A Qualitative Study of Therapists' Experiences of Countertransference with Borderline Personality Disorder.

Kristin T. Reilly

Student ID: 8494930

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Abstract

The concept of countertransference (CT) emerged out of psychoanalysis and is commonly understood as therapists' cognitive-affective reactions to clients. CT is widely considered an important therapeutic tool in psychodynamic therapies. More recently, some scholars and therapists from other therapeutic orientations, such as Cognitive Behavioural Therapy, have adopted the term CT. There is evidence that CT is a common experience that can have detrimental effects on the therapeutic relationship and therapy outcomes if poorly managed. There are few studies exploring the nature of therapists' CT reactions when working with clients with Borderline Personality Disorder (BPD), and little is known about how therapists conceptualise and manage CT. This thesis is a qualitative exploration of therapists' understanding and experiences of countertransference (CT) when working therapeutically with clients diagnosed with Borderline Personality Disorder (BPD) in New Zealand. In particular, this study investigated the types of CT reactions experienced by therapists working with clients with BPD and the way therapists conceptualised their CT reactions. It also investigated the ways they managed and utilised these reactions.

Thirteen therapists with at least three years' experience working therapeutically were recruited for this study. All therapists were trained in DBT and twelve therapists used DBT as their primary therapy approach with this client group within community mental health services. Prior to DBT, the majority of therapists were trained in CBT and some were trained in psychodynamic therapies. Ten identified as female and three identified as male. All therapists worked with clients with BPD and had between five and thirty five years of practice. The therapists were interviewed about their experiences of CT when working with BPD. The therapists were also asked about the types of CT reactions they had experienced, as well as the ways they conceptualised, managed and utilised their reactions. The data from the interviews were analysed using thematic analysis.

Six types of emotional reactions were identified: anxiety, frustration/anger, sadness, disconnection, hopelessness and joy/pride. Therapists described anxiety as common early in their career, often in response to the perceived chaos of their clients' lives. They highlighted anxiety in response to clients' suicidal behaviour as well as feeling threatened by their clients. Feelings of frustration and anger were reported in response to clients' slow progress, receiving clients' verbal attacks from clients, and clients' suicide attempts/behaviours. Therapists

reported CT reactions of sadness in response to their clients' suffering, and in some cases, therapists described wanting to rescue their clients. Feelings of disconnection were described in response to clients disconnecting from their emotions or from therapy. Some therapists spoke about feeling despair in response to their clients' ongoing self-injurious or suicidal behaviour and in response to their clients' despair. Lastly, many therapists described joy or pride as a common CT reaction when their clients made therapeutic progress.

All therapists viewed CT as an important aspect of the therapeutic relationship. Differences emerged regarding the ways the therapists conceptualised CT and this appeared to be influenced by their training and preferred therapeutic models. CT was understood as a common reaction in response to either something their clients "pulled" or "evoked", something in the therapists' personal history, or a combination of both. Surprisingly, none of the therapists used the term CT in their work settings because they either preferred to use other language to describe their experiences, or because they felt they needed to be cautious about the language they used in a Mental Health System that favoured behavioural models and behavioural language. Therapists predominantly practiced from a DBT framework, and preferred to use terms emotional responses or reactions rather than CT.

Therapists described a number of ways they managed their CT reactions. DBT consultation teams and using DBT skills were spoken about as being helpful ways of managing CT reactions. Engaging in self-care and talking with supervisors, colleagues and their own therapists were also emphasised as important CT management strategies. Some therapists described utilising their CT responses in therapy if they thought that it would be therapeutically helpful to do so. Therapists spoke about naming or disclosing their responses to their clients for the purposes of checking in with the client, problem solving with the client, or to communicate therapists' limits to the client.

The findings of this study are discussed in relation to the existing literature on CT and BPD. The study considers the implications for therapists' training, clinical practice, limitations and future research directions.

Keywords: Countertransference, Borderline Personality Disorder, Qualitative Research

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Chapter One – Introduction

This thesis presents a qualitative interview study that investigated therapists' experiences of countertransference (CT) when working therapeutically with clients who have been diagnosed with Borderline Personality Disorder (BPD) in New Zealand. Specifically, this study examined the types of CT reactions therapists experienced and the client behaviours, therapist sensitivities, or therapy situations that gave rise to these reactions. It sought to understand the ways therapists from different therapeutic models conceptualised their CT reactions and the ways therapists both managed and utilised their CT reactions.

CT was identified as an important area to investigate given it is a common therapeutic experience for all therapists, regardless of their therapeutic orientation (Betan & Westen, 2009; Cartwright, Rhodes, King, & Shires, 2014). Moreover, CT is impactful and can inform negative therapeutic outcomes if unmanaged (Hayes, Gelso, Van Wagoner, & Diemer, 1991; Hayes, Gelso, Goldberg, & Kivlighan, 2018; Rosenberger & Hayes, 2002). Indeed, a recent meta-analysis reviewed the empirical research on CT, its management and the relationship with therapeutic outcomes (Hayes et al., 2018). The findings revealed that CT is a universal phenomenon in therapy, and that more frequent CT reactions are associated with poorer therapy outcomes. Moreover, effective management of CT is associated with fewer CT reactions and with more positive therapy outcomes. There is also evidence that therapists have strong, often negative reactions when working with BPD (Betan, Heim, Zittel Conklin, & Westen, 2005; James & Cowman, 2007). However, there is a lack of in-depth research into the nature of therapists CT reactions with BPD, including client and therapists factors that contribute to such reactions. Moreover, there appears to be minimal research pertaining to the ways in which therapists attempt to manage and utilise their CT reactions when working with clients with BPD.

In New Zealand and Australian training programs, cognitive and behavioural therapies are the primary taught mode/s of psychotherapeutic treatment (Cartwright, Barber, Cowie, & Thompson, 2016; Kazantzis & Munro, 2011). As such, therapists practicing from cognitive-behavioural approaches, such as dialectical behaviour therapy, were invited to participate in this study. Therapists from psychodynamic orientations were also invited, given the psychodynamic origins of CT. It is noteworthy that CT is not widely taught among training programmes in New Zealand given the orientation towards cognitive behavioural approaches.

That being said, there is a CT training that has been introduced to several universities and to therapists throughout New Zealand (Cartwright et al., 2016). This training introduces psychodynamic conceptualisations of CT and applies these to a range of therapeutic models.

Chapter One of this thesis study provides an overview of the relevant research and clinical literature on CT and BPD that formed the context for this study. Chapter Two outlines the qualitative methodology, and presents the study's method. Chapters Three to Five present the results of the thematic analyses pertaining to therapists' conceptualisations of CT; the types of CT reactions they experienced in their work with clients with BPD; and the ways therapists manage and utilise their CT reactions. Lastly, Chapter Six discusses the main findings and how these contribute to the existing CT literature. It also considers the implications for clinical practice, limitations, and implications for future research directions.

The first section of the present chapter begins with an overview of CT and the ways the term has been conceptualised from various theorists and therapeutic modalities. The second section introduces BPD, followed by a brief review of clinical and empirical research to understanding and treating BPD from psychodynamic, cognitive-behavioural and dialectical-behavioural therapeutic orientations. These approaches were chosen as they are common treatment approaches used by therapists in New Zealand. The third section then presents the research relevant to therapists' experiences of CT reactions when working clinically with clients diagnosed with BPD. Finally, this chapter concludes with the current thesis study's research aims.

In the next section various conceptualisations of CT are presented, including psychoanalytic/psychodynamic perspectives and cognitive-behavioural perspectives.

History and Conceptualisation of Countertransference

A consistent definition of the term countertransference (CT) does not exist to this day (J. Holmes, 2014; Parth, Datz, Seidman, & Löffler-Stastka, 2017). In reviewing the literature on the development of CT, it appears three main conceptualisations have been defined. The following section presents the literature on CT, with regards to the three conceptualisations commonly cited: classical, totalistic and complementary.

Psychoanalytic/Psychodynamic Conceptualisations of Countertransference.

Classical View.

The term countertransference (CT) originated with Freud (1910) and grew within psychoanalytic and psychodynamic paradigms. Freud conceptualised CT as the therapist's unconscious reactions in response to the client's transference (Freud, 1910; Kernberg, 1965; Rosenberger & Hayes, 2002). Transference is one of Freud's earliest discoveries, described as manifestations of old, unconscious, wishful phantasies (Freud & Strachey, 1964), universal in all human relations and enacted with various relationships, such as patient and analyst. Freud did not write extensively about CT, although it is commonly stated he viewed CT as something problematic (J. Holmes, 2014). Indeed, Freud regarded CT to be detrimental to the therapeutic relationship (J. Holmes, 2014) and therefore required containment and management (Freud, 1910). Freud argued that to combat CT, the therapist must undertake their own psychoanalysis in order to recognise CT in an attempt to ensure the therapist's own personal conflicts remain out of the therapeutic relationship (Freud, 1910).

Totalistic View.

Freud's classical definition of CT as an unconscious response to be overcome resulted in CT acquiring a taboo status, thereby receiving little attention for some time (Benedek, 1953). Following this, a new understanding of CT, later termed the totalistic definition, emerged in the 1950's (Heimann, 1950; Kernberg, 1965; M. Little, 1951). This definition suggests that CT represents all conscious and unconscious reactions (feelings and attitudes) to the client (McHenry, 1994), and that all therapists experience CT regardless of therapeutic orientation (Gabbard, 2001a; Heimann, 1950; G. Holmes & Perrin, 1997; M. Little, 1951). Under this broad definition, therapists are encouraged to utilise their reactions as a therapeutic tool to gain insight and understanding of the client (Heimann, 1950).

Around the same time, Winnicott (1949) also advocated for the usefulness of CT. He introduced the idea that CT has both "subjective" and "objective" components. Subjective CT reactions result from the therapist's own personal history and unresolved conflicts (Winnicott, 1949). On the other hand, objective CT refers to the therapist's natural responses to the client's personality or behaviour (Winnicott, 1949). According to this view, the client's way of relating or behaving provoke responses in the therapist that are similar to responses of others in the client's life. Indeed, recent research has supported the notion that clients can provoke the same types of reactions for multiple therapists who come into contact with that client (Betan et al., 2005; Lingiardi, Tanzilli, & Colli, 2015; Tanzilli, Colli, Del Corno, & Lingiardi, 2016).

Psychoanalyst Heinrich Racker (1957) also proposed two manifestations of CT, complementary CT and concordant CT. He described complementary CT as the therapist's identification with an internal object representation that has been projected by the client on to the therapist (Racker, 1957). For instance, a client who has experienced childhood abuse may hold an object representation of an abuser and a self-representation of a victim (Gabbard, 2017). Over the course of therapy, the client may project feelings of being abused or victimised, resulting in the therapist feeling like they have harmed the client in some way, thereby identifying with the client's object representation. Racker (1957) described concordant CT as closely related to empathy, whereby the therapist identifies with the client's subjective affective state or self-representation. For instance, a therapist may resonate with a client's sense of hopelessness to the extent that both therapist and client are sharing the client's affective experience.

Complementary View.

The complementary definition - which is not to be confused with Racker's (1957) view described above - developed from interpersonal, relational and object relations theory (Anchin & Kiesler, 1982; S. Butler, Flasher, & Strupp, 1993; Levenson, 2017), and views the therapist's CT reactions as complementary or counterpart to the client's transference (Gelso & Hayes, 2007; Levenson, 2004). Indeed, the therapist's reactions result from certain interpersonal "pulls" exhibited by the client toward the therapist (Kiesler, 2001; Levenson, 2004), which in turn effect the client (Kiesler, 2001). Consistent with the totalistic definition, the complementary definition also shares the view that therapist reactions are inevitable, but it also hypothesises that both client transference and therapist CT influence the interpersonal processes between the client and therapist (Levenson, 2004). Moreover, CT allows the therapist to understand the client's interpersonal style of relating as the client's behaviours serve as important cues to understanding interpersonal relationships the client has experienced previously (Kiesler, 2001).

Cognitive Conceptualisations of Countertransference.

Traditionally, cognitive theorists and therapists have placed little emphasis on the importance of CT. It has been argued cognitive therapies should not use terms transference and CT as cognitive therapies do not work with the unconscious, which has an important role in CT (Ivey, 2013). Cognitive therapists Aaron Beck and colleagues (2015) noted a preference

for using the term “therapist emotions” to refer to the term CT, so as to not confuse their understanding of CT with psychodynamic conceptualisations of CT. However, some cognitive theorists and therapists disagree, arguing that issues related to transference and CT have been discussed since cognitive therapy was first established (Prasko & Vyskocilova, 2010). In this regard, CT has been given more attention and discussion by cognitive theorists and therapists in recent years (Leahy, 2007).

Whilst some cognitive theorists and therapists prefer not to use the term CT, others are in favour of the terms use (Leahy, 2007; Newman, 2013; Vyskocilova, Prasko, Slepecky, & Kotianova, 2015). Cartwright (2016) notes that within cognitive perspectives, CT has been described as involving cognitive, emotional and behavioural responses, developing from particular beliefs about oneself, others, and relationships. Similarly, Newman (2013) describes CT as the therapist’s cognitive, affective, and behavioural responses to the client. In their review of the Cognitive Behaviour Therapy (CBT) and CT literature, Vyskocilova and colleagues (2015) conclude that CT occurs in CBT when the therapeutic relationship activates automatic thoughts (ATs) and schemas in the therapist, which have the potential to influence the therapy, or the therapeutic alliance if unmanaged. Together, it appears cognitive perspectives conceptualise CT as the thoughts, emotions, and behavioural responses to a client that develop from beliefs about oneself, others and relationships.

Some cognitive theorists have written about the importance of managing CT reactions (Beck et al., 2015; Leahy, 2012; Prasko & Vyskocilova, 2010). Prasko (2010) noted that examining cognitions related to the therapist in the context of CT are an integral part of CBT. Beck and colleagues (2015) emphasised that traditional cognitive-behavioural approaches, such as cognitive restructuring, should be used to examine, understand and manage one’s own therapy-related thoughts and feelings as they can result in problematic behaviours if unattended. Leahy (2012) advised cognitive therapists to challenge their own cognitive distortions. They argued that ignoring CT may result in negative consequences such as guilt, avoidance, inability to set limits and/or overextending therapy. Once the cognitive therapist recognises their CT towards a client by identifying ATs or schemas (Vyskocilova et al., 2015), it is recommended the therapist seek supervision to address and potentially resolve the source of the feelings and challenge any cognitive distortions (Prasko & Vyskocilova, 2010).

Hence, cognitive perspectives emphasise the emotions, cognitions and behaviours of the therapist as being important aspects of CT. CT is believed to stem from the therapist’s

beliefs, schemas and responses to problematic behaviours of the client, as opposed to stemming from unresolved conflict or unconscious dynamics as understood from psychodynamic perspectives (Cartwright et al., 2016). Cognitive therapists tend to agree that attending to CT is a vital part of the therapeutic process and if left unattended, can negatively impact the therapy or the therapeutic alliance.

Dialectical-Behavioural Conceptualisation of Countertransference.

In an examination of the published research and clinical literature, no mentions of CT and DBT were found. Clinical writing highlights that DBT recognises clients' relational styles and interpersonal behaviours are influenced by and may reflect early attachment and relationship experiences (S. Little, 2011). However, this is understood through behavioural principles rather than transference and CT (Swales & Heard, 2007). In DBT, the therapeutic relationship is described as a "real" relationship (Linehan, 1988), emphasising a transactional process whereby both therapist and client mutually influence one another over time (Koons et al., 2001; Linehan, 1993; Swales & Heard, 2007). Through their reciprocal interactions and shared experiences during therapy, both client and therapist are viewed as influencing one another in a meaningful way that can promote change in both (Koons et al., 2001). In accordance with learning theory, DBT posits that the therapeutic relationship can serve as a motivator for client change and thus, the therapist can be used as a reinforcer to increase adaptive behaviour or extinguish maladaptive behaviour in the client (S. Little, 2011). For instance, a therapist may increase warmth in response to desired client behaviour, or become cooler and more matter of fact towards a client engaging in therapy interfering behaviour (Koons et al., 2001).

While the term CT is not used in DBT, concepts related to the term are discussed. Therapy interfering behaviour (TIB) is a term that commonly occurs within DBT literature, which may describe elements of CT. Therapy interfering behaviour (TIB) refer to any client and/or therapist behaviours that directly interfere with effective delivery of the treatment (Dimeff & Linehan, 2001; Van Dijk, 2013). These behaviours are inevitable and can be intentional or unintentional (Chapman & Rosenthal, 2016). Bedics and McKinely (2020) note that TIBs are an acknowledgement that the therapy relationship is a genuine, real relationship that can be addressed via problem solving in therapy. Clinical writing postulates examples of therapist TIBs could include re-scheduling an appointment or cancelling due to sickness. Examples of therapist TIBs that some therapists may describe as a result of CT include

expressing unhelpful emotions, placing unrealistic expectations on clients, or avoiding topics (Chapman & Rosenthal, 2016; Van Dijk, 2013). From a DBT framework, therapists are required to assess and problem-solve any TIBs as they can interfere with effective treatment (Bedics & McKinley, 2020).

Similarly, therapists observing their own limits is another essential component of DBT (Linehan, 1993). Observing limits requires the therapist to notice the client behaviours that interfere with the therapist's ability or willingness to continue therapy, (otherwise described as client TIBs). Therapists discover their limits as situations unfold in therapy, as therapists can only observe their limits once they have been pushed (Van Dijk, 2013). Once a limit has been observed, it is advised that the therapist is honest with their client and communicates their limits, whilst validating the clients own wants and needs (Lindenboim, Lungu, & Linehan, 2017). Linehan (1993) notes that therapists are to be mindful of signs that their limits may have been crossed, such as feelings of discomfort, anger or frustration.

