findings on BPD whereas it is not as crucial for the other participants to be to stay up to date as they have fewer patients with BPD and it is likely that these patients have a less severe form of the disorder.

Four of the nine participants felt that the therapeutic relationship as a vehicle for change is more important than using a specific treatment methodology when treating a BPD patient. Participant M spoke of developing the therapeutic relationship as her primary aim when working with someone who has BPD.

*M: My number one aim with my borderline clients is developing a good relationship, a good therapeutic relationship so that, they've got to feel safe with me, so that for me will take precedence to anything else and if have to I will set aside anything else that comes up to make sure that is unchanged. Once I sense that they feel safe with me then I'll go to those deep and dark, difficult, scary places with them ya, I work very much on that and becoming much more aware of the transferences.*

Participant R also mentioned the importance of the therapeutic relationship and spoke specifically about the importance of establishing a sense of connectedness with the patient.

*R: It is my goal to enhance that feeling of connectedness using the therapeutic relationship as a vehicle for healing. So, therapeutically part of that is also a consistency in my behaviour, that no matter what they bring into the space, whether it's rage, the need to devalue, the need*

*to split, the desire to hurt themselves or if they've acted upon that and have hurt themselves. That my behaviour is, and my work with them is, consistent with a sense of wanting to connect with the person, wanting to connect with the person despite the injury and sometimes because of the injury.*

While participant R mentioned the importance of consistency, participant E felt that congruency was the most important facet of the therapeutic alliance with a BPD patient.

*E: Especially with a borderline you've got to be totally congruent, if I'm struggling to love you right now and you're really pissing me off, I'm going to tell you I'm angry with you because that's going to give them a model of how to deal with uncomfortable emotions. And I think borderlines, maybe this is what am I trying to say, they're probably more skilled at picking up when you're not congruent cos of their own sensitivity.*

*I: So for you an important part of working with BPD patients is honesty and congruency?*

*M: (nods) If they miss an appointment and I'm angry with them I'll tell them, that was very inconvenient for me, you can't do that, you know what I mean*

The above excerpts highlight the participants' belief in the importance of the therapeutic relationship as a vehicle for change when working with people who have BPD. Evidence suggests that the therapeutic relationship is associated with positive outcomes across different forms of psychotherapy (Spinhoven et al., 2007) but perhaps treatment of BPD would be more successful if the therapeutic relationship were used in conjunction with treatment modalities proven to be effective in treating BPD.

### **3.2 Personal experiences of clinicians - what it is like to work with people who have BPD?**

As stated in the literature review there is a stigma attached to the diagnosis of BPD. Mental health professionals are inclined to view BPD patient as being "manipulative" (Cauwels, 1992; Chitty & Maynard, 1986), "difficult" (Gallop, Lancee, & Shugar, 1993; Lewis & Appleby, 1988), "angry and noncompliant" (Everett & Nelson, 1992), and "hateful" (Groves, 1978). This section focuses on the participants' personal experiences of working with people who have BPD, to see whether their experiences are in line with the findings of research

which suggest that people with BPD are difficult patients (Clarkin & Posner, 2005; Ma, et al., 2008; Paris, 2005a). This section focuses on the countertransference experiences of the participants that arise when working with people diagnosed with BPD. Here the term countertransference denotes the clinicians feelings towards the patient that arise during the course of therapy. I also look at factors that seem to affect the personal experiences of the participants in their work with people with BPD. This includes the role of external support or supervision and personal prior experiences of working with BPD. Finally I address the general stigmatisation of BPD referred to in the literature review.

### *'The difficult client'*

Literature suggests that BPD remains stigmatized, with most mental health professionals avoiding or actively disliking their borderline patients (Gunderson, 2009). Research suggests this attitude of dislike towards people with BPD is pervasive among mental health professionals (Aviram, Brodsky & Stanley, 2006; Cauwels, 1992; Fraser & Gallop, 1993; Nehls, 1998; Schafer & Nowlis, 1998; Simmons, 1992). Some comments made by the participants reflect this dislike of working with people who are diagnosed with BPD. For instance, participant P admitted she would prefer not to work with someone who has BPD.

*P: If I had a choice of a patient, I would definitely choose not to work with borderlines, ya I think I do shy away from them.*

When participant P was asked why she would choose not to work with people diagnosed with BPD she shared that working with BPD patients can be “*overwhelming*” and “*taxing*”.

Participant A made a joke about ‘paying his dues’ when referring to working with people with BPD. The use of this phrase suggests there is something about the nature of working with people diagnosed with BPD that feels particularly difficult or challenging to participant A.

## EXPLORING CLINICIANS' EXPERIENCES OF WORKING WITH BPD

*A: Well you know I used to tease my colleagues that I never seemed to have to many borderlines in my practice, I was always wondering why they struggled. But in the last few years I seemed to have paid my dues more (laughs).*

Participant A also admitted that clinicians might hate their clients with BPD.

*I: You were speaking about clients with personality disorders being the type who you'll sit up at night and worry about.*

*A: They come into mind, they get under your skin.*

*I: So do you think there's more of a countertransference particularly with borderlines and that you do worry more about their health and safety than you might about other clients?*

*A: It's not about worry, I don't think, I don't think most clinicians worry about borderlines, they hate them.*

These excerpts show that participants P and A feel some reluctance towards working with people who have BPD. Participant A's comment suggests that there is something in the nature of the countertransference that clinicians experience as difficult. Participant G expressed her belief that people with BPD are only difficult and demanding when they are unmedicated or improperly medicated.

*G: Okay it's like borderlines... have quite a bad reputation when you think of them as personality disordered because of the personality disorders obviously they the most time consuming, most difficult and most challenging. But as I said I would not be able to work with borderlines not using medication. The thing with the borderline is when it comes to medicating a borderline it's like cooking, you're either a good cook or you're not a good cook because you can just feel it, you can taste it, and you just know. And if you don't have that feeling then borderlines will be your worst nightmare, they'll be your headache of all headaches because then they will become demanding, then they will become extremely draining on resources and things.*

Participant E highlights the idea that the term 'borderline' has become synonymous with difficult clients and that clinicians might over-ascribe borderline pathology to clients whom they find difficult to treat.

*E: I think it is over-used by certain therapists, I have probably over-used the term myself sometimes, just to help explain the real, what's the word I'm looking for, recalcitrant.*

*I: So the difficult patient becomes the?*

*E: The difficult patient becomes the borderline, ya*

The reasons that participants gave for finding working with people with BPD difficult varied. However, one common reason that participants cited was that they felt that people with BPD required more work than other clients. The reason for this seems to be a shared sense that people with BPD need more from the clinician in terms of emotional support and containment, meaning that they take up more time and energy than other clients and this then plays a role in why they are viewed unfavourably. In the excerpt below participant P speaks about people with BPD being tough to work with because they take up a lot of energy and are more needy than other clients.