Further, one of the main types of therapist disclosure in DBT is self-involving self-disclosure, which is a form of observing limits (Linehan, 1993). It involves a therapist disclosing their immediate, personal reaction to a client (Koerner, 2011; Linehan, 1993), which Linehan (1993) indicated could be referred to as CT in psychodynamic terminology. Self-involving self-disclosure is described as one of the ways DBT therapists make use of natural contingencies for the clients benefit. Through the therapist's disclosure, the client is able to understand the contingency between their behaviour and its effects on the therapist (Koerner, 2011). In DBT, self-involving self-disclosure should only be used if it is helpful to the client and the therapeutic relationship (Van Dijk, 2013). At the same time, it is important that therapists balance self-disclosure with observing their own limits. Therapists may seek support through their DBT consultation team to discuss TIBs and their own limits, as consultation support can help manage and minimise the frequency of TIBs and ensure therapists are observing their own limits (Chapman & Rosenthal, 2016).

The overarching purpose of the consultation team is to reinforce and/or shape therapists behaviour, with the intention of improving adherence to the DBT model (Linehan & Wilks, 2015). Specifically, consultation team members provide therapists with support; help them develop their skills using the DBT model; provide support to those treating clients at imminent risk; use problem solving skills to manage any difficulties; and also to discuss cases during which the team also helps therapists explore any feelings of burnout and TIB (Linehan, 1993;

Van Dijk, 2013). During consultation, it is expected therapists disclose any TIB, so the rest of the team can help the therapist understand the TIB and consider ways to manage and prevent additional TIB (Linehan, 1993).

Based on the above, it may be that the nature of DBT - with its consultation meetings for therapists – may implicitly acknowledge and support the management of therapists' CT reactions, without referring to them as CT.

Countertransference: Common and Crucial

Although a consistent definition of CT does not exist today, the term CT has been used widely across psychotherapeutic modalities to refer to therapists' cognitive-affective reactions to clients during therapy (Gabbard, 2004). CT is commonly understood as a jointly created experience by therapist and client contributions, that is an inevitable part of the therapeutic relationship (Abargil & Tishby, 2020; Gabbard, 2001a). Although CT has a central focus in psychodynamic therapies, past research supports the notion that CT occurs across all therapeutic models, and is independent of therapists' theoretical preferences (Betan et al., 2005; Colli & Ferri, 2015; Hayes, Gelso, & Hummel, 2011). For instance, in a longitudinal qualitative study of CT, eight experienced therapists from a range of therapeutic approaches, considered expert therapists by their peers, reported CT reactions to clients in 80% of 127 therapy sessions (Hayes et al., 1998).

To support this, Hayes and colleagues (2011; 2018) conducted several meta-analyses of both quantitative and qualitative studies examining the empirical research on CT, its management and the relationship with therapeutic outcome. Hayes et al., (2011; 2018) found that CT is a universal phenomenon in therapy, and that more frequent CT reactions are associated with poorer therapy outcomes. However, that effective management of CT is associated with fewer CT reactions and better therapy outcomes. These findings indicate that CT is indeed an important therapeutic factor which can largely effect therapy outcomes depending on how it is understood and managed.

Hence, CT is a common therapeutic phenomenon experienced by therapists regardless of therapeutic orientation. Moreover, frequent, unmanaged experiences of CT are associated with poorer therapy outcomes, whereas management of CT has positive effects on therapy outcomes. In the next section, Borderline Personality Disorder (BPD) is introduced, followed by a brief review of clinical and empirical research pertaining to the understanding and

therapeutic work with BPD from psychodynamic, cognitive-behavioural and dialectical-behavioural therapeutic orientations.

Borderline Personality Disorder

The Development of a Diagnosis.

The term "borderline" was first used by Adolf Stern (1938) to describe a group of patients who did not fit into the standard psychiatric categories of the time: "neurotic" or "psychotic" (Stern, 1938). Following this, object relation theorists introduced "borderline" as a personality organisation which was thought to arise from a fixation in the separation-individuation developmental stage of the child (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989; Kernberg, 1995; Kernberg & Caligor, 1996). It was defined by defences such as splitting, projective identification and identity confusion. Other theorists viewed "borderline" patients as being on the borderline between schizophrenia and non-schizophrenia (Noble, 1951), and also between normal and abnormal (Rado, 1956).

Gunderson (1975) introduced the first operational definition of BPD. His introduction of the disorder formed the groundwork for the inclusion of BPD into DSM-III (American Psychiatric Association, 1987). There have only been minimal changes regarding the way in which BPD has been characterised in all versions of the DSM (American Psychiatric Association, 1987; American Psychiatric Association, 1994; American Psychiatric Association & American Psychiatric Association, 2000; American Psychiatric Association, 2013). Notably, all versions of the DSM indicate that BPD is more common for women than for men.

Behaviours often described as symptoms of 'Borderline Personality Disorder' (BPD) were first documented about 4000 years ago (Howell, 2018). Hysteria, also known as the 'wandering uterus', was initially understood as an illness originating in the womb (Gilman et al., 1993), whereby any movement of a woman's reproductive organs was understood to be the cause of emotional and physical distress. Gunn and Potter (2014) propose that the development of BPD as a diagnostic conceptualisation is a logical outcome reflecting well established views about women through history. Indeed, from early conceptualisations of hysteria to BPD, it could be argued that such diagnoses – which fail to acknowledge the social context such as childhood sexual abuse - pathologise the ways that women respond to adversity (Shaw & Proctor, 2005).

Borderline Personality Disorder Today.

Although there is controversy regarding the diagnosis of BPD, the American Psychiatric Association describes it as a severe and pervasive personality disorder affecting 1.1-2.5% of the adult population, with roughly 70% being women (American Psychiatric Association, 2013). BPD is associated with high utilisation of psychiatric services, accounting for roughly 15-20% of psychiatric inpatient admissions and outpatient clinic service users (Korzekwa, Dell, Links, Thabane, & Webb, 2008; Zimmerman, Chelminski, & Young, 2008), thus representing a disproportionate need for psychiatric services relative to prevalence in the population. BPD is characterised in the DSM-5 as a pattern of instability of interpersonal relationships, self-image, emotions, and marked impulsivity. This begins by early adulthood and is seen in a variety of contexts. Individuals are diagnosed with BPD if they exhibit five or more of the symptoms below (American Psychiatric Association, 2013):

1. Frantic efforts to avoid real or imagined abandonment.

2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).

5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

The Role of Trauma.

Past research has found individuals diagnosed with BPD have often experienced or witnessed trauma (sexual, physical, and/or emotional) at some point throughout their lives, often in childhood (Elzy, 2011; Herman, Perry, & Van der Kolk, 1989; Zanarini, Williams, Lewis, & Reich, 1997). Interview and survey studies indicate that up to 80% of individuals diagnosed with BPD have experienced trauma (Herman et al., 1989; Zanarini et al., 1997). Indeed, Zanarini (1997) interviewed 358 patients with BPD about adverse childhood experiences and found 91% reported having been abused, and 92% reported having been neglected, before the age of 18.

Individuals diagnosed with BPD are more likely to have experienced child sexual abuse, physical abuse and/or witnessed domestic abuse compared to those without the diagnosis (Herman et al., 1989; Ogata et al., 1990; Sansone, Songer, & Miller, 2005; Zanarini et al., 1997). Herman and colleagues (1989) interviewed clients with either borderline diagnoses, borderline traits or other diagnoses about their experiences of major childhood trauma. They found significantly more clients with BPD diagnoses (81%) reported histories of physical abuse, sexual abuse, and witnessing domestic violence compared to those without the diagnosis. Another review study found that those with BPD diagnoses were significantly more likely than those with other personality disorders to report having been emotionally and physically abused by a caretaker and sexually abused by a non-caretaker (Zanarini et al., 1997).

Given exposure to trauma is common for many individuals diagnosed with BPD, it has been suggested that the term 'complex post-traumatic stress disorder' is more appropriate for many individuals (Herman, 1992). Krawitz and Watson (2003) noted that clients tend to prefer this term as it acknowledges and validates trauma as having had an important impact on one's life, whereas BPD does not have any regard for the cause of a person's symptoms/suffering. Whilst abuse, particularly sexual, is correlated with BPD (Zanarini et al., 1997), it is not required for a diagnosis. Consequently, a shift to the use of the term 'complex post-traumatic stress disorder' may not successfully capture all individuals who meet current criteria for BPD.

Individuals with BPD diagnoses attempt to avoid real or imagined abandonment, and often respond with inappropriately intense anger when they perceive rejection/abandonment (American Psychiatric Association, 2013). This perception can lead to severe changes in their self-image, affect, cognition, and behaviour. Disruptions to self-image are often associated with

damaging behaviours, such as gambling, binge eating, unsafe sexual intercourse, reckless driving, self-injurious behaviour (e.g. head banging, cutting self, scratching, cigarette burns, overdosing, self-stabbing, asphyxiations) and suicidal threats and attempts (American Psychiatric Association, 2013). Individuals diagnosed with BPD are prone to dramatic shifts in relational dynamics with others, for example, alternating between extreme idealisation and devaluation of others.

Whilst symptoms of BPD are acknowledged across therapeutic modalities - and all modalities acknowledge the aetiological importance of childhood abuse, neglect and invalidation in BPD (Krawitz & Watson, 2003) - the way in which the symptoms arise and subsequently, the way they should be treated, differs among therapeutic modalities.

Borderline Personality Disorder across Three Therapeutic Modalities.

The following sub-section will provide a brief overview of the literature on BPD and the three therapeutic modalities of interest for this thesis study: psychodynamic therapy, cognitive behaviour therapy (CBT), and dialectical behavioural therapy (DBT). In particular, the following section will highlight the aetiology of BPD, treatment techniques, and treatment efficacy from the three therapeutic orientations.

Psychodynamic Therapy and Borderline Personality Disorder: aetiology, treatment techniques, treatment efficacy.

Psychodynamic theorists posit that individuals diagnosed with BPD have a poorly formed identity as a consequence of disrupted psychological development in childhood (Krawitz & Watson, 2003). In understanding the development of BPD, early psychodynamic theorists have drawn upon models of unconscious conflict derived from ego psychology, object relations theory, and attachment theory (Gabbard, 2004). Psychodynamic theorists posit that the psychopathology of BPD needs to be understood in its developmental context (Boag, 2014; Bradley & Westen, 2005), as human relationships are the primary force influencing behaviours or symptoms. (Greenberg, 1983; Kernberg, 1995). For example, from a psychodynamic perspective, an inability to self-soothe is thought to emerge from childhood experiences of apathetic, unavailable, or abusive parents who did not facilitate emotion regulation from a young age (Adler & Buie, 1979).

Early psychodynamic perspectives, such as object relations theory, suggest that children form attachments to good 'objects' and bad 'objects', based on their internal representations of self and other (Fairbairn, 1963; Klein, 1946). Because many individuals with BPD have experienced traumatic or rejecting early relational experiences (Herman et al., 1989), it is suggested that they become attached to 'bad' objects and continuously recreate such relationships with others. By forming relationships with those who are bound to reject and disappoint, individuals with BPD perpetuate a belief that the world is bad and rejecting. It has been proposed that children who experience abuse and/or emotional neglect have loyalty towards the bad object, blame themselves, trick themselves into thinking it was their fault, and reject offers of help from good objects (Fairbairn, 1963).

Transference-Focused Psychotherapy is a modified psychodynamic treatment based on Kernberg's (1984) object relations model of borderline personality disorder, focussing on the development of mental representations, which arise through the internalisation of early attachment relationships (Clarkin, Levy, & Schiavi, 2005). Kernberg (1984) posited that individuals with BPD are unable to integrate representations of themselves and others, resulting in a 'split' psychological structure, whereby negative representations of the self and others are split off from positive representations (Levy, Meehan et al., 2006; Levy, Clarkin et al., 2006). TFP focuses on the themes that emerge in the relationship between the client and the therapist in the here-and-now of the transference (Clarkin et al., 2001). Transference and CT between client and therapist are considered as repetitions of early relationship patterns which have been internalised (and often distorted) with a particular affect and have become the structures (or blueprint) that determine the client's current way of experiencing relationships (Foelsch & Kernberg, 1998). These distorted, internalised relationships unfold during therapy, and as such, provide a means of understanding and intervening in the client's internal world (Foelsch & Kernberg, 1998).

Mentalisation Based Therapy (MBT) is another, more recent psychodynamic treatment for BPD (Bateman & Fonagy, 2010). Mentalising is the process by which individuals make sense of themselves and others, in terms of intentional mental processes, such as personal desires, needs, feelings, and beliefs (Bateman & Fonagy, 2004; Bateman & Fonagy, 2010). It is hypothesised that disrupted mentalising process are often caused by psychological trauma in childhood, which undermines the development of appropriate social and cognitive abilities necessary to think about mental states of self or other, or provide coherent descriptions of past relationships (Bateman & Fonagy, 2010). From an MBT perspective, individuals with BPD

exhibit reduced abilities to mentalise which give rise to difficulties with emotional regulation and impulsivity. Thus, the aim of MBT is to facilitate the development of mentalisation, particularly within the context of intimate relationships (Bateman & Fonagy, 2004).

Considering the above, psychodynamic therapies see the aetiology of BPD as nested within developmental understandings of the client and their relation to others. Mentalisation-Based Treatment (MBT) and Transference-Focussed Psychotherapy (TFP) are considered two primary psychodynamic approaches to treating BPD. Both frameworks respect the development of the self in relation to others, as well as address affects, beliefs, conflicts and defences (Boag, 2014). However, neither TFP nor MBT are commonly used in New Zealand. MBT, however, is slowly gaining more traction and is being introduced in some public Mental Health Services. A brief overview of the efficacy of MBT for treating BPD is presented below.

Research is emerging on the longitudinal effectiveness of MBT as compared to standard care for treating individuals with BPD (Bateman & Fonagy, 1999; Bateman & Fonagy, 2008; Bateman & Fonagy, 2009; Bateman, Constantinou, Fonagy, & Holzer, 2020). Bateman and Fonagy (2009) conducted a Randomised Controlled Trial (RCT) with a 134 clients diagnosed with BPD to test the effectiveness of an 18 month MBT programme in an outpatient setting compared to outpatient structured clinical management. The clients were assessed every 6 months on a range of outcomes, such as crisis events (suicidal behaviour, self-injurious behaviour, and hospitalisations), self-reported symptoms, and social and occupational functioning. At the end of treatment, the results indicated substantial improvements in both conditions across all outcomes. Those who received MBT, however, showed a steeper decline across suicide attempts, hospitalisations, and self-reported symptoms. Of the original participants, 98 agreed to be followed up for eight years (Bateman et al., 2020) to assess the same outcomes used in the first study. The follow up results from annual interviews revealed that the beneficial outcomes at the end of treatment were maintained for both groups (Bateman et al., 2020). They researchers also found that those in the MBT group showed better social and occupational functioning and reported less use of professional support services.

Other literature has examined the effectiveness of MBT in treating BPD as compared to other psychotherapeutic interventions (Bales et al., 2015; Barnicot & Crawford, 2019; Edel, Raaff, Dimaggio, Buchheim, & Brüne, 2017; Kvarstein et al., 2015). Bales and colleagues (2015) assessed both 18 and 36-month treatment outcomes on psychiatric symptoms and personality functioning for 58 individuals with BPD who received either day hospital MBT (18

months followed by another 18 months of maintenance) or another psychotherapeutic treatment. In this study, other psychotherapeutic treatments included a variety of treatment settings, durations, and theoretical schools considered to be beneficial for treating personality disorders. At both 18 and 36-month follow up, psychiatric symptoms and personality functioning (identity integration, relational functioning, responsibility, self-control, and, social concordance) had reduced for both groups, with larger effect sizes in favour of MBT (Bales et al., 2015).

The research comparing the efficacy of MBT compared to other specific therapies is sparse. However, given DBT is a widely known treatment for BPD (Bohus et al., 2004; Linehan et al., 2006), some studies have sought to compare DBT and MBT for treating BPD (Barnicot & Crawford, 2019; Edel et al., 2017). Edel et al., (2017) proposed that whilst DBT is effective in reducing certain symptoms of BPD such as self-harm, other problems such as social cognition may be better addressed with approaches such as MBT. The researchers conducted a pilot study to examine the efficacy of MBT as an adjunct to DBT, compared to DBT alone for an inpatient sample of 73 individuals diagnosed with BPD. They observed reductions in BPD symptoms for both groups, however the DBT and MBT combined group was superior in reducing fearful attachment, improving affective mentalising and was the only treatment to reduce self-harm (Edel et al., 2017). This suggested that combining MBT with BPD is an effective treatment for BPD symptoms, and that this combination may be more effective in reducing self-harm than DBT alone.

In another treatment approach comparison study, Barnicot and Crawford (2019) conducted the first study comparing the effectiveness of MBT versus DBT for treating BPD. The researchers compared clinical outcomes in a group of 90 individuals diagnosed with BPD who were receiving either MBT or DBT over a 12-month period. The results indicated that those who received DBT reported a steeper reduction in self-harm and emotion dysregulation at 12 months compared to those receiving MBT. No differences were found regarding symptoms of BPD or interpersonal problems, indicating that both DBT and MBT are equally effective in reducing BPD symptoms and improving interpersonal relationships over a 12 month period. However, reductions in self-harm behaviours and improvements in emotion regulation may occur quicker for individuals receiving DBT compared to MBT. That being said, outcomes for this study were not assessed beyond that 12 month period so may not represent the clinical effectiveness of these approaches for treating BPD.

Cognitive Behaviour Therapy and Borderline Personality Disorder: aetiology, treatment techniques, treatment efficacy.

From a cognitive-behavioural perspective, BPD is characterised as a pattern of intense instability interfering with most aspects of a person's functioning, including relationship, self-image, affect and behaviour (Beck et al., 2015). All second and third wave cognitive behavioural models place emphasis on early childhood environments (often traumatic experiences) as being important to the development of BPD (Davidson, 2007). Cognitive theorists have suggested childhood trauma or abuse does not directly cause BPD. Instead, the way in which the child processes and attaches meaning to particular events/circumstances gives rise to the development of certain beliefs and coping strategies (Beck et al., 2015; Pretzer, 1990; Zanarini et al., 1997).

CBT theorists posit that exposure to adverse events - such as child abuse or neglect - may lead to beliefs that others are dangerous, unpredictable, or hostile; and that oneself is bad, defective, or unacceptable (Arntz, Dreessen, Schouten, & Weertman, 2004; Pretzer, 1990). Such beliefs are thought to result in specific assumptions about oneself and others, often reflecting themes of paranoia and dependency, which give rise to other symptoms associated with BPD (Beck et al., 2015; Pretzer, 1990). For instance, Butler and colleagues (2002) examined the unhelpful beliefs held by individuals with BPD, in order to construct a BPD belief scale to inform cognitive therapy for BPD. They found that beliefs of helplessness, distrust, fears of abandonment, and loss of control are common for people presenting with BPD (A. Butler et al., 2002), and that such beliefs influence behaviours such as self-harm, avoidance and dependence.

CBT is a direct, time-limited, structured approach that aims to alleviate clients' distress by assisting them to develop helpful, more adaptive ways of thinking and behaving (Beck et al., 2015; Fenn & Byrne, 2013). CBT is based on the cognitive model, which posits that peoples' emotions and behaviours are influenced by their perceptions of an event or situation (Beck, 1964). The cognitive model is used as a framework to understand clients' presenting concerns to ultimately modify their cognitions and maladaptive behaviours (Davidson, 2007; Fenn & Byrne, 2013). CBT is generally 5-20 sessions (Fenn & Byrne, 2013), however, CBT for BPD is often much longer due to the pervasive nature of the symptoms and greater difficulty building and maintaining a therapeutic relationship (Davidson, 2007).

CBT employs a range of cognitive and behavioural techniques to modify unhelpful core beliefs and assumptions and decrease maladaptive behaviours (Beck, 1964). Specific cognitive techniques include modifying core beliefs (Beck et al., 2015), examining evidence for and against dysfunctional assumptions (Fenn & Byrne, 2013), and using thought record diaries to increase awareness of negative automatic thoughts and explore their impact on emotions and behaviours (Greenberger & Padesky, 1995). Cognitive techniques require the therapist to engage with a stance of guided discovery (Greenberger & Padesky, 1995) to assist clients in increasing awareness of their beliefs and ultimately find more adaptive solutions to problems. Behavioural techniques include activity scheduling and behavioural experiments to increase functioning and positive experiences (Fenn & Byrne, 2013). From a CBT perspective, the aims of treatment for BPD are to modify unhelpful beliefs and assumptions and to decrease self-damaging behaviours that may cause harm to oneself or others (Davidson, 2007).

CBT has been found to be an effective treatment approach in treating personality disorders (Brown, Newman, Charlesworth, Crits-Christoph, & Beck, 2004; Davidson et al., 2006; Leichsenring & Leibing, 2003). There is some evidence to suggest that CBT may be an effective treatment approach for BPD (Brown et al., 2004; Cottraux et al., 2009; Davidson et al., 2006; Davidson, Tyrer, Norrie, Palmer, & Tyrer, 2010). Brown and colleagues (2004) conducted a clinical trial to examine the effectiveness of CBT in treating BPD for 32 participants who met criteria for BPD. Treatment consisted of 50 minute individual sessions for 50 weeks over a one year period. The aim of treatment was to teach participants to identify and modify their core beliefs, which may indirectly modify the self-destructive and self-defeating behaviours. Comprehensive interviews were completed to assess BPD symptoms, suicidal ideation, depression, hopelessness, self-injurious behavioural and dysfunctional beliefs at baseline, six months (midway through treatment), 12 months (at the end of treatment), and at 12 months (six months after ending treatment). The authors found that participants experienced a reduction in depression, hopelessness, suicidal ideation, and symptoms of BPD from the baseline interview until the end of the therapy and the 18-month assessment follow up (Brown et al., 2004). Moreover, they found that participants showed improvements in unhelpful beliefs that reflected themes of dependency, helplessness, distrust, and fears of abandonment. The findings from this study suggest that CBT may be an effective treatment in reducing a range of BPD symptoms, included unhelpful beliefs that are thought to give rise to self-damaging behaviours. Moreover, these benefits may be maintained up to six months after termination of treatment. However, this study did not have a control group so it cannot be

concluded that CBT was a more effective treatment than treatment as usual (TAU) for treating BPD.

Davidson and colleagues (2006) carried out a RCT to compare the effectiveness of CBT plus TAU versus TAU alone for treating 106 participants with BPD. Those in the CBT plus TAU group received up to 30 individual sessions focussing on identifying and monitoring core beliefs and behaviours that impair adaptive functioning. The TAU group received general practitioner care, contact with community mental health services, and contact with emergency services as required. All participants were evaluated at 12 months (end of treatment) and at 24 months (follow up) to assess suicidal acts, in-patient hospitalisation, accident and emergency attendance, and acts of self-harm. The researchers found that both groups demonstrated improvements in number of hospitalisations and accident and emergency contacts. There were no significant differences for depression, social functioning, quality of life, psychiatric symptoms and interpersonal problems. Individuals in the CBT plus TAU group showed greater improvements in their dysfunctional beliefs in comparison to the TAU group (Davidson et al., 2006). Davidson and colleagues (2010) completed a six-year follow-up with the original RCT cohort. They found that over half of the participants who met criteria for BPD upon entry into the RCT, no longer met criteria. Moreover, the reductions in suicidal behaviour seen at one-year were maintained at the six-year follow up. Lastly, they found that the duration of hospital stays and overall costs to services were lower for those who were in the CBT plus TAU group compared with the TAU group alone (Davidson et al., 2010).

Schema therapy is a third wave cognitive behavioural therapy, developed by Jeffrey Young (Young, 1994; Young, Klosko, & Weishaar, 2003) that draws on a range of theoretical models (i.e. CBT, object relations, attachment theory) with a direct focus of treating personality disorders. Similar to CBT formulations, schema therapy suggests that certain schemas or modes (pattern of being that starts in childhood and repeats throughout one's life) develop as a result of dysfunctional relational experiences in early childhood (Davidson, 2007; Young, 1994). Schema therapy posits four specific schema modes considered characteristic of borderline personality disorder: the abandoned/abused child mode, the angry/impulsive child mode, the detached protector mode, and the punitive parent mode (Arntz & Van Genderen, 2020; Young et al., 2003). One of the main goals of schema therapy for BPD is to help clients to strengthen their Healthy Adult mode (Arntz & Van Genderen, 2020), and learn to understand and manage their other modes. Schema therapy achieves this through a range of behavioural, cognitive, and experiential techniques, with the therapy relationship seen as a vital component

of change, as the therapist can confront the client empathically when their schema modes have been activated in therapy (Young et al., 2003).

Dialectical Behavioural Therapy and Borderline Personality Disorder: aetiology, treatment techniques, treatment efficacy.

Marsha Linehan, the founder of Dialectical Behavioural Therapy – another third wave cognitive behaviour therapy - observed that a pattern of parasuicide (intentional, acute, self-injurious behaviours such as suicide and self-harm) was most associated with BPD, and that this had previously been overlooked by behaviourists and analysts as an important treatment target (Dimeff & Linehan, 2001; Linehan, 1987a). Consequently, Linehan created DBT in an attempt to develop a more successful approach for treating individuals with BPD. DBT is based on biosocial theory (Linehan, 1987a; Linehan, 1993), emphasising the reciprocal interaction of both biological and social factors in the development of BPD (Shearin & Linehan, 1994).

Linehan's DBT model suggests that clients with BPD are characterised by a dysfunction in emotional regulation that causes a strong reaction to stressful events and slow return to emotional baseline following such events (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Linehan et al., 2015). Linehan (1993) proposed that the environment of the client was (and often still is) an invalidating environment. Moreover, that poor responses from caregivers to children's emotions contribute to their problems with regulating, understanding, and tolerating their emotional experience. Empirical research reveals that these individuals are often exposed to trauma – such as childhood sexual abuse - and find maladaptive ways of coping, such as behaviours like self-mutilation (cutting, burning, hair pulling) or preoccupation with suicide (Wagner & Linehan, 1994). Linehan (1993; 2015) suggested that parasuicidal behaviours occur when the individual believes parasuicide to be the best possible solution to an inescapable or intolerable situation. Parasuicidal behaviours impact an individual's ability to interact with their environment effectively which account for feelings of emptiness, abandonment, rejection, helplessness, and unstable relationships – notable as symptoms of BPD.

DBT conceptualises BPD as behaviours (parasuicidal behaviour) that are maladaptive ways of coping with challenges in life (Ward-Ciesielski, Limowski, & Krychiw, 2020). Consequently, treatment aims to 'build a life worth living' so that such behaviours are no longer necessary and the diagnosis is no longer warranted (Bedics & McKinley, 2020). DBT is

directive and intervention-oriented, combining cognitive, behavioural and mindfulness based techniques, with an overarching philosophical framework of dialectics (Linehan, 1987a; Ward-Ciesielski et al., 2020). Given the dialectical focus in DBT, the therapist aims to adopt a balance between acceptance - by validating that the client is doing the best they can - while focussing on change (Linehan, 1987b; Linehan, 1993). Efforts are made to combine matter-of-fact attitudes about suicide and problematic behaviours with warmth, flexibility and responsiveness. Furthermore, therapists attempt to reframe suicide and dysfunctional behaviours to the client as a learned form of problem solving in the hopes of replacing such behaviours with more skilful behaviours that are in line with a life worth living.

Linehan (1993; 2015) suggests four primary modes of treatment in DBT: individual therapy, group-based skills training, telephone contact from client to therapist, and therapist consultation groups. In individual therapy, which generally takes place once a week, the primary emphasis is on replacing maladaptive behaviours with adaptive behaviours and responses (Linehan, 1993). The behaviours in focus are hierarchically arranged into 1) life interfering behaviours, 2) behaviours interfering with therapy, 3) behaviours interfering with quality of life, 4) behavioural skill acquisition, and 5) any other goals the client wishes to work on (Linehan, 1987b). All modes of teaching focus on replacing dysfunctional ways of coping with more functional problem solving skills, such as mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness (Linehan, 1987b; Linehan, 1993), with the goal that clients build a life worth living. For example, radical acceptance is a distress tolerance skill taught in skills group which refers to a complete acknowledgement and acceptance of reality for what it is in that precise moment (Linehan, 2014).

DBT is considered the front-line therapeutic approach for treating individuals diagnosed with BPD (Ward-Ciesielski et al., 2020), and has the largest body of research for treating this client group (Storebø et al., 2020). Since the development of DBT, numerous randomised control trials (Bedics, Atkins, Comtois, & Linehan, 2012; Linehan, Suarez, & Allmon, 1991; Linehan et al., 2006; Linehan et al., 2015) and meta-analyses (DeCou, Comtois, & Landes, 2019; Kliem, Kroger, & Kosfelder, 2010; Panos, Jackson, Hasan, & Panos, 2014) have been conducted to determine the efficacy of DBT for treating clients with BPD. In an early RCT, Linehan (1991) evaluated the effectiveness of DBT compared to treatment as usual (TAU) for 44 women diagnosed with BPD who were randomly assigned to one of two treatment groups for one year. Participants were assessed four, eight, and 12 months. At each

assessment point, there was a significant reduction in frequency of parasuicidal behaviours among participants who received DBT. Those who received DBT displayed 1.5 parasuicidal acts per year compared with nine acts per year for those who received TAU. Similarly, those in the DBT group had less inpatient admissions throughout the duration of treatment. DBT group participants had an average of eight days of in-patient admission compared with 38 days for the TAU group. No differences were found on outcomes of depression, hopelessness or suicidal ideation between the two treatment conditions (Linehan et al., 1991).

In another RCT, Linehan at al. (2006) examined whether DBT was a more effective treatment compared to treatment offered by non-behavioural psychotherapy experts for 101 women with BPD. Participants received one year of either DBT or other (unspecified) community treatment by experts. They were assessed every four months up until one year after termination of treatment. The researchers found that, depression, suicide ideation, and reasons for living improved significantly in both conditions. Moreover, over a two year period, those who received DBT attempted suicide 50% less that those who received non–behavioural therapy by experts. The researchers also found that DBT was more effective in reducing emergency department visits and inpatient care for suicidal ideation compared to the other treatment condition (Linehan et al., 2006).

Given the effectiveness of DBT in reducing suicide attempts and crisis admissions, Linehan and colleagues (2015) conduced a RCT to examine which components of DBT were required for positive outcomes. They found that DBT interventions that included the DBT skills training component were more effective in reducing self-injurious acts and improving other mental health problems than a DBT intervention without skills training. These results indicate that DBT programs which adhere closest to the model, including all modes of treatment, may be most effective for treating clients with BPD (Linehan et al., 2015).

Several meta-analyses have examined the efficacy of DBT for treating clients diagnosed with BPD (DeCou et al., 2019; Kliem et al., 2010; Panos et al., 2014). The most recent meta-analysis identified 18 controlled trials of DBT that assessed self-injurious behaviour, suicide attempts and access of psychiatric services (DeCou et al., 2019). The authors concluded that DBT is effective in reducing self-harm behaviours and frequency of crisis services, however, there were no significant effects with regards to reducing suicidal ideation. Recently, Rudge and colleagues (2020) provided a critical review of the literature regarding mechanisms of change in DBT for treating BPD. Although the authors concluded that

continued investigation is required to determine the specific mechanisms that are active in treating BPD, they did highlight that there are several key points which are explained by Linehan's (1993) DBT biosocial model of BPD. They highlighted that deficits in emotion regulation and self-control appear to be improved through the therapeutic alliance and investment in treatment, which subsequently, leads to increased skill use, thus resulting in improvements in symptoms of BPD (Rudge et al., 2020).

Harvey and colleagues (2019) conducted a recent systematic review of the literature investigating the effectiveness of DBT in reducing emotion dysregulation, relative to TAU or waitlist control designs. The review identified 14 studies from 2010 to 2018, all of which used the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004) to measure emotion regulation. The authors concluded that DBT does not show consistent benefits in improving emotion regulation (Harvey et al., 2019), noting significant methodological limitations in some of the studies included, thereby increasing risk of bias across study outcomes. Furthermore, the authors found high variability across DBT programs and minimal investigation regarding adherence to the DBT model (Harvey et al., 2019), as no study included in the review delivered the full DBT protocol outlined by Linehan (Linehan, 1993; Linehan et al., 2015). Whilst this study did not focus on BPD specifically, it is important to acknowledge in the present literature review as emotion dysregulation is a core feature of BPD (Kröger, Vonau, Kliem, & Kosfelder, 2011).

Summary of the Efficacy of various Treatment Approaches for BPD.

There are a number of psychological treatments for BPD that are effective in reducing particular behaviours, or symptoms, experienced by individuals who are diagnosed with BPD. A number of studies support that notion that MBT, a modern psychodynamic therapy, is superior to standard care/TAU for clients with BPD diagnoses in reducing BPD symptoms and improving quality of life, and that these benefits may be maintained years after completion of treatment. Several studies indicate that CBT as an addition to treatment for BPD may reduce some symptoms of BPD, and that these reductions in symptomology may be maintained years after treatment is terminated. However, the research examining the effectiveness of CBT for treating BPD is sparse, and therefore it cannot be concluded that CBT is as effective as other therapeutic approaches for treating clients with BPD. There is a large evidence base for DBT and its effectiveness with clients with BPD, with many studies highlighting the effectiveness of DBT in reducing suicidal and self-injurious behaviours as well as reducing use of crisis or

inpatient services. There is minimal research comparing the efficacy of specialised treatments, such as DBT and MBT, for treating clients with BPD. However, the most recent Cochrane review (Storebø et al., 2020) assessed the effects of various psychological interventions for BPD and concluded that while MBT is superior to treatment as usual (TAU) at reducing self-harm, suicidality and depression, DBT is the most effective treatment at reducing BPD severity, self-injury, and improving psychosocial functioning (Storebø et al., 2020).

The final section of this chapter considers the clinical literature relevant to therapists' CT experiences when working with clients diagnosed with BPD; and then examines the research in this area.

Countertransference and Borderline Personality Disorder

Clinical Literature.

A number of therapists have written about their experiences and observations of CT in work with BPD. Gunderson (2009) and Maltsbeger and Buie (1974) note that CT is inevitable in all therapy but particularly when working with clients with BPD. Others have noted that therapists may find therapy with this client group challenging because of their clients' fluctuations in clinical presentation, unpredictability of behaviours and intense range of emotions often displayed during therapy, although they also note CT reactions fall on a continuum and vary in both frequency and intensity depending on the severity of clients' disorder (Gabbard & Wilkinson, 2000; Meissner, 1988).

Some authors have described a range of CT reactions alongside the client behaviours and relational patterns that appear to give rise to such reactions (Gabbard, 1993; Gabbard, 2001b; McHenry, 1994). McHenry (1994) described an array of CT reactions and enactments therapists may experience toward clients with BPD. These include confusion and inability to think clearly when clients are needy and demanding; boredom and sleepiness when clients are not taking responsibility for themselves; grandiosity when being idealised by clients; punitiveness when clients are uncooperative; hate when being devalued by clients; over involvement when clients are needy; and lastly, notes that therapists may allow their own boundaries to be violated when their clients regress or are needy (McHenry, 1994) .

Similarly, in his seminal work, Gabbard (1993; Gabbard & Wilkinson, 2000) addresses the behaviours and ways of relating of clients with BPD that can evoke certain CT reactions

for therapists. Clients with BPD may shift from idealising to devaluing their therapists, resulting in therapists CT reactions of helplessness or worthlessness and feeling incompetent or deskilled. CT reactions of anxiety or terror can arise and therapists fear they may say or do the wrong things and cause clients to become angry and impulsive. Gabbard and Wilksinson (2000) note that therapists may excessively try to keep clients alive, which sets therapists up to be at the mercy of clients' demands. Gabbard and Wilkinson (2000) also observed that rescue fantasies are common in response to therapists' perceptions that clients are helpless and need things done for them. Therapists may also experience CT reactions of guilt and a sense of responsibility for clients' deterioration over the course of therapy, if this occurs. To avoid client anger and risk-taking behaviour, therapists may go beyond their usual limits and extend sessions or allow extra phone calls. Therapists' own feelings of rage, hatred, and resentment may also occur when therapists feel used or are being held hostage to suicide threats. In some cases, this may result in therapists feeling tempted to retaliate against a client as a way of defending themselves against perceived attacks (Gabbard, 1993; Gabbard & Wilkinson, 2000).