*I: What's it been like working with people diagnosed with borderline personality disorder?*

*P: My experience of working with borderlines is that I find them tough to work with because they take up a lot of energy and they need very firm boundaries. So in an inpatient setting they often do quite well, because they've got quite firm boundaries but as a clinician you also need to implement those boundaries. For instance having regular sessions, shorter sessions, because they seem to be that much more needy than other clients.*

Participant P also spoke about not working with too many clients who have BPD at any one time because it would leave her feeling overwhelmed.

*P: I think just in terms of patient load, so if you've got a patient load of five and you've got one or two borderlines it feels overwhelming, so I think in the context of an inpatient setting it is, it feels a lot more taxing. Whereas I think it would be different if I was in private practice or so, where it would be, there would be more space.*

In this excerpt Participant P mentions that if she were working in a private practice she might not feel so overwhelmed. Participant A, who does work in a private practice also makes reference to not having too many people with BPD as clients at any one time as it will lead to burn out as a result of their continuous acting out.

*A: The rule of thumb in the field is that, for psychiatrists and psychologists, you don't want to have more than one or two borderlines in your practice at a time because they'll burn you out.*

*I: Why them more than others?*

*A: Just cos they keep acting out. You know you can have a borderline who will send you ten emails a day or phone you five times or you know you'll come to work with like ten messages on your answering machine, nobody else does that.*

Participants P and A refer to feeling overwhelmed and burnt out when working with too many BPD patients at one time. They suggest that they can cope with working with one or two people diagnosed with BPD at a time but that more than that would deplete them and leave them feeling stressed and unable to cope. Part of the reason that the participants felt they would be unable to cope with too many BPD patients at a time is because there is an idea that working with people who have BPD is more time-and-energy-consuming than working with non-BPD patients. Seven of the nine participants made reference to the demanding nature of a patient with BPD and how they felt as if they were required to give more of themselves as a result.

Literature supports the finding that clinicians experience clients with BPD as more demanding of their time and energy than other clients (Gallop, Lancee, & Shugar, 1993; Lewis & Appleby, 1988; Swift, 2009a). In speaking of an experience working with someone diagnosed with BPD, participant T said that *'it was a lot of effort and a lot of energy, and I felt as if they would suck me dry.'* This statement shows how participant T experienced the demands of his patient as inexhaustible and in response he was left feeling *"a real sense of hopelessness... I would sit up at night and think about it and what do I do differently and am I a bad clinician."* Participant S referred to a similar experience, where she spoke of *"the sense of futility that no matter how much I give this patient it's never going to be enough, it's never going to make it better."* Not only does participant S express the idea that *"it's never enough"*, she also alluded to the feelings this aroused in her. Literature has shown that

clinicians may experience feelings of hopelessness, futility, inadequacy and desperation in response to the immensity of need that is often exhibited by people with BPD (Bland & Rossen, 2005; Conklin & Westen, 2005; Cleary, Siegfried & Walter, 2002).

Six of the participants also felt that their clients with BPD were more likely to require time and thought outside of the therapeutic frame. Participant J expressed her belief that 'more' was demanded of the clinician when working with a client who had BPD.

*I: And that stepping outside of the boundaries, outside of the normal therapeutic frame, is that something that you experienced when you were working with borderlines?*

*J: I think that it's sort of asked of you, it's demanded of you much more than it would be demanded by somebody else. So I would be more inclined to do it for them because they would be so desperate for it and so for example you know going to the emergency unit, that would be more for a borderline patient than for anybody else, in my experience.*

*I: Has that happened to you?*

*J: Mmm (nods) ya, ya or just phone calls and sort of intrusiveness into the therapist's life outside of the therapy.*

Participant J refers to an 'intrusiveness' on the part of the client that brings the client into the clinician's life outside of the therapeutic frame. Participant A also spoke of the tendency of people with BPD tending to 'spill out' of the frame and how difficult it is for him to hold the therapeutic frame with his clients who have BPD.

*I: So it sounds like you're saying that borderlines demand more from the therapist perhaps than other clients do.*

*A: Definitely and they also, the trouble is the nature of the acting out, you know it's that you never know, you know they might just not pitch up at the session. Now have they committed suicide, are they in hospital, are they just cross with you, are they, you know and then you know you'll phone them and they just don't answer their phone and they don't get back to you and you know you're sitting there thinking you know are they going to come next session, should I hold their next session, don't I hold their next session, you know where's the frame. Ah, so you're, you're left with clutter which other patients don't leave you with, stuff is tidy, tidier. You know what is dealt with is in the frame of the session, you know with a borderline it spills out everywhere, so that constant acting out ah you know it, it wears you down, it wears the frame down, ah it's, it's difficult to maintain that. Now if you have too much of that ah it will burn you out as a therapist, it's just unsustainable.*



While participant A seemed to feel that making extra time available outside of therapy was problematic because he has a heavy patient load and does not have time to spare working outside of therapy, participant M spoke of making extra time available to her clients who have BPD in a manner that suggested she did not find it much of an inconvenience.

*M: I have a friend when I was doing my master's thesis she actually said with borderlines it's sometimes important to give them a once a week spot in between sessions where they can just phone and make connection. I remember that and with some of my clients I do that. I don't have a special time but I say to them you're free to send message me or to sms me and when I can I will respond. So in between one or two of them do that so they can say hi mom how are you and when they do that I go right back into it for the duration of the phone call, 5 or 10 minutes but then I'm able to actually again set it aside. I'm able to do that quite nicely, to be right in it but then to put it aside and be right there in the next one, so I can see clients in a row and it's almost as if you're in a different, almost family set up each time.*

Participants S, P and A cited the high degree of emotional dysregulation and excessive emotionality as reasons for why they found working with people with BPD difficult.

Participant A spoke about not being able to understand what her client was going through because her own subjective emotional experience was so different from that of her client.

*S: I think I remember saying to my supervisor at the time that I didn't get what she was going through subjectively. So my understanding of someone who, for example might be struggling with depression or with anxiety, was easier to understand their subjective experience only because in ordinary day life we all experience anxiety at times or you know our mood drops. So that gives you some sense of what they might be going through, but with her I really didn't know what subjectively was going on there. And because her descriptions and the way that she presented was quite dramatic, though not all patients are like that, and because she would be so vividly upset and distressed about things that I couldn't understand, I couldn't connect her distress to what she was telling me caused the distress and I think that was my bewilderment, I wasn't quite sure how to respond to her really.*

Participant P spoke of similar experiences when working with BPD clients which left her unable to connect empathically with her clients because their emotional experiences were so different from her own.