Therapists have also written about their observations of CT reactions of hate or aggression towards clients with BPD (Gabbard, 1993; Kernberg, 1985; Maltsberger & Buie, 1974). Maltsberger and Buie (1974) noted that clients with BPD experience transference-hate in relation to a deep sense of abandonment and craving for closeness, which results in continuously questioning the worth and reliability of others, including the therapist. Moreover, therapists are often treated as if they are as cold and uncaring, which can result in CT of hatred or rage. Similarly, Kernberg (1985) posited that CT conflicts of aggression are common for therapists working with BPD. Moreover, over the course of therapy, therapists can come to identify with their clients' aggression, which can be problematic if uncontained and unmanaged.

Therapists also emphasise the importance of successful management of CT (Gabbard, 2001b; Gunderson, 2009; McHenry, 1994; Meissner, 1982). Gabbard and Wilkinson (2000) note that management of CT sets the foundation for the rest of the therapeutic work, as unmanaged CT can interfere with the formation of a successful therapeutic relationship and the therapeutic work. Similarly, McHenry (1994) postulated that if a therapist's CT is not acknowledged, understood and worked through, the client's difficulties will be maintained and relational templates repeated in therapy, as opposed to altered. Along the same lines, Gabbard (2001b) notes that therapists CT reactions can be used to help clients understand when past

relational patterns are being repeated in the therapeutic relationship. Given the nature of their clinical presentation and relational instability, Gunderson (2009) highlights that work with clients with BPD should not be done alone, and that supervision and consultation with colleagues can serve to safeguard against CT enactments.

Empirical Research.

An examination of the research literature revealed only a small number of studies have investigated therapists experiences of CT when working with clients diagnosed with BPD. Most of the studies identified are quantitative and only four studies actually used the term CT. Two questionnaire studies (Brody & Farber, 1996; Liebman & Burnette, 2013) examined therapists CT reactions towards clients via clinical vignettes found that therapists experience stronger CT reactions, and less empathy, towards clients with BPD compared to other client groups. Brody and Farber (1996) investigated the reactions of 336 therapists in response to clinical vignettes describing clients with depression, BPD or schizophrenia. They found that therapists exhibited greater anger and irritation and less empathy and nurturance toward clients with BPD compared to other client groups.

Another study examined the client factors and therapist factors that to contribute to CT reactions towards clients with BPD (Liebman & Burnette, 2013). Liebman and colleagues (2013) asked clinicians (Psychologists, Psychiatrists, Psychotherapists and Social Workers) to complete an anonymous online survey and respond to a case vignette describing a client with BPD and to assign a diagnosis and answer questions assessing their reactions to the client. The researchers found that participants were more accurate in diagnosing female clients with BPD than male clients. Participants with more clinical experience generally reported more positive CT reactions. Clinicians who assigned a diagnosis of BPD to a client reported less empathy toward them, and viewed the client as more unwell than those to whom they had assigned other diagnoses (Liebman & Burnette, 2013).

Other studies have investigated therapists' experiences towards clients with BPD compared to Major Depressive Disorder (MDD) (Bourke & Grenyer, 2010; Bourke & Grenyer, 2013; McIntyre & Schwartz, 1998) and found that the nature of the therapists' reactions towards clients differed among the diagnoses. Indeed, in a mixed methods study, Bourke and Grenyer (2013) investigated 20 therapists' experiences of therapeutic process when treating clients with either BPD or MDD. The therapists participated in a five minute recorded interview about relational experiences from therapeutic work with clients with BPD and then again for

MDD. The therapists then completed the Psychotherapy Relationship Questionnaire (Westen, 2000) - a 90 item questionnaire designed to measure a wide range of relational patterns – in reference to the client they had discussed in the interview. Content analyses of the qualitative data identified a theme of 'therapist response'. Words such as 'emotional', 'distressed', and 'rejected' were reported by therapists to describe their responses working with clients with BPD. Comparatively, words such as 'empathetic' and 'sad' were reported by therapists in regards to clients they had treated with MDD. Regarding the PRQ results, therapists believed that clients with BPD expressed relational patterns of hostility, narcissism, anxiety, avoidance, dismissiveness and sexualisation during therapy. Conversely, therapists generally reported on a positive working alliance with their clients with MDD (Bourke & Grenyer, 2013).

Similarly, McIntyre and Schwartz (1998) conducted a survey study comparing 155 therapists' CT reactions to clients diagnosed with either BPD or MDD. CT reactions were assessed using the Impact Message Inventory (Perkins et al., 1979) and the Stress Appraisal Scale (Carpenter, 2016). The researchers found that therapists reported reactions of hostility and dominance towards clients with BPD and reactions of submissiveness and friendliness towards clients with MDD (McIntyre & Schwartz, 1998). The findings from this study support the findings from the previous studies and the clinical literature discussed above that highlight the challenging nature of CT reactions towards clients diagnosed with BPD relative to other client-groups.

Two studies have examined the relationship between therapists emotional reactions and clients' personality disorders (Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; Tanzilli et al., 2016). Both Colli et al., (2014) and Tanzilli et al., (2016) asked therapists to complete both the Therapist Response Questionnaire (Betan et al., 2005; Zittel Conklin & Westen, 2003) to identify patterns of emotional responses, and the Shedler Westen Assessment Procedure-200 (Shedler & Westen, 2007) to assess personality disorder and psychological functioning. Both studies found that therapists reported stronger CT reactions of helpless/inadequate, overwhelmed/disorganised and special/overinvolved when working with BPD compared with other personality disorders (Colli et al., 2014; Tanzilli et al., 2016).

In line with this, a recent New Zealand study examined 267 clinicians (Psychologists, Psychotherapists, and Psychiatrists) CT reactions to working with clients at risk of suicide (Soulié, Bell, Jenkin, Sim, & Collings, 2020). The researchers asked clinicians to complete the Therapist Response Questionnaire (Betan et al., 2005; Zittel Conklin & Westen, 2003), with

reference to a client at risk of suicide. The researchers found that those who were reporting on reactions towards clients with personality disorders, mainly with traits of BPD, reported significantly more entrapped/rejecting, aroused/reacting, informal/boundary crossing, ambivalent/inconsistent, and mistreated/controlling CT responses and less fulfilled/engaging CT responses compared to therapists who reported on reactions to clients without personality disorder diagnoses (Soulié et al., 2020).

Some researchers have examined the types of reactions therapists experience towards clients with BPD in the context of clients' challenging behaviours. In a questionnaire study, Treloar (2009) asked 140 health professionals (Psychologiststs, Nurses, Social Workers, Occupational Therapists and Psychiatrists) across Australia and New Zealand working in either mental health or emergency medicine about their experiences working with clients with BPD. The participants were given an open ended question and asked to comment about their experiences working with clients with BPD. The therapists reported uncomfortable personal responses to clients with BPD such as feeling challenged or inadequate, perceiving their clients to be too difficult or too frustrating, and feeling unsure how to respond. The therapists also reported on behaviours of BPD that they thought contributed to such responses. Clients were perceived as manipulative, to have poor coping and interpersonal skills, to be time consuming, and to be using self-injurious behaviour to communicate distress (Treloar, 2009). Although this study did not use the term CT, it provides evidence that certain behaviours associated with BPD contribute to the challenging, often strong reactions that therapists experience when working with this client group.

Similarly, two unpublished thesis studies captured the client behaviours that impact therapists' CT reactions towards clients with BPD (Bieke-Rapske, 2016; Fritz, 2012). Fritz (2012) conducted a qualitative thesis study investigating the attitudes and feelings of 11 clinicians (Social Workers, Psychologists, Marriage and Family Therapists) towards clients with BPD. Clinicians reported working with clients with BPD to be challenging and described clients' impulsivity, emotion dysregulation, and lack of progress as factors that result in therapists finding the work challenging. Feelings of fear and caution were described by some therapists, particularly in response to their clients' self-harm or suicidality. Although some of the therapists in the study spoke about not being eager to work with BPD clients, many described empathy towards their clients and the struggles they live with (Fritz, 2012).

Bieke-Rapske (2016) carried out an interview study with 12 psychotherapists' to explore CT experiences working with clients with BPD. Therapists reported strong CT reactions of fear and anxiety associated with the unpredictability and uncertainty of their clients' emotional shifts, as well as uncertainty determining the best course of treatment. The therapists also reported experiencing fear that their clients with BPD would harm themselves, which resulted in therapists feeling a desire to keep their clients safe. A range of emotional reactions were also described, including: frustration with clients' perceived attitude or slow progress, anger when clients were seen as lying or manipulative, guilt when therapists felt like they did something wrong, shock in response to hearing about clients' histories, and, feeling overwhelmed when clients were experienced as overpowering. Some therapists in the study also spoke about feelings of pride and accomplishment when clients made progress. They described this as a rewarding experience compared to working with other client groups because of the difficulty involved working with clients with BPD (Bieke-Rapske, 2016). This study did not examine the ways that therapists conceptualised, managed, or utilised their CT reactions.

As previously discussed, recognition and management of CT reactions is associated with more positive therapeutic alliances and better therapy outcomes and (Hayes et al., 2011; Hayes et al., 2018). In reviewing the literature, no published studies were identified that examined therapists' management of CT when working with clients with BPD. However, three thesis studies were found that revealed the importance of therapists' management of CT for therapeutic outcomes when working clinically with BPD (Feinberg, 2020; Hunt, 2003; Wyman, 2008).

Feinberg (2020) investigated the characteristics of therapists who worked with BPD to gain understanding of the ways in which therapists may enhance or impair treatment. The therapists in this study completed a range of questionnaires assessing burnout, ability to manage CT, and cognitive and emotional CT reactions. The researcher found therapists who were able to manage their CT when working with BPD reported less negative emotional and cognitive CT experiences. Moreover, they were more likely to perceive their work to be more effective when they felt able to manage their CT reactions (Feinberg, 2020). Similarly, Hunt (2003) surveyed 55 psychologists' experiences of CT, CT management ability, empathy, and working alliance with BPD clients. The researcher found that therapists' ability to manage their CT reactions decreased when their CT behaviours increased, thus implying that the more therapists allowed CT reactions to go unnoticed and unmanaged, the harder they were to

manage. Wyman (2008) conducted a qualitative study interviewing therapists about their experiences working with clients with BPD. The therapists in this study spoke about the challenge of managing CT whilst maintaining the therapeutic relationship when working with clients with BPD. Specifically, some therapists discussed the importance of engaging in supervision, peer consultation, and their own therapy as helpful in assisting them to manage their CT reactions. Moreover, therapists described specific behaviours within sessions effective in helping manage CT, such as: staying present, being calm, tolerant and non-reactive (Wyman, 2008).

In sum, the research presented indicates that therapists experience stronger and more negative CT reactions towards clients with BPD compared to clients with other diagnoses. Types of CT reactions identified in relation to clients with BPD included: hostility, helplessness, fear, feeling overwhelmed, feeling overinvolved, and feelings of guilt. One study observed that therapists experienced a sense of pride. There is also evidence that therapists perceive clients with BPD more negatively than other client groups, and that certain behaviours and ways of relating displayed by clients with BPD contribute to therapists CT reactions. For instance, clients' emotional shifts, poor coping skills, self-harm behaviours, threats of self-harm, and interpersonal difficulties were noted as contributing to therapists' responses. Results from three unpublished thesis studies suggest that therapists who are able to manage their CT reactions towards clients with BPD report less CT experiences and perceive their therapeutic work to be more effective. These findings support those from meta-analyses on CT that managing CT reactions is associated with better therapy outcomes (Hayes et al., 2011; Hayes et al., 2018).

Present Study

Previous research into CT suggests that CT is a common experience for all therapists regardless of their therapeutic origin (Betan et al., 2005). CT is an important therapist factor that can effect therapy outcomes depending on how it is understood and managed (Hayes et al., 2011; Hayes et al., 2018). Moreover, therapists working with clients with a diagnosis of BPD experience a myriad of CT reactions (Gabbard & Wilkinson, 2000; Rossberg, Karterud, Pedersen, & Friis, 2007; Sperry & Sperry, 2015) and often find these clients more challenging to work with than clients with other diagnoses (Brody & Farber, 1996; McIntyre & Schwartz, 1998). Previous studies examining CT and BPD have been mainly quantitative (Colli et al., 2014; Tanzilli et al., 2016) or unpublished thesis studies (Bieke-Rapske, 2016; Fritz, 2012;

Wyman, 2008). Little research has qualitatively examined the nuance of the types of CT reactions therapists experience with BPD, including the client behaviours and/or therapy situations that activate such reactions. Moreover, there is a lack of research that has qualitatively examined the ways therapists conceptualise their CT reactions when working with BPD. Lastly, although it is established that managing CT when working with BPD is important (Hunt, 2003; Wyman, 2008), research on the specific ways therapists manage and utilise their CT is sparse. Given the above, the aims of this study were:

i) To examine the types of CT reactions that therapists experience when working with clients with BPD; and the client behaviours, therapist sensitivities, or therapy situations that give rise to these reactions.

ii) To examine conceptualisations of CT of therapists from different therapeutic approaches when working with individuals who have been diagnosed with borderline personality disorder.

iii) To understand how therapists manage and utilise CT in therapy.

Chapter Two - Overview of Methodology

This study aimed to investigate therapists' experiences of CT when working therapeutically with clients diagnosed with BPD. Specifically, it examined the types of CT reactions therapists experience when working with clients with BPD, including the client behaviours, therapist sensitivities, and therapy situations that give rise to these reactions. Also, this research sought to gain an understanding of the way in which therapists conceptualise, manage and utilise their CT reactions. This study analysed qualitative data collected from thirteen interviews with therapists in New Zealand, who worked, trained and/or practiced from different therapeutic perspectives.

This chapter outlines the qualitative methodology used in this study, including the steps taken to ensure the overall quality of the study. The method of this study is then presented, including the recruitment of participants, participant demographics, and the process of data collection. Lastly, the chapter provides a detailed description of the data analysis.

Qualitative Methodology

Quantitative research has historically been the preferred method of choice for the social sciences (Denzin & Lincoln, 2011). Quantitative research describes facts and characteristics of a specific phenomenon, or relationships between events and phenomenon, presented in numerical form (Merriam & Tisdell, 2015). It has been argued that this approach to research is not suited for studies that aim to capture the subjectivity of human beings (Bowling, 2014). In contrast, qualitative research has developed due to the limitations of quantitative research to capture human experience (Flick, 2009). Qualitative research focuses on understanding human experience in a variety of contexts, as well as investigating social dimensions such as social processes and discourses (Bauman et al., 2002). Qualitative research involves interviews, observations or written texts as a means of data collection (Braun & Clarke, 2013). Hence, whilst quantitative research uses numbers as data and analyses them using statistical analyses, qualitative research uses words (Braun & Clarke, 2013).

Characteristics of Qualitative Research

There are fundamental distinguishing characteristics common to many qualitative approaches. Firstly, qualitative research methods aim to gain a rich understanding of the ways people make meaning of their lives and experiences (Bowling, 2014; Merriam & Tisdell,

2015). In this study, value is placed on understanding the ways therapists experience and conceptualise their CT experiences when working therapeutically with clients diagnosed with BPD. Secondly, the researcher is the primary instrument for data collection and analysis (Merriam & Tisdell, 2015; Merriam & Grenier, 2019). Thus, whilst participants' perceptions and understandings are at the centre of qualitative research, the data, as interpreted by the researcher, cannot be separated from the researcher's background (Watt, 2007). However, steps can be taken to mitigate the subjectivity of qualitative research and increase the trustworthiness and quality of the research. The steps undertaken for this thesis study are outlined in the following section. The third characteristic shared by qualitative methodologies is that they use inductive analysis to develop and contribute to theories instead of testing hypotheses (Merriam & Grenier, 2019). Inductive analysis involves the generation of themes by organising data – from interviews, observations or written texts - into comprehensive and abstract categories or groups of related data (Merriam & Tisdell, 2015). Lastly, the final product of qualitative research is rich and descriptive (Merriam & Tisdell, 2015), using words instead of numbers to capture human experience (Bowling, 2014). With these characteristics, sample sizes in qualitative research often small and purposeful (Moriarty, 2011).

Qualitative Approach of this Study

Whilst all qualitative methodologies have similar characteristics, their ontological and epistemological paradigms can vary greatly (Guba & Lincoln, 1994). Ontology refers to what is believed about the nature of reality (Creswell & Poth, 2016; Merriam & Tisdell, 2015). Qualitative research typically holds the assumption that multiple realities or interpretations of a phenomenon exist (Merriam & Tisdell, 2015). The current study is influenced by a critical realist perspective in that reality is believed to exist, however, perceptions of reality are influenced by social and cultural experiences (Braun & Clarke, 2013). This study postulates that therapists have an understanding that CT exists, however their experience will be understood through their own biases informed by their social contexts, cultural background, and training experiences.

In qualitative research, epistemology concerns the nature of knowledge and the ways in which a researcher attempts to discover knowledge (Creswell & Poth, 2016). An interpretivist epistemology is the most common type of qualitative research (Merriam & Grenier, 2019) and is based on the assumption that peoples' understandings of a given phenomenon are subjective, as they are influenced by their own beliefs and experiences

(Madill, Jordan, & Shirley, 2000). Interpretivist researchers are interested in how people make sense of their experiences (Kaplan & Maxwell, 2005). This research held an interpretivist position to investigate the aims of the study, as the research sought to understand the ways therapists conceptualise, manage and utilise their CT reactions in the context of their own experiences.

Quality in Qualitative Research.

Ensuring research is valid and reliable is an important aspect of all research (Brink, 1993). A qualitative approach is based on different assumptions to traditional quantitative research. Thus, many theorists argue different criteria should be employed when assessing the quality of qualitative research (Brink, 1993; Merriam & Tisdell, 2015). Guba and Lincoln (1994) argue that it is important to specify ways of assessing quality of research that serve as an alternative to validity and reliability standards, which assume there is one single account of social reality. Guba and Lincoln's (1994) criteria to help ensure the 'trustworthiness' of a study are credibility, dependability, transferability, and confirmability. A number of strategies are outlined below that I employed to address these criteria.

Credibility refers to how representative the interpretations and descriptions are of participants' reported experiences (Merriam & Tisdell, 2015; Thomas & Magilvy, 2011). For this study, credibility is the consistency between therapists' experiences of CT when working with clients with BPD diagnoses and the results of this study. To ensure credibility, I met with my primary supervisor regularly to debrief and review the research process. My supervisor reviewed the data coding against the interview transcripts to ensure the codes were representative of the data. I also reviewed the development of the themes and the write-up with both my primary supervisor and another researcher to ensure the findings and interpretations were valid and represented the experiences reported by the participants.

Dependability refers to the consistency of the research process relative to accepted standards for particular methodologies and methods (Tolley, Ulin, Mack, Robinson, & Succop, 2016). To demonstrate dependability, this study used a specific, well-established procedure for both data collection and data analysis. Detailed descriptions of these processes are outlined in the data collection and data analysis section.

Transferability refers to the extent to which the research findings are relevant to their particular field of research and able to be applied to others (Merriam & Tisdell, 2015; Thomas

& Magilvy, 2011). In this study, transferability refers to the applicability of the findings to therapists working with clients with BPD and to training programs of therapists. This study also outlines a detailed account of the participants' demographic information and the methodology used to provide the context of this study to ensure readers can question the relevance of the findings in regards to working clinically with BPD.

Lastly, confirmability is established once steps are taken to ensure the findings of the study reflect the experiences and ideas of the therapists who participate in this research study, rather than the researchers own ideas (Morrow, 2005; Tolley et al., 2016). Although the researcher's subjectivity is generally considered to be a unique and positive aspect of the research, the researcher's subjectivity can cloud the findings if unchecked (Brink, 1993; Merriam & Tisdell, 2015). Thus, it is essential that the qualitative researcher reflects on, and manages their own responses to the data. To decrease the likelihood of introducing bias, I kept a diary to document the research process, including any observations, thoughts, feelings, and responses with regards to data collection and data analysis. I also met regularly with my supervisor to discuss the research process, including the recruitment of participants, initial coding, the development of themes, and the write up process.

Personal Reflection.

My interest in CT began prior to my clinical training as, in my late teenage years, I read several books on psychoanalysis and psychodynamic therapy. This led to an interest in the ways early experiences of trauma and relational adversity influence people later in life. Before commencing my training, I knew wanted to work clinically with people diagnosed with 'Borderline Personality Disorder'. I had always wanted to work with trauma and had conceptualised the diagnosis as a set of behaviours that could be likened to a complex trauma presentation. Hence, as a trainee psychologist, it seemed fitting that I sought to explore therapists' experiences of CT when working with this client group. Throughout this research project I have been exposed to various conceptualisations of CT through my academic institution, with the CT training focussing on applying psychodynamic views of CT to a range of therapeutic modalities. I also learnt about psychoanalytic views of CT through training I have sought elsewhere. During the last year of my clinical training, I had the privilege of working therapeutically with clients who had been diagnosed as having BPD. Throughout that time, I paid attention to my own CT reactions that I experienced with these clients, and often

reflected on these in my research diary to minimise the possibility of my own experiences working with BPD influencing the ways I had interpreted the data or written up the findings.

Method

This section of the chapter will outline the methods used in this thesis study. Ethical approval for this research was granted by the University of Auckland Human Participants Ethics Committee on 7th June 2018 (reference number 021316).

Recruitment

Following ethics approval, participants were largely recruited for this study via an online advertisement (see Appendix A), which was distributed to members of the New Zealand College of Clinical Psychologists (NZCCP). The advertisement was also placed into the New Zealand Association of Psychotherapists (NZAP) newsletter. Some therapists were also further recruited via word-of-mouth networking and hearing about the study from others who had either seen the advertisement or participated in the study.

Participants

As shown in Table 1, thirteen therapists responded to the advertisement and participated in the study. The therapists were ten females and three males, aged between 31 and 61 years (M = 45, SD = 11). Two of the therapists had dual registration. The therapists had training in various therapeutic models. Nine had training in CBT, two had training in Acceptance and Commitment Therapy, three had training in Schema Therapy, one had training in MBT, one had training in Transactional Analysis, and five had training in other unspecified psychodynamic therapies. All participants had training in DBT and 12 of 13 participants identified DBT (or DBT informed therapy) as the main therapy approach they used to treat clients with BPD. The participants estimated working with between 20 and 100 clients with BPD throughout their careers (M = 70, SD = 63). All participants were of European descent. The therapists had between five and 35 years of practice (M=17, SD = 9). At the time of the interview 11 participants worked primarily for the public mental health system and three of the 11 also worked part time in private practice. The other two participants worked clinically at academic institutions. Prior to training in DBT and working from a DBT approach, nine therapists had trained in CBT and five had training in psychodynamic therapies. Training in CT was variable, as three participants had no training in CT and other participants had learnt

about CT through CT workshops, supervision, personal therapy, or psychodynamic therapy trainings. Table 1 below shows participant demographics

Table 1

Participant demographic information

Variable		N	%	M (SD)
Gender				
	Male	3	23	
	Female	10	77	
Age (years)				45.17 (11.19)
	20-29	0	0	
	30-39	5	38	
	40-49	2	15	
	50-59	5	38	
	60-69	1	8	
Ethnicity				
	NZ European/Pakeha	8	61	
	Other European	5	39	
Professional Registration				
	Clinical Psychologist	11	83	
	Psychotherapist	3	23	
	Registered Nurse	1	8	
Years in Profession				17.42 (8.55)
	0-4	0	0	
	5-9	4	31	
	10-14	1	8	
	15-19	1	8	
	20+	7	53	
Years (working with BPD)				13.72 (6.98)
	0-4	2	15	
	5-9	4	31	

	10-14	1	8	
	15-19	1	8	
	20+	5	39	
Primary Employment				
	Public Health System	11	83	
	Private Practice	3	23	
	Academic Institutions	2	15	
Number (BPD clients)				70.67 (63.52)
	1-49	4	31	
	50-99	7	54	
	100+	2	15	
Therapies Trained				
	DBT	13	100	
	CBT	9	69	
	ACT	2	15	
	Schema Therapy	3	23	
	MBT	1	8	
	Transactional Analysis	1	8	
	Other Psychodynamic	5	39	
Training in CT				
	None	3	23	
	Workshops	5	39	
	Supervision/Personal Therapy	3	23	
	Psychodynamic Training	5	39	

Note. Total sample consisted of 13 participants.

Data Collection

The therapists expressed their interest in participating in the study by emailing the researcher. In response to their emails, they were sent a Participant Information Sheet (PIS) and Consent Form (see Appendices B and C), which they completed before the interview. Participants were asked to complete a demographic form, confirming their name, age, gender, ethnicity, years of practice, number of clients they had worked with who had BPD diagnoses, current and previous places of work, main therapeutic approaches used, and training in CT (Appendix D).

Interviews.

The interviews took place in a setting chosen by the participants. Options for interview setting included the participants' workplace, the university, via telephone, or via Skype/Zoom. Eight interviews were conducted in the workplace and five took place via Skype. The interviews lasted between 50 and 90 minutes, and the average length was 70 minutes (see Appendix E for the interview schedule). The semi-structured interview involved questions that focused on examining participants' experiences of CT when working therapeutically with clients diagnosed with BPD. This included discussing the types of CT reactions therapists had experienced, and the client behaviours, therapist sensitivities and therapy situations that gave rise to the CT reactions. The interview also involved enquiring about the ways therapists conceptualised, managed, and utilised their CT reactions when working with BPD.

Throughout the interviews, participants were asked to speak about their CT experiences generally. An example question from the schedule was: "What has your general experience been like working with clients diagnosed with BPD?". Participants were also asked to think and speak about specific examples with particular clients, whilst protecting their clients' identities. An example question aimed at this was: "Can you think of a time you experienced a CT reaction towards one of your clients with BPD and then describe your reaction?". Although the participants were asked to think about specific clients, the focus of the interview was the therapist, the therapy, and how they conceptualised, managed and utilised their CT experiences. The participants were also encouraged to discuss any other matters of relevance regarding their experiences of CT with this particular client group.

All interviews were recorded using a digital voice-recorder and were transcribed verbatim by either the researcher (eleven interviews), or a professional transcriber (two

interviews). Microsoft Word files containing the transcribed interviews were then imported into a qualitative software package, NVivo 12, which assisted with the management and organisation of the data for qualitative analysis.

Data Analysis: Thematic Analysis

Thematic analysis is a common method for analysing qualitative data (Braun & Clarke, 2006). The method of thematic analysis is flexible, as it can be used within different theoretical frameworks, for various purposes (Braun & Clarke, 2006). The findings that arise from thematic analysis provide rich and detailed descriptions of the data about an area of interest, often focusing on human experiences and understandings. In this study, thematic analysis was used to analyse the data from the interviews. Data from the interviews were initially divided into four main data sets pertaining to the research questions. These datasets were: types of CT reactions; conceptualising CT; managing CT reactions; and utilising CT reactions. Thematic analyses were carried out for all four sets of data. Braun and Clarke (2006) identify six steps that guide the process of thematic analysis, including 1) familiarisation with the data, 2) generating of initial codes of data into meaningful groups, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes, and finally 6) producing the final report.

Step 1: Data familiarisation.

Braun and Clarke (2006) note that transcription can be an important first step to becoming familiar with the data. Thus, it was important that I transcribed as many interviews as possible. I transcribed eleven interviews and an approved university transcriber transcribed two interviews. I also kept a research diary, to store any ideas, questions and initial thoughts about the data. This allowed me to begin forming ideas about possible patterns emerging in the data.

Step 2: Generating codes

After becoming familiar with the data in each data set, I printed each interview. I carefully went through the first five interviews for each data set and wrote brief statements/initial codes (Braun & Clarke, 2006) to summarise each unit of data in the margin of each page. The initial codes were determined based on meaning. This process resulted in a list of initial codes. If a code was repeated within the data across interviews from different participants, this was recorded so that it was clear how many times the code was represented. Following this process, I met with my supervisor to check and review the initial codes.

Step 3: Finding themes

The codes were then reviewed and organised into related ideas and similarities to establish initial proposed themes and subthemes. Braun and Clarke (2006) note that a theme captures a patterned response or meaning within the data that relates to the research question. The initial proposed themes for each of the four data sets were:

- *Types of CT reactions:* anxiety/fear with chaos and risk; frustration/anger with slow progress and attacks; sadness and a pull to rescue when clients are suffering; disconnecting with the client disconnects; the pit of despair; joy when the client makes progress.
- *Conceptualising CT:* psychodynamic ideas; it's just behaviour; responses tell us something
- *Managing CT:* trust in the model of DBT; talking with others; well-structured day including non-mental health activities.
- *Utilising CT:* it depends; naming responses and using disclosure.

Step 4: Reviewing themes.

To determine whether the potential themes captured the data set, the remaining eight interviews were reviewed to check the data against the themes by allocating a different coloured highlighter to each theme. Once the themes were established as consistent across data sets, the word documents containing the transcripts were uploaded to NVivo 12. The transcripts were then organised into the themes relevant to each of the four data sets. Throughout this process, any thoughts or observations were stored in my research diary.

After the themes were organised in NVivo, a thematic map was developed for each of the four data sets to visually depict the relationships between the proposed themes. The researcher then reviewed this process and the thematic map with the supervisor. Following this review, it was agreed that capturing both the therapists' reaction and the potential trigger for the reaction for each theme within the first data set - types of CT reactions - would be important. It was also discussed to combine both managing and utilising CT data sets into one data set, as there was less data for these in comparison to the other two data sets. Lastly, it was recommended to rework the themes for data set two - conceptualising CT - as some of the proposed themes and subthemes were unclear. Thus, the data in this data set were re-coded and new themes were established and reviewed with both the researcher's supervisor and a peer.

Step 5: Defining and naming themes.

The next step involved continuing to analyse the themes to ensure they captured the content. During this stage, I met with my supervisor to review, define and refine the themes. For example, for the second data sat (conceptualising CT), the theme ‘it’s just behaviour’ was renamed ‘it’s just behaviour: using DBT concepts to make sense of reactions’. The initial themes and final themes are presented in Table 2.

Table 2

Initial themes and final themes

Initial Themes		Final Themes	
Types of CT reactions	Anxiety/fear with chaos and risk	*Types of CT reactions*	Anxiety and fear amidst chaos
	Frustration/anger with slow progress and attacks		Frustration and anger with ongoing challenges
	Sadness and a pull to rescue when clients are suffering		Sadness with suffering
	Disconnecting when the client disconnects		Disconnecting when the client disconnects
	The pit of despair		Hopelessness and despair with ongoing self-harm and suicidality
	Joy when the client makes progress		Joy and pride with progress
Conceptualising CT	Psychodynamic ideas	*Conceptualising CT*	Is CT about me or them?
	It's just behaviour		I don't use the term 'countertransference'
	Responses tell us something		It's just behaviour: using DBT concepts to make sense of reactions
Managing CT	Trust in the model of DBT	*Managing CT*	Trust the DBT model
	Talking with others		Talking with others
	Well-structured day including non-mental health activities.		Self-care
Utilising CT	It depends	*Utilising CT*	Naming or disclosing reactions
	Naming responses and using disclosure		It depends – using CT if helpful therapeutically

Step 6: Producing the report.

Once the themes were finalised, the last step involved writing up the results. The results were separated into three chapters pertaining to the data sets described. The aim of this phase was to ensure the report provided a clear description of each theme. Extracts in the form of quotations were used to capture the essence of each theme. The analysis for each theme was completed before moving on to the data for the next theme. The written analyses were reviewed and links were made between the themes in order to tell an overall story about the data. To protect the therapists' identity, the therapists were randomly assigned a number from one to 13.

Chapter Summary

The present study used a qualitative approach to investigate the types of CT reactions therapists experience when working therapeutically with clients diagnosed with BPD. It also examined the ways therapists conceptualised, managed and utilised their CT reactions. An interpretivist approach was used to gain an in-depth understanding of how therapists make sense of their CT experiences towards client with BPD. Thirteen therapists were recruited via an advertisement to participate in semi-structured interview lasting 50-90 minutes, focused on their experiences of CT. An inductive process of thematic analysis was carried out on the interview transcripts, as outlined by Braun and Clarke (2006). Steps were taken to ensure the validity and reliability of the findings and to minimise researcher bias, including, regular reviews with my primary supervisor and a continued process of self-reflection and documentation of my own observations, thoughts, feelings and responses throughout the process of data collection and analysis.

Chapter Three - Results

Thematic Analysis: Therapists' Conceptualisations of Countertransference.

This chapter presents the results of the thematic analysis of data pertaining to the ways the therapists conceptualise, or understand, 'countertransference' (CT). Therapists were asked to describe their understanding of countertransference, or describe what came to mind when they thought about the term. Several ways of understanding CT were spoken about, which provide context to the ways therapists made sense of their CT reactions towards clients with BPD. Three main themes were identified which serve to capture ways the therapists conceptualise the term CT. These were: 1) Is Countertransference about me or them?; 2) I don't use the term 'countertransference'; and 3) It's just behaviour: using DBT concepts to make sense of reactions.

These three themes and associated subthemes are presented in the following section. Quotes from the therapists are provided to illustrate the themes. The themes and subthemes are outlined in Table 3. Table 3 also presents the number of participants that endorsed each theme.

Table 3

Therapists' conceptualisations of countertransference – themes and subthemes

Themes (N=13)	Subthemes
Is Countertransference about me or them? (N=11)	Clients pull, invite and evoke Therapists' own history plays a role
I don't use the term 'countertransference' (N=13)	Being cautious with language in a "behavioural" system Psychodynamic ideas are too conceptual
It's just behaviour: using DBT concepts to make sense of reactions (N=9)	

Theme One: Is Countertransference about Me or Them?

Eleven therapists spoke about their understandings of whether CT reactions are more about therapist contributions, client contributions, or a combination of both. Many therapists spoke about CT being "unique" or "subjective" and specific to therapists and their own history, and/or "global", "objective" reactions that many people may experience in response to a client. The remainder of this section presents the therapists' explanations about the ways in which their CT reactions may stem from client contributions or therapist contributions. Two subthemes were identified: clients pull, invite and evoke; and, therapists' own history plays a role.

Clients pull, invite, and evoke.

Eight therapists spoke about CT as arising in response to a "pull", or "invitation" from their clients. They explained that CT reactions can be "global" or "common" experiences for several therapists in a team who work with a particular client. When asked about what comes to mind when they think of CT, several therapists spoke about CT as being something that initially comes from that client, that the therapist is "invited into" (P11). As one therapist noted, his CT response will "depend very much on what the client brings" as his CT reactions often "reflect something about the client" (P8). One therapist said her CT is a response to "whatever [her] client is consciously or unconsciously bringing and projecting" (P2), whilst another stated CT is "a response to the client and what they bring and how they are and what emotions they illicit in me" (P7). When asked about what CT is, another therapist said,

> I think it's the idea of how do clients affect us. Like, how do we get invited to be pulled in when clients are doing different behaviours and what does that mean for us as therapists and how do we want to respond … Like how can we respond therapeutically when we get tugged on in sessions in different ways. (P12)

Several therapists described CT reactions could be "objective" or "common among therapists", as one therapist noted objective CT to be "a more shared or generalised countertransference that perhaps many would have in response to that client and what they're saying and doing" (P6). Similarly, another therapist used the term objective CT and defined it as "countertransference which is maybe something that other people also experience and is common to many therapists in that situation who feel that same way" (P9). Some therapists described this by using case vignettes. For example, one therapist described feeling a

"yearning", "protective quality" to take care of a client who experienced a traumatic upbringing and was engaging in life threatening behaviours. The therapist described experiencing a "pull" to keep her safe and "save her" from her "aloneness". The therapist spoke about his response to be "common with people who got to know her in a professional capacity, it's like oh my god, you know, you poor thing" (P10). Another therapist described a case example to illustrate that her CT reaction of frustrated "critical parent mode" as well as "rescuer" was experienced by others in response to this client. She said,

> If she was irritable and wilful and challenging then people would wanna tell her off and tell her that she has been naughty … if she was sad and you know showing her self harm and had her head down talking about trauma then you'd get people stepping in and wanting to do more … And often I'd get calls from random people about her who she'd only met once or something and they would call me and tell me I wasn't doing enough to help her and she needs help and support she's so vulnerable … There's evidence other people are feeling the same way. (P9)

Some therapists - several of whom used the term objective CT - discussed the notion that their CT reactions may provide information about clients' current or past relationships. Some therapists said they found their CT useful as their reactions allowed them to think about the ways their clients had been "treated in the past" (P11) as well as think about their clients "in the context of how other people in the person's life are likely to be responding to them" (P6). One therapist said CT reactions inform her about the ways her clients may be interacting with others in their life by saying,

> I guess the anger, frustration, dread, probably gives me a bit of insight into what life might be like for them. I often think if this is the way they're interacting with me, how are they going about interactions with other people? Their flatmates, their friends, their family, and how challenging must that be. (P5)

One therapist spoke about his sense that his reaction of frustration towards a female client was "indicating some transactional patterns in the rest of her life" (P10), which were becoming evident in the therapeutic relationship. Similarly, another therapist spoke about how his CT response of repulsion towards a client "made sense in terms of the problems she had in her life" and indicated "what it might be like for her to be in the world and have people respond negatively to her" (P8). Another therapist used a case example to illustrate her CT response of frustration serving as information about the client's relationship with her family, which allowed the therapist to make adjustments to the way she responded to the client so as not to replicate her other relationship. She said,

> My feeling at the time, or my thinking at the time was, this is why she drives her family nuts. You know, this is what happens. And therefore I have to get alongside this young woman somehow, not jump onto that you are such a pain in the neck bandwagon and actually be therapeutic to bring about change … So when I felt that feeling I would think, now what would be a useful way of doing that? Because otherwise I'm just gonna be her Mum. (P11)

Overall, these therapists understood that CT reactions may arise in response to a pull or invitation from their clients. Moreover, that such reactions may be common experiences for multiple therapists working with a particular client, given the client is thought to invite or evoke the reaction. They described their CT reactions as providing important information about their clients' current or historic relationships. The therapists noted that their CT reactions allow them to understand more about how others in their clients' lives may be relating to them as well as understand more about the ways their clients may have been treated in the past.