*P: I think what really strikes me first and foremost when working with a borderline is when they feeling an intense emotion that I as a therapist often don't feel it. So they'll be raging or*

*they'll be like crying and I actually feel nothing. So that often tells me that I'm with a borderline because I ya I don't feel moved in the same way that I do with another client.*

*I: So the intensity of the emotion doesn't match the context in a way.*

*P: Hmm very much so, so immediately I note that if those are my feelings then often that's what I'm working with. Ya, which also makes it harder I think as a therapist because there isn't that same degree of empathy that you have with other clients because the emotional intensity out ways the event and it feels histrionic often so that there's a sense of not being authentic.*

Another factor which may impact on why people with BPD are seen as being difficult to work with is the difficulty they have in establishing trust in relationships (Unoka, Seres, Aspan, Bodi, Szabolcs, 2009). Three of the participants, such as participant S felt that the difficulty in trusting easily meant that the work takes longer as one has to work longer and harder to establish a therapeutic alliance with the client.

*S: Ya in terms of building a therapeutic relationship it's always harder (laughs) it takes much longer because there are very clear issues around trust and that people are potentially harmful too.*

Participant M also felt that developing the therapeutic relationship may take longer with a BPD patient because they are very sensitive to any perceived rejection by the therapist.

*I: Do you find that it takes longer to create the space with borderline clients than with other clients?*

*M: Sometimes, you have to be that very much more, because they are very sensitive, generally borderlines are very sensitive to rejection, very sensitive. Not having had enough parenting one has to be very careful with rejection. Like if I'm off one week or I'm on leave or I might make some comment that they interpret as they're not good enough.*

Difficulty in trusting others and a fear of abandonment are hallmark features of borderline pathology (Kaehler & Freyd, 2009; Paris 2005a), and are often responsible for the difficulties people with BPD have in interpersonal relationships. Therefore it is not surprising that these factors would hinder the development of a therapeutic relationship with a patient that has BPD.

In summary the participants ascribed multiple reasons for finding working with

people who have BPD difficult. Among these reasons participants felt that people with BPD were less trusting, had higher degrees of emotional dysregulation and were more needy than other clients, in that they required more emotional containment both inside and outside of scheduled therapy time. This meant that participants often experienced difficulty in holding the therapeutic frame with BPD clients. Two participants mentioned experiencing a difficulty in forming an empathic connection with patients who have BPD because their emotional responses are often histrionic and out of proportion to life events.

### **Factors that mediated participant's experience of difficulty in working with BPD patients**

The data suggests that the participants found working with people who have BPD to be at times difficult and challenging. However, the data also reveals a number of factors that seem to operate as mediators in the clinicians' judgement of the client as difficult. These factors include support for the clinician, previous professional experience and an understanding of the nature of borderline pathology.

#### ***Support***

Two thirds of the participants spoke of the importance of having additional support when working with people diagnosed with BPD. For some this support comes in the form of working in a multidisciplinary team. The excerpt below relates an anecdote where participant P, who was at the time an inexperienced counsellor, struggled with a client diagnosed with BPD.

*P: Ah, ok well for instance I had a client, that her name was \*Susan and she was clearly borderline and for instance (sighs) the splitting is very prevalent with borderlines so it's necessary to cover your tracks in every regard. So for instance we were working on her relationship with her mother and one of the recommendations was, because there was a very enmeshed relationship with her mother was that she put in a boundary with her mom and then she bought into the whole concept that actually this was good for her therapeutically. But then when she got on the phone to her mother she said "P says we need to have no*

*contact. "Well I was a fairly new counsellor and it was my first real quite hectic borderline so I found myself being quite surprised because I had made it so clear that it was, that she had brought into the concept. So I was very surprised when the mother was on the phone and wanting to, you know, speak to me and 'how dare I' and all of that. Thank goodness the team were there they helped me to see how that it certainly a common occurrence and that it's nothing unusual but without the help of the team around me I think I would have been a bit more flummoxed. But I had the backing of my supervisor and ya and the whole team to work with it ya... Well it did end up feeling a bit like a personal attack because I had the mother calling in to speak to the clinical director and wanting to fire me (laughs and shakes her head). But it was as I said only having the insight of the team like around me really helped because they like see it from the distance but, ya no it, it was hard, particularly as a fairly new counsellor to deal with that.*

Participant P felt that throughout this event the team she worked with was a source of support, which acted as a buffer from the occurrence feeling like a personal attack from her client and the client's mother. The team allowed participant P some relief from the difficulty of the occurrence and as such mediated her experience of her client being difficult. While other participants did not work as part of a team they made reference to other forms of peer engagement as being important forms of support that help them deal with the difficulties that arise in working with people who have BPD. Participant A spoke about the fundamental importance of receiving support in the form of supervision when working with people who are diagnosed with BPD.

*A: The most vital ingredient in working with these sort of patients is your ongoing contact with your peer group, a reading group as in theory but also and probably more important like a peer supervision group or individual supervision and hearing cases yourself, peer groups very important cos you hear other people's cases and you reflect on and the best way to learn is to teach as well.*

Participant S also felt that support is an important aspect of working with BPD.

*S: you need support if you're going to do this work and sometimes I think maybe we're not wanting to acknowledge our own vulnerability, not wanting to say you know that I actually need support and I need to validate that in other people who work with these patients and as soon as you realise that maybe your vulnerabilities are going to come out then it's not so scary.*

Participant S's comment on the role of support suggests that at times clinicians may find it difficult to ask for help or admit they need additional support. She goes on to say that admitting one's vulnerabilities allows the clinician to be less defended and therefore less likely to blame the client for the difficulties in the therapeutic relationship. Participant R spoke about "a kind of internal supervision" that for her meant "being aware of what my feelings are after a session and sitting and giving myself the opportunity to actually do an internal debriefing before the next session." Many of the participants shared the view that support was crucial when working with someone diagnosed with BPD. They offered different ways in which support could be provided such as by working in a team, or being part of a peer supervision group or even relying on one's internal supervisor. Regardless of the manner in which support was given it seems that it provides clinicians with a means of diffusing the difficulties that arise when working with people who have BPD.

### ***Professional experience***

Another factor that seemed to mediate whether or not the participants experienced BPD patients as difficult was their prior, professional experience. Some of the participants felt their capacity to effectively treat patients with BPD was partly determined by their previous experiences of working with people with BPD. Participant M spoke of her prior professional experience as providing her with a better understanding of the needs and requirements of a patient diagnosed with BPD.

*I: Do you think the way you work with borderlines now is different from the way you started off, has there been a shift?*

*M: I think I have much more awareness now... I think now I have much more of a deeper understanding of needing to provide that missing parent relationship.*

Participant M mentions having more awareness of the needs of her BPD patients than she did in the past, which allows her to meet their needs in a conscious, deliberate manner. While participant M's excerpt suggests that her prior experience of working with BPD has allowed

her to gain insight into the disorder, participant E felt that his prior experience provided him with stamina that he previously did not have.

*E: Well the ones [BPD patients] that did exhaust me probably go back to more than five years ago. I can't actually think of any recent experiences where a borderline exhausted me because they don't exhaust me anymore, although they sometimes frustrate me a bit.*

Participant E didn't mention why it is that he no longer feels exhausted from working with BPD patients but he did comment that having unrealistic therapeutic objectives with a BPD patient can leave one feeling overwhelmed and drained. Perhaps clinicians begin their career with optimistic ideas of the degree to which they can help others and generally these ideas are tempered by experience. Therefore, it is possible that participant E no longer feels exhausted by his BPD patients because he is no longer trying to achieve "unrealistic therapeutic objectives" with them.