Therapists' own history plays a role.

Seven therapists, some of whom also spoke about common or objective CT above, talked about the relevance of their own personal history in their CT reactions. They spoke about "subjective", "personal", and/or "unique" CT reactions, determined by the therapist's own experiences or early relationship patterns. As one therapist noted, CT can be "the reactions and responses that I have to my client that are a result of my own personal experiences, history, and emotional stuff. And often I guess, it being based on maybe prior relationships that I've had rather than the relationship that I am having with that client" (P6). Similarly, another therapist described her life experiences having an important role in the way she conceptualises CT by saying,

> My awareness of it [CT] is about what happens inside of me when I am dealing with a client. From the word go, from when I notice their name in my diary or from when I get their first call or first open the door to them. What happens inside of me when I am interacting with this client … I am obviously an individual with my own history and my own blueprint and I will respond to things accordingly. (P13)

Several therapists spoke about the importance of their own history with regards to CT, consequent to noticing in their clinical work that they would adopt "roles" that they played in their own lives, or, had CT reactions in response to something that resonated with them, based on their personal history. For example, one therapist spoke about wanting to save or rescue one of her clients, saying "that's a longstanding role for me in my personal life … it's a comfortable and easy role to fall into cos that's what I've done my whole life" (P9). The same therapist

spoke about clients' experiences of trauma resonating with aspects of therapists' life histories, which can influence the CT response. She said,

> Often people can have trauma history and there's some sort of resonation with your own experience and that's always a lot harder. So your experience with that is going to be different if there's something that sounds familiar … Usually you have more intense emotions around that so there's a sadness of the here and now but an extra layer of that if it hits close to home. (P9)

Similarly, another therapist described CT reactions of sadness, fear, or dread in response to situations with clients that were reminiscent of events or circumstances from his own life. For example, he spoke about feeling fear when working with a male client who was verbally abusive towards him. The therapist said "I'm not very good with angry men I don't like violence of any form at all. I've had enough of that when I was younger from bullying and stuff at school so I have a very strong response to it, to physical threats" (P8). The therapist described how this was a unique response of fear, based on his past experiences by noting "for me it would be fear … for other people it'd be angry" (P8).

Hence, several therapists acknowledged that their own personal history influences their CT reactions, as they described experiencing personal or unique responses to clients with BPD, which were coloured by their own early experiences or relational templates.

Theme Two: I don't use the term 'countertransference'

Although the therapists had ways of conceptualising their CT experiences, they all reported that they do not use the term CT. Several said they were "interested in countertransference" (P12, P5), but "not in those terms" (P5). One therapist said "I just talk about my experience without saying 'this is my countertransference'" (P7). Most therapists said they use terms such as "emotional responses" or "reactions" instead of using the term CT. The therapists also noted a preference to describe their experiences by saying "I noticed I had a strong response" (P5) or "I found myself doing this", "I found myself saying that" (P6), as a way of communicating their experiences of CT to others, without naming the reaction as CT. The therapists were asked why they did not use the term CT with colleagues or supervisors. Two key subthemes emerged and these are presented in the next subsections.

Being cautious with language in a "behavioural" setting.

Four therapists, all of whom had training or interest in psychodynamic paradigms, and often thought about CT, said they do not use the term CT in their work settings. These therapists spoke about the need to be "cautious" about the language they use, as the public mental health system in New Zealand is a "medicalised setting", that prefers short-term "behavioural" interventions. One therapist described the term CT as being disproved of by saying "the word countertransference belongs to a model that is not encouraged … so, I think there is a level of cautiousness around how we do our work and how we language our work" (P2). She emphasised that the way her work needs to fit within the system she works by saying,

> It needs to fit with what we are officially paid to do. And it is encouraged that you use more behavioural terms. And I think that plays into why we're cautious with the language … because the psychotherapists bring this framework of attachment, working with transference and countertransference, holding other things in mind that make the work deeper ... thus longer … And the emphasis is on brief, effective, measured before and after, there you are. Anxiety has dropped, depression indicators have dropped, you must feel better. (P2)

Another therapist noted the term CT was more commonly used in the country of her training, where psychodynamic ideas were more commonly taught and accepted. She said "therapists would say I can't see that client I feel too much countertransference", whereas in New Zealand colleagues and supervisors tend to say "how does it make you feel?" they haven't said to me "ah that's countertransference" (P13). Another therapist noted different services have different ways of conceptualising the therapeutic relationship. She explained this, emphasising the need to be cautious with the term CT,

> I think there's an understanding of how important [CT] is and how we use countertransference for the client's greater good and for our own understanding and formulation but I think there are varying perspectives of that. And I think working in a medicalised setting there's not a lot of space actually with other disciplines in particular to talk to that. Often if you do share how you are feeling about a client, that can be either supported or you can be judged for that as not having your own psychological stuff sorted or um not being competent as a clinician or being too sensitive or being too burnt out. … It's something that has gotta be approached with caution because you can easily feel isolated with strong feelings. Especially if they're negative. (P9)

Hence, these therapists - who had training or interest in psychodynamic therapies and CT - described not using the term CT, because of the need to be cautious working in a medicalised setting or in order to be consistent with behaviourally focused settings, given the term CT

originates from paradigms that are not commonly practiced or accepted within their workplaces.

Psychodynamic ideas are too conceptual.

Four therapists, all of whom worked predominantly from a DBT framework described not using the term CT as it is "too conceptual", "too complicated" (P10) or "not behaviourally specific" (P12)". One therapist stated "countertransference…I don't like the term. It implies something that is located in the patient" (P3). Another therapist spoke about psychodynamic language being "not useful" (P8). This therapist said he prefers to "find the simplest way to describe something" in "behavioural language". He said,

> In DBT we just describe as best as we can the thing we're experiencing in behavioural language … And I actually think that gives you more information than you know if I say to someone "I had a really strong countertransference response" … but if I go "hey team I need your help. I find that with Emma I'm often overwhelmed by her sense of hopelessness and it's hard for me not to feel hopeless as well. I need help"… People know exactly what I'm talking about without me having to talk about countertransference. So I hardly ever use the word. It hardly ever comes into my mind. I don't see a need for it. (P8)

Another therapist spoke about cognitive behavioural theorists and therapists "looking through the wrong lens" (P10) with regards to conceptualising the therapeutic relationship. He said cognitive behaviour therapists should "get back to the behaviour and get out of all the concepts", such as CT. He further explained,

> I think I know the history of why psychologists are so besotted with the terms transference and countertransference. Cos there was just such a big hole in you know, second wave cognitive therapies … It's like no one had really figured out a way to conceptualise or act skilfully with, with the experiences they were having. So they looked under the fence and oh look they've got this transference thing, well let's just borrow that. But, but I think the problem is when we track down using psychodynamic language and evoking psychodynamic constructs is that we get really confused. And we don't know what we're doing. (P10)

As such, several therapists, all of whom considered themselves dialectical behavioural therapists, described not using the term CT because it is either too conceptual or not behaviourally specific. They spoke about preferring to use behavioural language to describe their experiences.

Theme Three: It's just Behaviour: Using DBT concepts to make sense of reactions

Nine of the therapists, all of whom worked with BPD primarily from a DBT perspective, described using DBT concepts to conceptualise CT reactions. Several therapists noted although CT is not a DBT term, the idea that therapists have emotional reactions to clients either based on their history, the client, or a combination of the two is still relevant to DBT. One therapist said that "countertransference is woven into the structure of DBT" (P5). Another therapist noted, from a DBT perspective, therapists may have questions about the therapeutic relationships such as "is that a response most people would be having in this moment or is it more specific. Like, is there is a meaning that's specific to me or how do I make sense of this?" (P12). She spoke about this as be "similar to countertransference", but that ultimately, from a DBT perspective, therapists "understand these psychological phenomena differently … probably we would say thoughts and emotions" (P12). Another therapist summarised these ideas by saying,

> I think without calling it countertransference, it's very much built into DBT but just in very behavioural language and with a differently worded relational perspective. (P8)

In this sense, some of the therapists understand CT as a phenomenon "acknowledged", "woven" or "built in" to DBT concepts and practice using behavioural language. Nonetheless, many of the therapists emphasised that CT, and any terms relevant to the therapeutic relationship "need to be translated into behavioural terms" (P7). The therapists said they not only preferred to use behavioural terms such as "emotional responses", "behaviour", and "data" instead of CT, but also emphasised the importance of describing their experiences in behavioural language to DBT consult members. As one therapist said,

> One of the benefits of working in a DBT group is that we have a shared language and so we're trying to describe things, but behaviourally. And so in DBT we just describe as best as we can the thing we're experiencing in behavioural language. (P8)

As such, these therapists feel that DBT provides therapists with a shared language that helps them better understand and communicate their experiences to one another, such as in DBT consultation meetings. This is relevant to the notion that, from a DBT perspective, the therapists emotional reactions arise out of the "transactional model" between client and therapist (Linehan, 1993), which was discussed by many of these therapists.

Indeed, many DBT therapists described understanding the therapeutic relationship to be "reciprocal" and "transactional". These therapists noted that DBT operates from a "transactional model" whereby "what you do affects me and what I do affects you" (P12). In this regard, the therapists conceptualise their emotional reactions to clients to be "arise out of a transaction" (P10) between therapist and client. One therapist further described this by saying,

> In DBT what we're encouraged to do all the time is to recognise that all relationships are reciprocal and that whatever happens in a relationship, we affect each other. And you know DBT envisages or conceptualises the therapy relationship as a real relationship between equals … So even though there's two different roles, it's just two people in a room solving problems together. (P8)

Several therapists emphasised the idea that emotional reactions arise "out of the relationship" (P9), as opposed to coming solely from one person. One therapist said "I can't locate this in a client's behaviour or my own independently, there's some transaction" (P10). Similarly, another therapist said what she does affects her clients and what her clients do affect her, "rather than just pretending I'm just some objective person that doesn't care about you and is this all-knowing therapist." (P12). Another therapist said,

> My emotions in response to a patient are not just about the patient. It's about me. And it's a transaction between us … So it's much more reciprocal and transactional and it's based on behavioural principles as opposed to any assumptions about needs or boundary violations or things located in one person or the other person. (P3)

To illustrate the transactional nature of an emotional response, one therapist spoke about his reaction of wanting to take care of one of his clients. He said "having care for people is coming from me. And, and empathic appreciation of painful aloneness in our life is, I think coming from her. So it's a transaction between the two" (P10). Similarly, another therapist said,

> I felt totally helpless and inadequate and just wanting to find a solution to her problems. I was like, she's suffering and because she's feeling helpless and inadequate, I'm feeling helpless and inadequate as her therapist. (P12)

Hence, describing CT reactions as behaviour or emotional reactions that arise out of a transaction between therapist and client was described by several therapists who work with clients with BPD from a DBT model.

Chapter Summary

In summary, the therapists spoke about CT, or emotional reactions as being an important part of the therapeutic relationship. There appeared to be some differences in the way therapists conceptualised CT, based on their therapeutic training backgrounds and interests. Some therapists emphasised psychodynamic concepts, DBT concepts, and some therapists spoke about both psychodynamic and DBT concepts. However, most therapists spoke about CT as arising from a both client and therapist contributions. All therapists stated that they do not use the term CT in their places of work. Some therapists with training or interest in psychodynamic therapies described the need to be cautious using the CT as it comes from psychoanalytic therapies, and the settings they work in are medicalised and oriented towards behavioural therapy approaches. Other therapists said they do not use the term CT because they feel the term is not relevant or useful when working as DBT therapists.

Chapter Four – Results

Thematic Analysis: Types of Countertransference Reactions experienced by Therapists.

This chapter presents the results of the thematic analysis of data relevant to the types of CT reactions therapists experienced. Therapists were asked to recall times they experienced a CT reaction when working therapeutically with clients with BPD. Six main themes were identified which capture the CT reactions experienced by the therapists as well as the client behaviours, therapist sensitivities, or situations that activated such reactions. These were: 1) anxiety and fear amidst chaos; 2) frustration and anger with ongoing challenges; 3) sadness with suffering; 4) disconnecting when the client disconnects; 5) hopelessness and despair with ongoing self-harm and suicidality; and 6) joy and pride with progress.

In the following section, these six themes and related subthemes are presented. Quotes from the therapists illustrating examples of the themes are provided as evidence of the theme and to capture the therapists' views. The six themes and subthemes are presented in Table 4, including the number of participants that endorsed each theme.

Table 4

Types of countertransference reactions experienced by therapists – themes and subthemes

Themes (N=13)	Subthemes
Anxiety and fear amidst chaos (N=10)	It was hard early on Feeling threatened or tested Suicidal behaviour can be scary
Frustration and anger with ongoing challenges (N=12)	Slow or no apparent progress is frustrating Feeling frustrated or angry when clients attack or push limits Suicide attempts can be frustrating
Sadness with suffering (N=8)	
Disconnecting when the client disconnects (N=6)	
Hopelessness and despair with ongoing self-harm and suicidality (N=5)	
Joy and pride with progress (N=8)	

Theme One: Anxiety and Fear amidst Chaos

Most therapists described anxiety and fear as being a main CT reaction they had to some of their clients with diagnoses of BPD. This section presents the therapists' examples of anxiety as a CT reaction as well as descriptions of client behaviours that contributed to the reaction. Three subthemes were identified: it was hard early on; feeling threatened or tested; and suicidal behaviour can be scary. Some therapists described feeling anxious early in their career in response to the chaotic nature of their clients' lives, their clients' clinical presentation, and feeling overwhelmed with what to prioritise in therapy. CT reactions of fear and anxiety when feeling verbally attacked or threatened were also described. Lastly, some of the therapists spoke about feeling afraid, experiencing physiological responses, and a strong sense of responsibility when working with clients displaying risky behaviour or suicide attempts.

It was hard early on.

Eight therapists talked about their CT reactions of anxiety and fear when describing their early career experiences working with clients with BPD diagnoses. Therapists described feeling "scared", "overwhelmed", "anxious", and "useless" in response to their clients' "chaos" and "instability".

Many therapists described their experiences or their observations of their clients' chaos and unpredictability as being a challenge unique to working with this client group. One therapist said he was struck by his clients' "sense of chaos and tremendous need and anger and just changeability" (P8). The therapists reflected on the impact their clients' chaos ongoing life changes, impulsive behaviours, and emotional instability had on how they felt, including how they felt about themselves as therapists. One therapist said "generally it tended to be fairly chaotic … it's easy to be invited into feeling you're quite useless. And you have no idea what you're doing and the chaos is just raining all around you" (P11). Another therapist described each day as "an emotional rollercoaster". She said,

> It felt like there was a huge amount of chaos going on in their life … a lot of instability. And ah, I remember feeling, I guess quite overwhelmed by the sheer volume of information and the various directions that the session could actually go in. (P4)

Some therapists described the nature of their clients' suffering and "dysregulation" as difficult to work with early on. One therapist said it was "scary" because the clients would "go into distress so quickly" and "start being very angry and very loud". She recalled one client's

distress as "visibly big", which she described as, "I'm gonna die, I'm gonna cut myself, you will see blood and jumping off bridges." She further explained how her clients' distress impacted her early on in her career,

> I initially thought I'm not doing it right, there is definitely something wrong with me. And then I noticed myself being cautious or having anxious responses. You know, all that typical walking on eggshells around them, not to trigger, not to upset them. (P2)

Whilst some therapists described their clients' presentation in the room as challenging and anxiety provoking early on, they also talked about difficulty knowing what to prioritise in sessions with their clients because there was so much going on in their clients' lives. Many of the therapists described feeling "confused", "overwhelmed" and "unsure" how to work with this client group early on in their career. One therapist described this as feeling "completely out of my depth" (P2), whilst another said that there were "such a huge range of problems that it was really really hard to know where to start or what to do" (P8). Another therapist described,

> I think probably what was different was not having a really clear idea about what to attend to in the session. So the client would come in for a session and we'd be trying to set some sort of agenda and there'd been so much that had gone on between the last session and this session. So many social factors to need to sort out including perhaps some sort of crisis that was leading to wanting to self-harm in some way. And just not knowing what to deal with first. (P6)

Several therapists spoke about feeling scared or anxious in between sessions about making correct decisions or having complaints made against them. One therapist said she often felt "anxiety around making the right decision or the wrong decision in terms of treatment" (P6), and another described "I often felt scared about what I was doing as a therapist … whether I was going to have a complaint made about me … whether she or other people involved in her care were angry with me" (P3). Another therapist said she felt "overwhelmed" early on because she felt "invaded" by her clients as she could not get them out of her mind outside of work hours. She highlighted this by sharing an early career experience she had,

> I was so invaded by her that when I was shopping in the supermarket I thought I saw her and I really jumped (jumps) like that and I was actually convinced it was her. I started feeling shaky and thinking I have to avoid her … I knew she wasn't following me but I felt really like, you know when you have PTSD and you just startle and jump like oh my god she's here. And I don't know I was on the other side of the shop and I was like, I'll wait and I'll go back once she leaves. There's no way I am going to meet her in the supermarket. I was quite frightened. (P7)

Overall, it was common for therapists early on in their careers to have CT reactions of fear or anxiety in response to the perceived chaos and instability of their clients' lives and clinical presentation, such as emotion dysregulation. Not knowing what to prioritise in therapy was described as anxiety provoking by many therapists.