Participant A differed from participants M and E in that he felt that his prior experience of working with people with BPD makes the work slightly harder because he is now more aware of all the things that could go wrong.

*I: I guess what I'm wondering is, if with experience it's become easier to work with people who have BPD?*

*A: It hasn't become easier, I've become better at it, in fact I probably think it's become more difficult cos one can see too much ahead. So when I was beginning it was easier... but you know now I can see too much of what's coming and where it's been and, the stakes are much higher.*

*I: Meaning?*

*A: Meaning I can see how on a knife edge these things rest, you know when I was naive I was blissfully naive. Whereas now I can see when I'm working with a borderline, it's such a fine line and the risks are so high actually that you know it turns the notch, it turns it up a bit. The thermostat goes up because of having to think that bit more and you get a more mindful, you get a bit more careful instead of blundering through and hoping for the best. One's aware of everything, you know I suppose it's the equivalent of an experienced surgeon, he's much more aware of everything that can go wrong than a beginner surgeon and so you know it turns your stress up not down, even though you're better at managing when things go wrong.*

Participant A speaks about how his prior experience of working with BPD patients has primed him for predicting what lies ahead and this leaves him feeling that the stakes are higher because he is aware of the risks that are involved. However, he also adds that he feels more able to manage things when they do go wrong. This suggests that his prior experience has equipped him with an improved capacity to manage occurrences in the therapeutic relationship with a client who has BPD.

### ***Participants' conceptualisation of BPD***

The analysis of the interview material revealed that the way in which the participants conceptualised BPD mediated the degree to which the participants found people with BPD difficult to work with. It seemed that for two of the participants their experience of the patient as difficult was tempered by their theoretical understanding of the psychological difficulties people with BPD face.

*I: How do you find working with people who have been diagnosed with borderline personality disorder?*

*R: It is challenging, there is no doubt that there is a lot of holding that is required in terms of psychological holding. There's a lot of content that comes into play with the borderline personality in terms of the amount of chaos and the amount of splitting that's occurred. A lot of things come into play that really demand a focus on the person and the injury cos it's easy to get caught up in the content, and they will often come in with a great deal of content and the content is very compelling. So the challenge for me is to keep dealing with the underlying process and because there's usually been injury at an early stage of development.*

Participant R conceptualises BPD as an “*injury to the self*” that is the result of trauma and/or abuse experienced in early childhood. Her manner of conceptualising BPD seems to leave her feeling sympathetic towards people with BPD and allows her to ascribe the challenges she experiences when working with BPD patients to their illness rather than to the individual. In a similar manner participant M's conceptualisation of the neediness commonly displayed by people with BPD meant that she does not find such behaviour problematic.

*M: My experience of borderlines is not negative, it's just I like to use the word needy, they're very needy, emotionally needy, but I don't see it as problematic. I don't see it as something mean... So I see them as needy but I don't see them as oh borderline, oh trouble, I don't do that which was the impression that was created for me when I was a student.*

Despite the fact that participant M was exposed to the stigma associated with BPD patients in her training she does not currently experience BPD patients as difficult, even though she admits they are needy. Excessive neediness is commonly associated with BPD patients and is cited in literature as one of the reasons that clinicians do not like working with people who have BPD (Clarkin & Posner, 2005; Paris, 2005a; Piccinino, 1990). Interestingly participant M is not bothered by the neediness displayed by BPD patients because of the way she understands this particular symptom.

*M: The borderline people are usually the ones who for whatever reason did not get enough parenting, so in the therapeutic relationship I'm there to provide for the extra parenting that they didn't have. Now if children need mothers attention you can't say to them oh well I'll give you the attention next week on Thursday, you have to give it now and I feel that in the beginning stages of therapy the borderlines all go back to childhood and if you're in child mode you need your mother. If your mother is not available you can't feel safe, you can't feel secure, you can't feel loved... As the therapist-mother I need to be the container of their feelings and if I do contain them and it happens to be Tuesday evening instead of usual session time then for me it's part of my role as the mother-therapist.*

Participant M understands the neediness shown by BPD patients as resulting from not being given enough attention during childhood. As a result she feels it is her job to provide the additional attention BPD patients require in order to provide a reparative experience.

To summarise, the analysis of the interview material suggests that the participants experiences of BPD patients as difficult is mediated by the amount of professional support they receive, their prior experiences of working with BPD patients and the manner in which they conceptualise the disorder and its related symptoms.

### **Stigmatization of BPD**

The stigma associated with BPD is well documented (Aviram, Brodsky & Stanley, 2006;



Cauwels, 1992; Fraser & Gallop, 1993; Gallop, Lancee and Garfinkel, 1989; Nehls, 1998; Schafer & Nowlis, 1998; Simmons, 1992). This phenomenon was explored with the participants, querying whether or not they were aware of the stigma surrounding BPD and if so, how it affected their experience of working with BPD patients. All of the participants admitted that they were aware of the stigma BPD patients carry as difficult patients.

*I: In terms of working in the field of psychology and coming across other clinicians who work with borderlines, what do you think is the general perception that people have towards borderlines?*

*M: I can only go from my experiences when I was doing my internship cos from that, my internship year was the year that we first had regular supervision two or three times a week, and we got together with groups you know and I got a very negative impression of working with borderlines. It was 'oh she's borderline', 'oh god useless', and 'oh god I'm tearing my hair out borderline.' So my impression of borderlines was a very negative one cos of the lecturers, not students. Lecturers and sometimes students latched onto that saying the thing about borderlines, they're the one kind of clients that a) you don't want and b) if you get them they're going to be hard work.*

Participant M shares her experience of colleagues and staff in positions of authority expounding the notion that BPD patients are hard work and frustrating. Participant M also describes how she was left with a negative impression of BPD patients before she had even worked with anyone diagnosed with BPD. Participant S shares a similar example where during her training she became aware of the negative connotations associated with BPD.

*I: In terms of your colleagues, have you picked up from them any presuppositions about what it means to have a client who's borderline before you begin to work with them.*

*S: Oh ya, from right from when I was training there's always a whole lot of connotations associated with that term but I don't think that it's always used with a deliberate attempt to be punitive. I think that sometimes it's a way of coping, if I can use that word, a way of just carrying some of the anxiety or carrying some of the emotions that come up around working with these patients.*

Participant S's excerpt suggests that she understands that the stigma associated with BPD patients as a defensive strategy employed by clinicians to help them cope with the anxiety

that arises when working with someone with this disorder. Participant G also mentioned being aware of the stigma surrounding BPD.

*G: I mean when I was studying a lot of people used to go 'ag borderline', 'basket case' and 'throw them into the basket'. I mean I'm sorry to say that about my own profession but it's a fact. Okay it's like borderline can't cope and they had quite a bad reputation when you think of them as personality disordered because of the personality disorders obviously they the most time consuming, most difficult, most challenging.*

Participant R also alluded to being aware of the stigma associated with BPD, although she didn't comment on how she had come to know of this.

*I: Are you are aware that borderlines have a reputation of being difficult to treat?*

*R: Ya, oh yes*

Whereas participants M, S and G ascribed the stigma of BPD to their training and colleagues, participant J felt that the stigma arises from clinicians personal experiences of working with BPD patients.

*I: there seems to be a sort of common perception of borderlines as being difficult patients I'm not sure if that's something you've heard in the field?*

*J: Oh definitely ya, ya.*

*I: Where do you think that comes from?*

*J: It's from people's experiences of working with their borderline patients.*

The above excerpts indicate that the participants were aware of the stigma attached to BPD, though the ways in which they made sense of this differed. The participants' response suggests that the narrative of people with BPD being difficult patients is pervasive among mental health professional and prolific right from the time of training. The concern is that clinicians are forming preconceived notions of patients before they have even begun to interact with them and while it is true that there may be some particular difficulties in working with BPD patients, labelling all people with BPD as difficult assigns individuals with this disorder into a group that determines how they will be treated regardless of the

idiosyncratic nature of their illness.

It has already been stated that there is a stigma associated with the diagnosis of BPD and that clinicians find BPD patients to be difficult, demanding, manipulative and non-compliant (Cauwels, 1992; Chitty & Maynard, 1986; Everett & Nelson, 1992; Gallop, Lancee, & Shugar, 1993; Lewis & Appleby, 1988; Groves, 1978). One must then consider the feelings that clinicians experience when working with BPD patients and whether such feelings further entrench clinicians' dislike of working with BPDF patients.

### **Transference and Countertransference**

The terms transference and countertransference were coined by Freud as theoretical explanations of the relational dynamics that occur within psychoanalysis. Freud used transference to describe the phenomenon that occurs in psychoanalysis where a patient unconsciously relates to the therapist in a way that mimics their other critical intimate relationships. He conceptualised countertransference as the psychoanalyst's displacement of emotion onto the patient. Originally these terms were specific to psychoanalytic theory and used as theoretical explanations for the dynamics of the therapeutic relationship. Today however, they are commonly used by many mental health professionals who are not psychodynamically orientated as a means of describing the feelings that both the patient and clinician experience within the context of the therapeutic relationship. Transference and countertransference have become synonymous with the patient's and therapist's feelings towards one another as they arise therapy. (Eagle, 2000). For the purposes of this study the terms transference and countertransference will refer to this broader definition of these terms.

Studies show that transference and countertransference issues are a salient feature of the therapeutic relationship with a borderline client (Hinojosa Ayala, 2005; McHenry, 1994). Literature suggests that part of the reason clinicians find working with people who have BPD difficult, is because of the intense nature of the transference and countertransference in the

therapeutic relationship (Gabbard & Horowitz, 2009). Literature suggests that the quality of the transference and countertransference between clinician and BPD client is intense and elicits strong feelings on the part of both therapist and client (McHenry, 1994). Many of the participants in the study spoke of a strong transference and countertransference experience in their work with people who have BPD.

*T: It's just the transference and the countertransference that I got from this guy was just unreal. The attack that he gave me was like being hit by a ton of bricks and it's not the words but the way that he says things, that's the most difficult thing. And a part of me sort of bought into it and I was scared to go into a session with him because it was fear of where he was going to take it, you know all his anger would come out at me.*

This excerpt highlights how participant T, a male social worker working with a male client with diagnosed with BPD and comorbid substance dependence, experienced feelings of fear in response to his client's aggression. The aggressive response of his client may be understood as a transference phenomenon, where his rage towards his father was redirected towards participant T. The excerpt shows that participant T felt uncomfortable being on the receiving end of such strong emotion and that he did not confront his client because of his fear of the "anger that would come out at him." Gabbard and Horowitz (2009) speak about the dilemma of the therapist in using a transference interpretation with a client who has BPD because such an interpretation may be experienced as a form of criticism and may arouse strong feelings from the client.

Participant T spoke of his experience of his client's transference as an 'attack', participant R spoke about finding it difficult not to feel as if she was under personal attack from her clients who had BPD.

*R: Well it can be really tough, there were times when I cast my mind back to the first few cases when I felt punished. When I say punished it was a sense of having a lot of stuff projected onto me and having to really create the space to unpack that for myself so that I didn't carry that through in terms of my countertransference and wanting then to punish the person in return. So there were times that I felt really overburdened because of the very high*

*level of neediness and the lability of the emotions, the unpredictability, the unpredictable nature of it, these things certainly in the beginning of my work with borderlines I found really hard to deal with and hard not to take personally. So ya it was very challenging at times to not take it on as a personal attack.*

Participant R's account is a candid response about feeling punished or attacked by her clients and having to resist the urge to punish them in return. Aviram, Brodsky and Stanley (2006), speak of the difficulty clinicians have in maintaining the view that the problems that emerge within the therapeutic relationship with a borderline client reflect the nature of the pathology rather than the nature of the individual. They caution that if clinicians come to see their clients with BPD as 'the problem' they will be more likely to condemn their clients.

Participant R's admission that she found it difficult not to take her clients' responses personally speaks to this very difficulty of seeing the client's 'difficult' behaviour as a symptom of the disorder. Participant A also refers to this challenge:

*A: and so you know it's hard to feel empathy for those patients because they break you down and then after a while no matter how much you recognise where that comes from what that tends to do is evoke a lot of anger in you.*

Literature shows that people with BPD often leave the clinician feeling inadequate, afraid or attacked (McHenry, 1994). Participant S shares an example of his feelings.

*I: How did that leave you feeling?*

*S: Oh all the typical things, inadequate, failure, not able to help confused feeling like you know I was doomed if I did and doomed if I didn't (laughs), between a rock and a hard place. All of those emotional situations that the patients that have this diagnosis have probably experienced themselves the whole way through their lives. Ya, the sense of futility that no matter how much I give this patient it's never going to be enough, it's never going to make it better. So all of those themes you know came out and it was about learning that that had more to do with my patients' experiences than it had to do with maybe me as a therapist.*

McHenry (1994) argues that the nature of the transference and the types of defences typically used by clients who have BPD encourage the clinician to act out his or her own unresolved identity issues with the client. This then leads to mutual acting out on the part of the clinician

and the client within the therapeutic relationship. This acting out may take many forms and be experienced by the clinician as a personal attack through which he/she is made to feel scared, incompetent and angry. The client with BPD evokes not only profound affective responses from the clinician but also brings into question their personal identity of 'caring, compassionate healer' as well as their efficacy as a therapist.

However, it should be noted that the countertransference experienced by clinicians is not always of a negative type. Patients with BPD have a tendency to idealise their therapists at certain points in the therapeutic relationship and this can be a gratifying experience for the clinician (McHenry, 1994). In the following excerpt from participant J, she speaks of the protective feelings she experienced as countertransference in the therapeutic relationship.