Feeling threatened or tested.

Nine therapists identified CT reactions of anxiety when feeling threatened or tested by their clients. Therapists used words such as "fear", "scared", "anxious" and "paranoid" to describe how they felt in response to either feeling personally threatened, observing threatening behaviour towards others, or anticipating future threats. To illustrate their CT, the therapists described examples from individual or group therapy sessions.

Two therapists described situations in which one of their clients had become either angry or threatening during a DBT skills group. One therapist described a client who often said "extremely offensive things" to others and was struggling with "homicidal ideation". The therapist went on to say that during the group, when the client was interrupted by the other facilitator, she said to the facilitator "I am starting to have homicidal ideation right now and in my culture we take the scalps off of people". The therapist said she felt absolute "fear about what was going to fall out of her mouth next" (P3). Other therapists spoke about feeling a sense of fear in response to clients' verbal aggression and threatening behaviour in group situations. Participant 10 recalled an experience of fear in response to a client's anger during a DBT skills group,

> There was a guy in group, he was pretty rough … had a lot of problems, took a shit tonne of drugs … but he's a very complicated guy, cut his face open with a bottle intentionally and sort of oh my god. He's real angry and he had a lot of risk. You know, and, and he found group really difficult for a million reasons and he got up in group once, just stood up. And 'fuckin raaaa'. So I have fear … And then I'm kind of like, oh holy shit, what am I gonna do? Because it's kind of all up to me right? (P10)

Some therapists described feeling anxious or uncomfortable in response to being personally attacked verbally or "tested" by clients during a session. One therapist spoke about a client who "came across as being very young and very teenage-like" with a "fix me attitude". She described feeling "tested" and "uncomfortable" in response to the client's "huge amount of weighting or responsibility that she was trying to place upon me" (P4). Another therapist described a situation where he was "scared" in response to his client's verbal abuse. He explained,

> I remember one day you know I said to him "how's it going?" and he said "what a fucking useless way to start a session, what a useless fucking pathetic therapist you are" And because he would often react in that way, it's kind of really hard to know where to go next … And so overtime because I didn't have the courage to stop him and withstand his anger and redirect him, so therapy wasn't useful and we weren't getting anywhere. And when I did start to finally try and hold him he just got more abusive and more abusive … And so I left because I was scared and I had to have him escorted from the building…I think mainly it was fear. (P8)

Experiences of being idealised and then devalued were also spoken about by some therapists as eliciting responses of anxiety or fear. One therapist said "the clients can think you've done a great job and then very quickly denigrate and tell you that you're absolutely useless, the family think the service is useless, you don't know what you're doing" (P11). She went on to describe an experience where she felt idealised and was then devalued by a client, saying, and "suddenly I was sitting in front of a panel of three people investigating a complaint against me for the therapy I'd done with the client" (P11). One therapist said it is "uncomfortable, scary, it probably makes me also feel that I am failing" (P13) when clients suddenly become angry and decide they no longer want to continue therapy. Another therapist recalled several experiences of feeling "anxious and paranoid" in response to her clients becoming angry and aggressive towards her after she returned to work from a break. She explained,

> I went on holiday and when I returned back, she created some kind of a scene here in the corridor and started yelling and swearing about me in the waiting room. She was telling other people that I am stupid that I could not recognise that she was not doing her diary cards, that it's my fault and I am stupid that I didn't recognise that … I was really anxious and shaking. (P7)

Hence, some therapists described CT reactions of fear or anxiety in response to feeling threatened or tested by their clients. In particular, feeling fear in response to being verbally attacked in individual sessions or in a skills group context were spoken about by the therapists.

Suicidal behaviour can be scary.

Seven therapists spoke about feelings associated with fear in response to working with risky behaviour or chronic suicidal ideation. Therapists used words such as "scary", "concerned", "anxious", "apprehension", "panic" and "terrified" to describe how they felt when their clients' safety was at risk. Therapists described responses centred on concern for their clients' safety as well as a sense of responsibility to ensure their clients were safe.

Many therapists described responses of anxiety and fear when they felt concerned their clients may kill themselves. One therapist described feeling "so anxious" when she worked with clients who have BPD diagnoses because they are at greater risk of suicide compared to other clients due to the "chronic nature of it" (P4). Feeling apprehensive and "scared of the risk" regarding clients' safety between sessions was also experienced by some therapists, as highlighted in the following quote,

> I had a client who had previous suicide attempts and she's inclined to drink when her emotional issues are triggered. And one Monday I got to work and she had tried to hang herself. She was intoxicated and she tried to hang herself. And it was just shortly after we had a session and she talked a lot about abuse that had happened to her. So about her specifically I am still apprehensive … Because what if I get there on Monday and yep. (P13)

Several therapists alluded to a sense of pressure or responsibility they have felt to ensure their clients' safety. One therapist illustrated this by saying he felt "terrified" that if he stopped working with a particular client, that she would "kill herself" (P8). Another therapist provided a case illustration of a client who she feared would die by suicide, and the sense of responsibility she felt,

> So I am working with this young woman who just before she came to see me started using IV opiates … And despite everything that we've tried to do to really try and contain this and get some other skills on board her use has continued to escalate … She also is somebody who has very impulsive quite risky suicide attempts that just come out of nowhere … And just that anxiety around what if this ends badly. I would feel in some way at least partly responsible for this. Have I done my best? You know, have we served her or have we failed her? (P6)

Because of the fear of suicide and subsequent sense of responsibility to keep their clients safe, some therapists spoke about "doing more" than they usually would. One therapist described this as, "it's like we have to solve the problem so that I don't get anxious" (P12). Another therapist noted that she has contacted clients more than usual to communicate her care to clients when concerned about them,

> I phoned her yesterday afternoon (laughs) … Didn't get her, but yeah just made the decision that I wanted to try and get hold of her again and for no other reason for her to know that actually I'm still there and I still care in a way. So yeah contacting more than the agreed plan I guess. (P6)

Several therapists described physiological responses they had to their clients when afraid their clients may attempt suicide. One therapist said she "started having dizzy spells" (P7)

because she was so concerned about her clients that she could not stop thinking about them outside of sessions. Another therapist illustrated the physical nature of his anxiety regarding his clients' safety with the following case illustration,

> I was working with a woman and she had a long history of depression and overdoses and when I was seeing her in the DBT program she was still very very suicidal and still very depressed … The more I tried anything the more depressed she seemed to get … And I was getting more anxious that she was actually gonna kill herself. And um it got so bad that at one point she got admitted to hospital to a psychiatric hospital and I rarely get sick touch wood, but I did get sick then. Or at least I thought I was sick. I took the day off and I remember sitting at home and I thought I had a cold but in fact I wasn't sneezing and I didn't have watery eyes. I had sweat, I remember it I was sitting at my table and I had sweat dripping off my chin and I thought, that's not a cold, oh my god I'm having a panic attack. (P8)

Overall, some therapists experienced fear or anxiety in response to the possibility of clients' suicidal behaviour or attempts. Fear sometimes manifested as physical sensations and cognitions around feeling responsible and a desire to ensure clients were safe.

Theme Two: Frustration and Anger with ongoing Challenges

Frustration or anger were described as both strong and the most common CT reaction therapists described towards some of their clients with BPD. The following section outlines the therapists' examples of frustration or anger as a CT reaction to their clients. Three subthemes were identified: slow or no apparent progress is frustrating; feeling frustrated when clients attack or push limits; and suicide attempts can be frustrating. Some therapists described feeling frustrated when clients do not put effort into their therapy, or when clients are not progressing towards their goals. Reponses of anger or frustration were described as occurring when therapists experience their clients as angry or hostile towards them, or when they try to push the therapists' limits. Lastly, some therapists described feeling anger when clients engage in suicidal behaviours, particularly when agreements have been made to prevent this or engage in more adaptive behaviours instead.

Slow or no apparent progress is frustrating.

Nine therapists identified responses associated with frustration when they perceived their clients to be making little therapeutic progress. The therapists described feeling "frustrated", "irritated", "critical", "fed up", and "infuriated" in response to slow or minimal progress. The situations in which therapists tended to respond with frustration were when they

felt they were putting in more effort than their clients, when their clients were not seen to be making therapeutic progress, and, when they wanted to push their clients for change but their clients were not receptive. As highlighted in the following quote,

> It was just really frustrating as well around anything we were doing and nothing was making any difference … I remember one time … she'd told me she'd spent 36 hours on this Xbox game. And I was like, seriously? She would struggle to practice skills for a minute at a time and yet she could put 36 hours into a distraction … I couldn't help myself, you know, I had to say "if you'd put 36 hours practice into skills group where would you be now?" instead of playing a video game … and that was my frustration starting to come through. (P1)

Another therapist described his sense of increased frustration to continue offering therapy to a client who he felt was not willing to make therapeutic change by addressing his emotions. This therapist described his frustration,

> It didn't matter how well we got on it didn't matter what plans we made, he would go away and drink and not experience emotion and not do anything. And this just kept on happening and happening and happening and I was getting more and more frustrated … It was like he actually for whatever reason wasn't able to avail himself with what the therapy was offering. And it was frustrating for me to keep offering the therapy that someone wasn't willing to do (P8).

Feeling like they were working harder than their clients was described by therapists who felt their clients were making minimal effort in therapy. One therapist said she felt like it was her job to "do therapy to [the client]" (P7), as opposed to with the client. Another therapist described her sense she was working harder than her client by saying,

> [I have] a response of oh you know you come to therapy and you want me to fix you. And I should be doing my bit and extra while you do only half or only 10%? I do get a response like that … A sense of, I hold you in mind more, I am more invested in you getting better than you seem to be yourself. You're more comfortable carrying on the suffering that you know rather than pushing for a change that you don't know. (P2)

Therapists described feeling frustrated when clients weren't engaging or doing enough as it meant therapy felt repetitive, or clients' progress felt slow or non-apparent to therapists. One therapist explained this as "ahh why do we keep having to go through this again" (P12). As well as repetition in therapy feeling frustrating, one therapist described her client's continuous repetition of problematic behaviours as frustrating. She said "I was feeling really frustrated … it was that sense of, you are doing the same thing over and over and over" (P5). Another therapist highlighted how at times, she feels "fed up" with her clients' slow progress,

> Because of the moving two steps forward two steps back. Sometimes it's good and there's traction in therapy and then 'poof', crisis happens and everything unwinds and then again more steps forward and again we go back. It is quite an exhausting process to be with and you end up feeling, either, not progressing fast enough or this is too much back and forth. (P2)

Feeling frustrated and wanting to "push for change" was spoken about by several therapists. They described feeling "critical" or "frustrated" when they felt like their clients were ready to move forward therapeutically, but their clients did not or could not make the changes. One therapist said she sometimes falls into "critical parent mode having that desire to push for change and being sort of frustrated when people aren't doing what you think they should be doing" (P9). Another therapist described frustration when she wants to "move a client", but her clients don't make the progress that she believes they are ready to make,

> I sometimes feel a frustration when I am so certain that a client is ready to move, make a shift, learn from some behaviour, learn how to manage some emotions and behaviour differently, and they don't. It's like … I am expecting an amount of personal growth and when it doesn't happen I feel frustrated … So when the penny doesn't drop and the insight isn't there or the insight is there but they cannot make the shift to behave differently, I find that difficult. (P13)

Hence, some therapists experienced strong reactions of frustration in response to their clients making slow or no apparent therapeutic progress for extended periods. Having to repeat the same material or feeling like clients were engaging in the same problematic behaviours was described as frustrating for several therapists. Some therapists felt like they were working harder than their clients which resulted in them wanting to push their clients to make progress. Other therapists experienced a sense of frustration when they wanted to assist their clients in making change, but their clients were not ready for change.

Feeling frustrated and angry when clients attack or push limits.

Six therapists spoke about feeling angry or frustrated when they felt attacked by their clients, or when they perceived their clients to be pushing therapists' limits. The therapists used words such as "frustration", "fucked off", "angry", "defensive" "judgemental", "resentful" and/or "critical" to describe how they felt in response to either feeling personally threatened, or having their limits tested. To illustrate, the therapists often described examples from individual or DBT skills group therapy sessions.

Some therapists described feeling angry when their clients' anger or verbal attacks were directed at them, as one therapist said she notices "anger in myself if the hostility is directed towards me" (P3). When feeling personally attacked, some therapists described it being a challenge to not get angry back with their clients. They talked about "wanting to react in anger, but knowing it was not going to help the situation" (P1). One therapist illustrated his experience of feeling attacked and the anger he felt, with the following illustration,

> I noticed myself feeling angry with her at so many different times ways … I would recommend or prompt one of the tasks in therapy, "hey how's your diary card" for instance, and … she would literally sit forward in her chair, look at me, her voice would go up, "haven't done my fucking diary card" … But is a, a, a kind of intensity and relentlessness of, of feeling attacked … And being aware that I was starting to actually feel kind of fucked off with the whole deal, like I'm kinda over this you know … The risk is always acting on the anger and I guess in the sense of being provoked or feeling provoked, whatever is happening was, was a mystery. That's the challenge how do you not bite back? (P10)

Whilst some therapists spoke about the challenge of finding ways to not "bite back", other therapists described times where they had reacted with anger in response to their clients' anger. One therapist described a situation following a DBT skills group where he had become angry in response to his client's anger, in an attempt to justify his actions in the situation,

> Another client had basically asked if she could bring her dog to skills group because they couldn't find anyone to look after the dog … So I said "ok just once let's do this" and I hadn't consulted the skills group in advance. So, this client I saw after skills group was really angry at me for allowing this to happen because she has a dog and would have loved to bring her dog in, you know … So she came into the individual session and she was just ropable, she really was. It just felt like out of the blue a massive attack on me personally out of the blue. And I did react to it, I got really angry back and was trying to justify why I'd agreed and all these sorts of things. (P1)

Several therapists described feeling frustration in response to being "blamed" by their clients. One therapist said she has felt frustrated when her clients attacked or blamed her in the context of miscommunication. She went on to say "these clients they are just waiting … for me to do something wrong. And everything I did was wrong" (P7). Another therapist spoke about feeling "frustrated" when her clients blamed her for how the therapy was progressing. She described feeling a sense of relief when a particular client didn't attend therapy, as she wouldn't have to "struggle" with the blame. She explained,

> She would reliably blame me for how things were going … Which is hard to sort of take in an ongoing way … I know that I was genuinely pleased if she couldn't make an appointment … but there would be a sigh of relief you know if she didn't attend an

> appointment. Um when she chose not to do our year two DBT program I remember feeling quite relieved about that … means I am not going to have to struggle through one of those blaming sessions every week. (P6)

Some therapists described similar responses of frustration when they perceived clients to be testing their limits. For instance, one therapist said "when I feel like they're pushing like they're intruding on my own limits perhaps that's when that critical side comes up" (P9). Similarly, another therapist described, "when my limits are gonna be crossed, I'll often feel quite frustrated, kind of resentful, I'll often have more judgements about the person. I'll feel grudging about doing things, like legitimate tasks associated with the therapy" (P3).

Several therapists spoke about feeling resentful and frustrated when clients have not respected therapists' limits around DBT phone coaching. One therapist described that she requires flexibility around how she provides phone coaching so that it is "sustainable" in her life. She said she feels "resentful" and "irritable" when her clients have an expectation she call back quicker than she is able to. She went on to describe her response to a client saying they felt uncared for when she did not call them back straight away,

> Irritation. And maybe actually contempt … You know, the threat would have been, I am going to be at the mercy of calls and there is no way I want to do that. I know that about myself and it won't work. Having to call someone back as soon as they call, I get very irritable … my reasons for not calling you back earlier aren't about you. Like, it's not personal why does everything have to be personal? It was kind of like that. And also, like, um, you know, like I am available in the weekend what more do you want? (P3)

Another client spoke about a similar reaction of frustration with his clients' expectations that he is always available for phone coaching. He spoke about having to adjust his limits with a client, because she was calling so many times a day, he was starting to feel "burnt out". He described,

> I think I got quite burnt out with her as well so I had to start setting up some limits around phone calls in the evenings. Initially I was available 7 in the morning through till 9 at night then I had to reduce to only working hours because I was just getting no downtime from her at all. (P1)

Overall, responses associated with frustration were common for therapists who felt they were being personally attacked or having their limits crossed by their clients. Whilst some therapists described controlling their frustration to be a challenge at times, others spoke about acting on their anger or experiencing relief when there was some distance from their clients' anger.

Suicide attempts can be frustrating.