*I: Do you think that the counter-transference experience is of a different nature with clients with borderline?*

*J: It's usually very intense so it's you know it might be very protective, it might be very bonded and very protective of the patient. So it's not necessarily negative but it's demanding, it's that I've got to look after this patient and they need a lot from me.*

Literature suggests that clinicians who have unresolved narcissistic, co-dependent or nurturance issues will typically respond in a number of ways that collude with the patient's splitting, and avoidance of pain (McHenry, 1994). An example of this also comes from participant J where she relates an incident that occurred during the course of therapy with a client who had BPD.

*J: There was somebody who took an overdose and went into the emergency unit. I did arrive there after a while and she said that she was very traumatised, because she felt that she'd been very badly treated by the nursing staff and the medical staff. It felt very unacceptable the way that she said that she'd been treated and I sort of saw a little bit of that myself but I didn't see the whole picture. And then she asked me to write a letter to the hospital complaining about them and describing them, and I did. The medical person that was involved phoned me and told me her side of things and told me that she didn't like what I had done because it had caused some trouble you know for her and for the nursing staff. And I must say I thought about that after that and I thought that maybe that was wrong because I went along with my patients view on it and maybe her view on it was clouded, her judgement*

*was clouded because she had just taken an overdose and had other access to pathology. So maybe I shouldn't have taken her word for it and I should have been a little bit more cautious about hauling other staff, medical staff and nursing staff over the coals because I mean I wrote to the medical superintendent complaining about the way my patient was treated.*

This example highlights how participant J's countertransference response of nurturance and protection was elicited by her client's need as she felt she had to protect her client from the hospital staff and help her to "get back on her feet." If one looks objectively at this example it is curious that the clinician felt her client needed protection from the hospital staff who weren't treating her well, rather than from her own self-injurious behaviour, which had landed her in hospital. Her client successfully engaged participant J's nurturing side which then led to a collusive avoidance where the focus of intervention became the client's mistreatment in hospital rather than the reason she was in hospital in the first place.

Participant J had the experience of being nurturing and protective in response to her client's needs and termed the transference and countertransference to be positive in this relationship. She said that: "*she had a positive transference and my countertransference was also positive actually, ya I felt very sorry for her, everything she was going through.*" Even though participant J felt the nature of the transference and countertransference was positive, it resulted in an enactment in which the clinician and client colluded in order to shift the focus away from the client's own emotional pain.

It is common for clinicians to feel concern about losing their clients with BPD, either to suicide or through terminating therapy. Wheelis and Gunderson (1998), explain this as a form of projective identification in which the clinician displaces the client's abandonment concerns through reassurance about the client's specialness. An excerpt from participant M reflects this type of countertransference experience.

*One client, my instinct kept telling me that I must tell her she's special. But she didn't believe she was special, which is often the case with borderlines who have very poor self-esteem and she had a mom who was an alcoholic and she was constantly trying to rescue her mom and her sisters who all went wild in their own way and couldn't really look after mom... She was*

*actually the special one cos she been looking after her mother, you see now why she's special... I kept thinking this women is special, she's the kind of women that if she wasn't my client I would want to socialise with her, I would want to have coffee with her, I would want to go to the movies with her, she really special. I felt this really strong sense of wanting to get to know her you see. So obviously it's not appropriate, I knew that it's not appropriate. But how could I tell this women that she's special? I knew that she was special and I thought that if I tell her am I bringing my own stuff in, which is that I really like her and I want her to be my friend. I wouldn't have used that language but that's how it felt, but my instinct was saying you've got to tell her she's special and I started saying that. I said you're such a special person and she kept saying that you're only saying it to me because you know I don't think I'm special and you want me to believe it by saying that.*

This extract exemplifies the type of projective identification that Wheelis and Gunderson (1998), feel is common in the therapeutic relationship with someone who has BPD.

Participant M's client couldn't experience herself as special and therefore needed participant M to own her specialness for her. In such an interaction both clinician and client may feel gratified as the client is able to temporarily displace their concerns about abandonment and clinicians experience themselves as meeting their client's needs. In speaking about the same client participant M mentioned an incident during therapy where her client considered terminating due to her mistrust of participant M.

*I could feel as a therapist I knew what was going on and I could feel the sadness for her and I so wanted her back, almost like a mother wanting her daughter back but I couldn't say please come back I know I can help. I couldn't do that, I had to let her experience the anger and the distrust and all I could do was say okay I understand that you're upset when you're ready I'll be here. And by understanding her, it was more important that I understood she didn't believe me rather than to say come on you know I'm not going to do it to you like a bad mother, but the pain that I felt, the pain I felt like a mother who's lost their daughter, like their daughter no longer wants to have anything to do with her that was very strong both transference and countertransference ya.*

Participant M uses the metaphor of a mother losing her daughter to describe the way she felt when her client stopped coming to therapy. This shows the intense nature of the transference and countertransference in the relationship. When asked about the nature of transference issues in working with people with BPD, participant A spoke about erotic transference. He



was the only participant in the study who made specific reference to erotic transference as a salient feature in the therapeutic relationship with a BPD patient.

*A: And at times, as in the In Treatment series, it can be very erotic, so borderline patients can act out erotic stuff. Ya and I think particularly with borderline women it's much more difficult because if you got a borderline male patient acting out the erotic stuff and transferences, there's a shared knowledge actually that it doesn't play out in any way, with a female therapist obviously.*

*I: How, how, how come?*

*A: Mm, cos just culturally the perimeters are just much more defined. A male patient is not going to get up off his chair and you know grope you in a session, even if he wants to. A male patient can feel much more free to share his sexual fantasies about you but in the knowledge that you going to say look this is where the line is. But with a women borderline again it's much more ambiguous... Ah, with a female patient who's in love with a male therapist when she feels scorned it then triggers unbelievable rage which can get dangerous. So I know of borderline, female borderlines who will report the male therapist to council or threaten to.*

### **The Positive Side**

While the bulk of this study has focused on why clinicians experience people diagnosed with BPD as being difficult to work with, the interviews revealed that participants also felt there are positive aspects to working with people with BPD. Each of the participants mentioned an aspect of the work with BPD patients that they felt was positive or enjoyable. Participant T felt that he enjoyed the chaos and darkness associated with his BPD patients that in some way allowed him to live vicariously through them.

*I: You mentioned just now some aspects of enjoying working with borderlines, can you tell me a bit more about that?*

*T: I suppose it's the challenge and it's the chaos that they bring with, I like the chaos (smiles) I suppose also I find the darkness that they bring into the room quite appealing, you know that some of the scary things that they do are exciting. So in some ways I suppose you can live vicariously through them. I like that but it's a challenge, you know it's the constant what's going to come next, how do we deal with this, what do we do with this next behaviour, how do we manage this? So that's the exciting part, the chaos you know because it can be so challenging and there's so much you can work with.*

Participant G felt she enjoyed working with BPD patients because they are often dynamic and creative individuals.

*G: I love borderlines cos I find them interesting, challenging, everyone's different, subtle nuances, I mean what I've given you is like a very raw kind of broad template to work off but subtle nuances you find in each one of them. I find borderline patients incredibly interesting people. They very dynamic often, very creative, a lot of them are you know because of their creativity and all of these things they're in different kinds of industries, you know to say maybe accountants. Very rarely will you find an accountant to be borderline (laughs) okay.*

Participant J also reported that she found patients with BPD to generally be interesting and colourful individuals

*J: It can be very rewarding because they're not defended in the same way that other patients might be defended. So they're usually very in touch with their distress and sometimes very intelligent and so they're often very nice to work with, very satisfying to work with and interesting and the opposite of dull (laughs), colourful. There is also something rather nice about the connectedness of working with somebody like this, you know they can be very deeply connected to you in the transference and because they leap into trust they can really sort of bare their soul to you in a way that a much more defended person wouldn't. So it can be, it can feel like very powerful work although they doing before they're ready a lot of the time (laughs).*

Participant P felt that certain patients with BPD were a source of inspiration to her because they triumphed over their difficulties and even went so far as to assist others in doing the same.

*I: We've spoken about some of the difficulties and challenges in working with borderlines, is the, do you have any positive experiences from your work with them?*

*P: Ya absolutely, I think they are a challenge but I think also when they get certain concepts like that girl I described that's doing really well for two and half years. I think it's really inspiring to see how she's working her recovery and it's a testimony to the fact that she's deeply troubled yet she's working on it every day and keeping sober and not acting out and it's I think it is inspiring. Cos I think it is quite traumatic to be borderline, very traumatic for them I suppose. So ya and also noticing how, how she's sponsoring others and other borderlines as well and that she's doing phenomenally so that's definitely very inspiring to see.*

These excerpts suggest that despite the challenges that mental health professionals face when working with people diagnosed with BPD there are also rewards that come from the work. Participants P, G and J all referred to the enlivened nature they associate with people who have BPD and how they tend to be colourful, creative people who are dynamic and passionate. Participant J also referred to the level of connectedness that people with BPD can achieve with the therapist that allows them to “*bare their soul*” in a way that inspires empathy and a reciprocity of connectedness on the part of the therapist.

Literature suggests that people with BPD make up 15% to 30% of the primary care population (Schafer & Nowlis, 1998) and that people with BPD out of all personality disorders are the ones who most frequently present to mental health services (Moran, 2002). Therefore most professionals working in the sphere of mental health are likely to come across a person with BPD at some stage in their career. Thus there is a need to understand the challenges of working with people who have this diagnosis and in a sense to find a way to move beyond the challenges the work presents. Part of moving beyond the challenges is to hold onto the positive aspects of working with people with BPD.

## CHAPTER 4: CONCLUSION

The aim of this study was to explore the experiences and perceptions of clinicians working with people diagnosed with BPD. The exploration of their experiences can be divided into three main categories. The first category was the participants' working knowledge of BPD and this included their thoughts on the aetiology, clinical presentation, treatment and prognosis of the disorder. The second category focused on the participants' personal experiences of working with people diagnosed with BPD and the feelings that they experience in response to BPD patients. Finally the third category focused on the impact of the apparent stigmatisation of BPD on the participants' conceptualisation of the disorder and on the therapeutic relationship with a BPD patient. The findings related to each category of exploration are summarised below.

### *Working Knowledge of BPD*

The participants' interviews suggested that they are knowledgeable about the diagnostic features of BPD. All of them were able to recount the features most commonly associated with the disorder, such as the tendency towards self-harm or parasuicide, emotional instability, chronic feelings of emptiness, a pattern of unstable relationships and a fear of abandonment. In addition to these characteristics associated with BPD some of the participants highlighted other symptoms that they thought were indicative of borderline pathology. These symptoms included feeling lost and ungrounded and confusion regarding sexual identity.

One of the participants also mentioned level of severity as an important factor to consider in understanding the symptomatology associated with BPD. There is a tendency to think of 'borderlines' being a single uniform group rather than a cluster of individuals sharing common symptoms in a complex and individualised way. Thus it is important to remember

that clinicians in different settings are meeting different types of 'borderlines.' In substance abuse clinics and psychiatric hospitals one is more likely to find people who have severe borderline pathology with comorbid features versus the high functioning type of BPD patient that might be seen in private practice.

While the participants generally agreed on the clinician presentation of BPD their understanding of the aetiology, treatment and prognosis of the disorder was more varied. In terms of the aetiology of BPD, most of the participants ascribed environmental and relational factors, such as neglect and abuse as key determinants of the disorder. However, one participant felt that BPD results primarily from biological factors. The participants differed regarding their thoughts on the treatment and prognosis of BPD. Their thoughts on the prognosis of BPD ranged from optimistic to pessimistic and most of the participants described using different treatment methodologies to treat the disorder. It should be noted that much of the variation seen in the participants' responses can be ascribed to the context in which they were trained and currently work. For instance, those participants working in inpatient setting such as addiction treatment centres were more sceptical regarding prognosis. This may be due to the fact that the population of BPD patients in such settings tend to show a high level of severity regarding symptoms and they also have a comorbid diagnosis of substance dependence which may exacerbate their symptoms.

### ***Personal experiences of working with BPD patients***

Literature suggests that mental health professionals find it difficult to work with BPD patients (Aviram, Brodsky & Stanley, 2006; Cauwels, 1992; Fraser & Gallop, 1993; Nehls, 1998; Schafer & Nowlis, 1998; Simmons, 1992). The findings of this study show that most of the participants do indeed find BPD patients to be difficult for a variety of reasons. Their reasons included: experiencing difficulty in forming a therapeutic relationship with BPD patients

because they are less trusting, have higher degrees of emotional dysregulation and are more needy and demanding than other clients. As a result the participants felt they have to provide more emotional containment both inside and outside of scheduled therapy time which they felt could be burdensome and time-consuming. Another reason some of the participants cited was a difficulty in forming an empathic connection with patients who have BPD because their emotional responses seem histrionic and out of proportion to life events.

The participants also mentioned experiencing a number of difficult emotional responses in their countertransference to BPD patients. These feelings included feeling inadequate, incompetent, angry, fearful, punished and attacked. These feelings may also contribute to clinicians finding BPD patients difficult, because the responses that they evoke can be difficult to contain.

In the analysis of the interview material it became evident that a number of factors mediated whether or not the participants experienced BPD patients as difficult or not. These factors included: support, prior experience and the manner in which the participants conceptualised the disorder. A number of participants mentioned the importance of support when working with BPD patients. Such support may be manifest in different ways, such as working in a team or getting regular peer supervision. The participants who mentioned the importance of support when working with BPD patients felt that it acted as a buffer to the often intense emotional reactions of BPD patients which are often levelled at the clinician. Prior experience also seemed to increase the participants' capacity to deal with the difficulties that arise when working with a BPD patient. Finally it seemed that the way in which some of the participants conceptualised BPD allowed them to understand particular symptoms such as excessive neediness as a result of prior lack and this seemed to lead to an increase in empathy which allows them to be less negatively affected by such behaviour.

Although the participants agreed that working with BPD patients can be challenging

and may evoke negative emotional responses, they also cited positive aspects of working with such patients and often referred to them as unique, creative and interesting individuals. In the face of the negative press associated with this disorder it is heartening to remember that such patients are not wholly difficult and that mental health professionals can indeed derive satisfaction from working with BPD patients.

### *The impact of the stigma associated with BPD on clinicians' experiences*

The findings of this study suggest that all the participants were aware of the reputation that is associated with BPD patients, though some of the participants felt that people with BPD are no more difficult, challenging or demanding than other patients, especially patients with other PDs. The participants who did admit that BPD patients are difficult to work with ascribed different reasons for this. While it seems unfair that the diagnosis of BPD presupposes a patient who is likely to be difficult, demanding, manipulative and difficult to contain, the reasons the participants gave for finding working with BPD patients difficult are valid concerns. When speaking of the stigma associated with BPD patients one participant said that *"it isn't an accident that that's the way they get talked about, it comes from people's experience of working with their borderline patients."*

This suggests that the reputation people with BPD have for being difficult patients is not unfounded; people with BPD do tend to require a high level containment from mental health professionals. Their susceptibility to fears of abandonment coupled with a tendency to be impulsive does at times stretch the capacities the clinician might have to hold the therapeutic frame. This means that people with BPD may present as challenging clients to mental health professionals and part of this results from the symptomatology associated with BPD.

While this may be the case, literature suggests that other psychopathologies are

equally difficult to treat, for instance Bipolar Mood Disorder, Antisocial Personality Disorder and Narcissistic Personality Disorder (Schafer & Nowlis, 1998).

#### **4.1 Practical Implications**

This study aimed to explore clinicians' experiences of working with BPD patients. The findings suggest that to a degree the reputation associated with BPD patients is founded on the personal experience of mental health professionals as they do indeed find BPD patients to be difficult to work with. The implications of this finding suggest that the next step is to consider what is necessary to change the reputation associated with BPD and how clinicians can begin to empower themselves to deal more effectively with borderline pathology. The findings of this study suggest that support is useful in buffering clinicians against the difficulties that often arise when working with BPD patients. The implications of this finding suggest that further research into the efficacy of support in combating the difficulties that arise within the therapeutic relationship with a BPD patient would be valuable.

Literature suggests that the type of intervention used to treat BPD can have an impact on symptom reduction and overall prognosis (Bateman & Tyrer, 2004; Gunderson, 2009). The findings of this study seem to suggest that two thirds of the participants are finding it difficult to keep up to date with the latest research findings around effective treatment for BPD. Thus mental health professionals should consider what context would make it possible for clinicians working with BPD patients to have to begin to read more widely on the subject and ensure that they have access to the latest research findings around BPD.

#### **4.2 Limitations of the Study**

In this study only nine participants were used and therefore the data extrapolated from the interviews cannot be generalised to all clinicians working in the mental health profession.



Another possible limitation of the study was the result of the participants wanting to provide me with socially desirable responses to the questions I posed. Most clinicians are aware of the stigma associated with BPD and I felt that at times the participants wanted to show me that they were not affected by the stigma and did not experience any difficulties working with people diagnosed with BPD. This may be especially true for mental health professionals because their professional identity is constructed around their capacity for empathy and non-judgmentalism.

This study does have implications for future research as it suggests that clinicians do find BPD patients difficult to work for varying reasons. The study also suggests that certain factors such as peer support, prior experience and the clinicians' conceptual understanding of the disorder, seem to mediate the degree to which clinicians experience BPD patients as difficult. Future studies could focus on developing a greater understanding of such protective factors.

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## **Addendum A**

### **Interview Schedule**

#### **General diagnostic background**

1. To begin with can you share some information on your clinical past work experience?
2. In the work you do, is a psychiatric diagnosis important as a guide or source of information?
3. In the clinical setting in which you work who makes the diagnoses?
4. Do you tend to think in terms of diagnostic categories in the work you do?

#### **Diagnosing and understanding BPD**

1. Where did you first learn of borderline personality disorder?
2. How do you find working with people who are diagnosed with BPD? Can you explain further?
3. What are some of the common characteristics you associate with borderlines?
4. What is your experience and understanding of the comorbidity that is commonly found with borderline personality disorder?

#### **Personal experiences**

1. What literature have you read around treating and working with borderlines?
2. Do you ever find that your clinical experience of working with borderlines differs from what you 'know' about them in terms of what the literature on BPD says?
3. In your experience what have been the most challenging aspects of working with a borderline patient?

#### **What's it really all about**

1. What is your understanding of the defense mechanisms that borderlines employ?
2. Are you aware that borderlines have a reputation of being difficult to treat? Does this fit in with your personal experience of working with borderlines?
3. Does the knowledge of a diagnosis of BPD affect how you see treatment outcomes?

## **Addendum B**

### **Participant Information Sheet and Consent Form**

Greetings,

This information sheet will provide details on the study being conducted so that you might make an informed choice as to whether you would be interested in participating. Please read all information carefully.

**Why take part in this study?** – This is an explorative study interested in learning more about the experiences of clinicians who treat people diagnosed with Borderline Personality Disorder (BPD). The aim of the study is to better understand the complexities of the relationship between the clinician and the person diagnosed with BPD.

**What will participation involve?** – Participation in this study involves being interviewed on issues relating to personal experiences of working with people diagnosed with BPD. At any point during or after the interview should you wish to remove yourself from the study you may do so without facing any negative repercussions.

**How long will participation take?** – The interview will last approximately 1 hour.

**As an informed participant of this study I understand that:**

1. My participation is voluntary and I may cease to take part in this study at any time during or after the interview, without penalty.
2. My anonymity will be protected by ensuring that my name does not appear anywhere in the study.
3. The anonymity of my client's will be protected by ensuring that their name(s) does not appear anywhere in the study.
4. I am aware of what my participation involves.
5. I am entitled to a debriefing session once the interview is complete, should I feel I need one.
6. My questions about the study have been satisfactorily answered.

I, \_\_\_\_\_ have read the above information and agree to the terms of study and give my consent to participate.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_ have explained the above and answered all questions asked by the participant:

Researcher's signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Recording of Interviews**

In order for data to be properly analysed, all interviews will be recorded on tape. These recording will then be transcribed. All recordings and transcriptions will be kept in a locked



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cabinet for the duration of the study. Once the study is complete the recordings and transcriptions will be destroyed.

I, \_\_\_\_\_ have read the above information and agree to the terms of study and the manner in which all data will be collected and stored.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

University of Cape Town