Six therapists described CT reactions associated with frustration in response to their clients engaging in self-harm or suicidal behaviour, particularly if clients had been in treatment for some time. The therapists spoke about feeling "angry", "frustrated", "pissed off", "critical", "annoyed" and/or "irritated" when their clients acted on behaviours that put their lives at risk. As one therapist said,

> I remember once a woman took an overdose and I was really, really angry with her. And I noticed that anger, and I mean she wasn't in the room, I wasn't yelling at her or anything. But I was just, I was almost hopping mad that she went out and took this overdose. (P10)

Therapists spoke about feeling anger and frustration towards clients they had worked with for a longer period of time, as there were agreed expectations in place around how to manage unhelpful behaviours before acting on them. For instance, several therapists spoke about feeling frustrated when their clients, who had been in treatment for some time, engaged in self-harm. One therapist described feeling frustrated in response to a client attending DBT skills group who "repeatedly kept coming to the group with exposed self-harm cuts all over their arms and had them visible to everyone which we said was a group rule not to do" (P5). Another therapist explained,

> Often if they self-harm I feel pissed off and stern. And at this same time this is the nature of what we're working with. You know, my job is to help them. But it's quite interesting like at the start, I don't have that pissed off feeling it's just like, yeah I can help you with that. But if for example some time has elapsed and they've been in treatment for a while I'll be like, okay enough already this has got to stop. (P3)

Suicide attempts or plans were also described as evoking strong CT reactions of frustration or anger for some of the therapists, particularly when the client and therapist have been working together for a long period of time. The therapists described feeling frustrated as they felt like there were established plans in place to ensure their clients do not engage in suicidal behaviours. As one therapist said,

> One girl kept buying ropes to hang herself and the irritation that came up for me was like 'but we talked about this and you agreed you were not gonna do this anymore'. And that was after several weeks of her buying ropes. So it was something like that, like we've already dealt with this I don't wanna deal with it anymore. (P12)

Another therapist described feeling frustrated when her client called her to say she was midway through an overdose, and did not follow through with the plan agreed upon to keep her safe. She highlighted this situation with the following case illustration,

> I remember I had a client call me and she disclosed that she was midway through a serious overdose … And so we made a deal [which] was 'I'm gonna call you in five minutes you've gotta answer the phone while I call an ambulance for you'. And then when I called her back she didn't answer and I felt really frustrated at her about that. I mean she survived. But I felt like she could've done more in that situation. That felt really unfair. I still feel like that. But I remember feeling really critical of her in that sense because yeah it's like we're meant to be a team working on this together and that's like not a fair thing to. (P9)

As such, some therapists experienced frustration in response to their clients engaging in suicidal or self-harm behaviour. The therapists tended to feel most frustrated when they had been working with their client for a longer period of time, and there were agreed plans either not to engage in such behaviours, or to use their skills instead of harming themselves. In this sense, some of the therapists felt frustrated that their clients were not adhering to their end of an agreement.

Theme Three: Sadness with Suffering

Nine therapists described sadness as a CT reaction they have to their clients' suffering. This section presents the therapists' examples of sadness, which tended to arise after either hearing about difficult situations their clients were in and the impact it was having on them, and hearing about their clients' traumatic histories. Some therapists also spoke about a pull to "rescue" or "save" their clients from such difficult situations. The therapists used words such as "sadness", "upset", "yearning", "rescuing", "protective" and/or "parental", to describe their reaction.

One therapist spoke about a client who was surrounded by "a huge amount of instability" growing up. She said the client lost a friend to suicide who "was a person of real stability" for her. The therapist said she felt "saddened by the situation" as the client "had been exposed to a huge amount of suicide" (P4). Another therapist spoke about feeling sad, and possibly crying in the session, when hearing about her client's circumstances. She said,

> She was just really unhappy and had so many problems and kids and I thought I am really not doing anything for her. I'm not helping … And then I felt quite moved and really upset when she decided to get rid of her children, to adopt them out because she felt like

she was not a good enough mother … So she did that and it was really sad. I think I cried in the session. (P7)

Many therapists described feeling upset or sad when learning of their clients' experiences of trauma, and the enduring effects of such experiences. Several therapists described feeling "real sadness" when hearing clients are still struggling as adults with the effects of childhood sexual abuse. One therapist said "it makes me feel sad" (P4), and another described, "when people who have been abused as kids … when they talk about their abuse experience and we're doing trauma work, I'm in awe of their bravery and courage and survival, but afterwards I can just get incredibly sad about what they've experienced" (P12). One therapist spoke about his experience of hearing about his clients' trauma and the impact it has had on them,

> Sometimes when I work with self-harm my countertransference response is just incredible sadness … There's one woman I worked with and she had a long history of sexual abuse throughout her childhood. And um she's probably one the most visibly scared people I've ever met … It would often take her three or four minutes to respond with one word and when she did respond I couldn't actually hear the word cos she spoke so quietly … I just felt so sad … Just so deeply sad. And there was nothing I could do about it I couldn't make the sadness go away I couldn't quickly make her better and so there were times where I just, I just cried. It was just really hard to witness so much suffering (tears up). (P8)

As well as feeling sad, hearing about trauma and witnessing clients suffering resulted in some therapists wanting to "rescue" or save" their clients. Some therapists described feeling a parental, protective pull in response to their clients suffering. One therapist said "when the clients go into a vulnerable place … I notice my rescuing mother, warm and kind and I want to hold you tight and kiss you on the forehead type of affect" (P2). She went on to describe that her clients' "vulnerable hurt, loss of hope, I am bad/shameful" presentation invites more of a validating, compassionate stance within herself. Another therapist said he notices a "protective, paternal quality" in response to "the waifish kind of client" (P10). He went on to describe a client who he had a parental response to. He said,

> A client who was very alone in the world … her mother had died by suicide. Her mother had previously locked her out of the house and kind of semi disowned her once she found out the client was in a same sex relationship. She was a very, she was, had a history of restrictive type anorexia … self-harms and so on behaviour. Kinda over controlled kind of person though, and her father had died quite young and in a way that's quite traumatic to her. She just had this alone in the world and uncared for and I think, that was her experience of life. (P10)

This therapist said he wanted to "save" that client "from her aloneness" by saying,

> I certainly noticed a yearning quality, you know, to look after her, a protective, was it a parental quality … There's just you know, you wanna kind of somehow pluck that person magically out of their life and put them in some little safe, magical place, like your wardrobe at home or you know, your spare room. I didn't actually, I've never felt like taking somebody home and that sort of thing, but certainly a pull in that direction. (P10)

Other therapists spoke about feeling a pull to be warmer or more validating towards their clients when they are vulnerable and suffering. One therapist said she often feels an urge to "be more validating, supportive, like try and take pressures off them either in the room or reduce my expectations on them because they're vulnerable and helpless" (P9). Another therapist described feeling "a huge amount of empathy and warmth" when her client spoke of "a black hole of emotion and pain" they were experiencing. She went on to describe this response as "the urge to sort've soothe her and to comfort her, yeah, to let her know that it is okay to have these feelings … It is definitely a desire to help feeling … it's a sense of wanting to get alongside and support and be there with someone through their pain" (P5). Another therapist said she often feels "a pull to make life easier, to rescue, and to sort of wrap vulnerable people up". She illustrated this with the following case illustration,

> I had a client that emotionally quite young and had a long history of abusive experiences … And so I remember that when I started working with her she would shut down and cry or sort of just you know say things like "I really wanna do this but it's so hard and I can't and I just wanna give up" and like I remember saying things at the time that you know were all warm and compassionate hope instilling things. But just noticing that I was saying things that looking back was kind of too much to say … Which to me is a red flag that I've gone into a rescuer sort of maternal mode versus staying within my role as therapist. (P9)

One therapist described a similar response, whereby she has felt the urge to stretch her limits in an attempt to "fix" her clients' problems. She said "when people have very deep suffering and have been isolated and alone, like if they've got severe trauma and they haven't told anybody about that … it can bring up quite a lot of sadness" (P12). She went on to describe that such reactions can result in her wanting to stretch her limits and "go into problem solving". She illustrated this by saying,

> Like when I've offered extra sessions. When I've offered extra phone coaching. When I have tried to bend rules in DBT. Like the 24 hour rule and I've been like "what if we just bend it for this one person cos they're really struggling?". Like so many times I've been like "rules are made to be broken, let's be flexible, let's not be black and white with our rules. (P12)

Overall, many therapists described experiencing sadness in response to clients' difficult circumstances, experiences of trauma and their subsequent suffering. Feelings of sadness resulted in some therapists wanting to rescue or take care of the clients.

Theme Four: Disconnecting when the client Disconnects

Feeling disconnected from clients was a CT reaction described by six therapists as occurring in response to the client disconnecting. Client disconnection was spoken about as clients being unable to connect to their emotions; clients becoming animated or theatrical; and/or clients avoiding or disengaging from therapy. The therapists used words such as "disconnected", "bored", "sleepy", "fading", "distant", "fake", "jaded", "heaviness" and/or "shut down" to describe their reaction when their clients disconnect from themselves, the therapist or the therapy. The following section outlines the therapists' examples of disconnecting from their clients in response to their clients disconnecting.

Therapists' experiences of their clients being unable to connect with their own emotions was described as challenging for therapists. As one therapist noted "the difficulty he was having was actually allowing himself to feel that sadness and in many ways I found it very challenging to get him to a point where he was willing to actually experience sadness" (P1). Several therapists described feeling bored, disconnected and sleepy in response to clients' difficulty connecting with their emotions. One therapist said she feels "quite sleepy and disconnected" when her clients cannot connect with themselves. She also recalled instances where she was "falling asleep all the time" (P7) because a client of hers was disconnected in the sessions. Another therapist also described feeling bored or sleepy with clients when they "don't want to feel emotions" (P8). He said "they're sitting in the room with a whole lot of emotions they don't wanna feel and I find myself feeling like it's almost impossible to keep my eyes open." He illustrated a reaction he had to a client,

> I think I used to get sleepy with him as well and it was cos I was bored. I was bored with having the same conversations and it going nowhere. (P8)

Other therapists described feeling distant and/or sleepy when their clients disconnect from their emotions, and/or become theatrical or animated in session. One therapist said she can feel "jaded" or "heaviness" whenever there is an absence of emotion in the room. She said a client can be "quite animated and, and entertaining even sometimes. But there's a feeling missing somewhere", which results in her feeling "disengaged" and "feeling very sleepy"

(P11). Another therapist described feeling distant and "fake" when her client became theatrical and disconnected from emotions. She explained,

> She had a tendency to tell quite a lot of stories about herself in a slightly kind of theatrical way. And sometimes it felt like the emotion was quite removed from what she was saying. And she would talk quite a lot as well. So even though she was discussing difficult and upsetting things in her life, because that emotion felt separate from it … I guess it makes me feel more distant from the person and it makes me want to have more distance from the person … And so, I become kinda fake and say the right thing ... Like, I have to be fake to meet your fakeness. (P5)

One therapist said she finds it difficult when clients are "dissociated" from the present moment, making it hard to connect because they "shut you out and then to shut out the world and be collapsed" (P2). To illustrate, she provided an example of a client with a "difficult childhood" who would "disconnect and daydream" to avoid being in the present moment. She explained how this continued into adulthood and interfered with therapy,

> She tends to be very avoidant. What happens is, she comes to therapy and we both feel that we are working, content, process, and then she disappears for a few weeks … it has started to be a pattern. And, I feel it is interfering with our work … So, kinda, I get shut down when I try to reflect on this pattern and I notice myself feeling like, then we can't do much work … Every session where she is disconnected and disengaged feels like a hard one just putting her back together and it doesn't feel like we're actually doing therapeutic work underneath to help prevent this continuing to happen out there in the world. (P2)

In summary, some therapists described feeling disconnected in response to their clients disconnecting from themselves, the therapy, or the therapist. Therapists tended to feel disconnected and distant when their clients were unable to connect to their emotions; became animated or theatrical; and/or avoided therapy.

Theme Five: Hopelessness and Despair with ongoing Self-harm and Suicidality

Five therapists described hopelessness and despair as a CT response they have felt with some of their clients with BPD. Hopelessness and despair were described as occurring in response to "extreme" self-harm and chronic suicidality; sharing clients' hopelessness and despair; and, when desperately trying to instil hope. The therapists used words such as "hopeless", "desperate", "helpless" and "inadequate" to describe how they felt in response to their clients. The following section outlines the therapists' examples of hopelessness or despair and the contexts in which these reactions arose.

Several therapists described a sense of hopelessness they experienced working with clients who were either chronically suicidal, or repeatedly engaged in risky self-harm behaviours. One therapist spoke about their clients' difficulties as being "so pervasive and complex that it can be a bit like, well fuck how am I gonna get on top of all of this? How can we get a handle on this when everything feels super important and risky and difficult?" (P12). Some therapists talked about feeling hopeless when the more they tried to help their clients, the more depressed and suicidal the client would become. One therapist described the hopelessness he felt in response to his client's chronic self-harm. He conveyed his sense of hopelessness with the following case illustration,

> Her level of self-harm to my mind was quite extreme … she would stab herself in the abdomen. And she had done this quite enough that she had developed quite a decent stoma. And she would continually insert objects into the stoma as a form of self-harm … This went on for two years. It felt like, at one stage I was seeing her about 3 times a week, and I was getting a lot of afterhours phone calls from her as well … She was a lot of hard work and I tried everything I could think of, everything that my supervisor could think of, everything that the DBT team could think of, and it really just felt like nothing was making any difference … And that's where that degree of hopelessness came from. I was like, I don't think we're going to be able to make any difference here. (P1)

Several therapists described "sharing [their clients] hopelessness and despair" (P8). This tended to occur when therapists perceived their clients to be either remaining in difficult situations or engaging in behaviours that were not conducive to their therapeutic progress. For instance, one therapist spoke of several situations where she felt "despair" in response to her client's despair and continuous efforts to take her own life. To illustrate, Participant 12 provided a case illustration of a woman who disclosed she was still living with someone who was abusing her,

> I was working with a woman who disclosed that her dad was still abusing her … I was like, well I dunno I can't help you anymore. Cos it just felt so awful and overwhelming for her. And I think then I got into helplessness and despair … my thought at the time was, 'how can I help her recover from trauma if she's still living with her abuser and still getting abused by him'. Um and it had been going on for such a long time I had the thought of 'nothing's ever gonna work for her'. Um which is probably a thought that she has quite a lot. Cos she checks with me now and says "do you think I'll ever get better?". So I think she struggles with hopelessness and despair. (P12)

Overall, some therapists described feelings of hopelessness and despair in response to their clients' chronic self-harm and suicidality, sharing their clients' despair, or when trying to instil hope.

Theme Six: Joy and Pride with Progress

Eight therapists described having CT responses of joy and pride when their clients make therapeutic progress. Therapists spoke about feeling proud when hearing about their clients' achievements and the challenges they overcome. The therapists used words such as "pride", "joy", "warmth", "affection", "happiness", "admiration", "privileged" and/or "delight" to describe how they felt in response to their clients' progression and achievements.

Clients' progress in therapy and achievements were described as eliciting strong responses of joy and pride by the therapists, as often responses of anxiety and frustration are prevalent due to the perceived "chaos" and instability in their clients' lives. One therapist said, "when things are going well they feel really good … because they can be so bad, you can feel a bit like on a high and feel warm feelings towards your client that they're doing what needs to be done … and being kind of proud with them about what they've achieved" (P9). Feeling pride and joy for clients and what they've been able to achieve and overcome was talked about by many of the therapists, as highlighted in the following quotes,

> I've certainly experienced the emotion of pride in hearing recounts of what my clients have achieved. Just straight out joy … I think I've had tears of joy. Just when people totally smash very difficult situations and overcome stuff and you know, it's really rewarding. (P10)

> I've got one client at the moment who's half way through the DBT program. Such a chaotic past you know she nearly died so many times and she's got scars everywhere and kind of is a legacy … She's doing amazingly. Um so feelings of pride around that. (P6)

As well we feeling proud when clients achieve and overcome obstacles, several therapists described feeling admiration for their clients, and how they are able to overcome and talk about their experiences of trauma. One therapist said he sometimes feels "tremendous admiration" for his clients and their courage. He described how he feels privileged to "see how hope and love and compassion and creativity survives trauma and abuse and neglect" (P8). Participant 12 also described feeling "privileged" to be able to learn from a client and admire their bravery,

> She had a long long history of trauma … she talked about what it was like to exist in her body and I think I learned a lot from her … I think I just felt like odd that she could sit in a group and talk about those experiences. Like I felt um, I think … I felt privileged and super impressed with her bravery that she could do that. I was like holy shit she's so amazing cos she's being so vulnerable … And I still get that now when people show their vulnerability. I'm like, wow you're so brave. (P12)

Some therapists also described feeling joy when their clients speak about the future in a hopeful way. One therapist said she had a session with a client that was "really moving and beautiful" as her client "wrote a song and the lyrics were all about her journey of moving through mental health problems and coming out the other side" (P5). Another therapist explained feeling "a huge sense of joy" when her client spoke about the future,

> This [client] who this year reached the age of 24 and they actually said to me they never thought they'd reach this age and as a result they've realised they've lived so long and much longer than they thought that they think 'why not keep going?' … For the first time in the four years that I've known them, they have some future focussed thinking around what they wanna do after the leave university and plans around travel. Which for me is just like, oh my gosh, it's enormous … For this individual to say that, that was incredible for me. I had a huge sense of joy … this was the first time I'd heard her speak about the future. (P4)

Overall, it was common for therapists to experience feelings associated with joy and pride in response to their clients' achievements and progress. Some therapists described that, because therapy with clients with BPD can be incredibly challenging at times, therapists can feel warmth and pride towards their clients once clients make positive changes in their life. Some therapists spoke about feeling privileged or joy when clients are able to be vulnerable and also talk about their future in a hopeful way.

Chapter Summary

In summary, all therapists identified numerous types of CT reactions that they experienced in response to their clients who have diagnoses of BPD. Six main CT reactions were identified. Anxiety was a common reaction described by therapists in response to the perceived chaos and unpredictability of clients' lives. Therapists spoke about CT responses of anxiety earlier on in their career, as they did not know how to manage and work with their clients with BPD effectively. Many therapists also described responses of anxiety or fear when they felt threatened, or when their client engaged in suicidal or risk-taking behaviours. The most common CT response described was frustration or anger. This was talked about in response to slow progress, feeling attacked, or when clients attempt suicide. Some therapists talked about feeling sadness in response to their clients' suffering. This was spoken about when clients were vulnerable, or dealing with enduring effects of childhood trauma, and resulted in some therapists experiencing a pull to rescue or save their clients. Disconnecting from clients was another CT response spoken about by some therapists. Therapists described feeling disconnected or sleepy whenever their clients would disconnect from their emotions or from

therapy. Some therapists felt hopelessness and despair in response to their clients' ongoing self-harm or suicidal behaviour as well as in response to their clients' despair. Lastly, many therapists described joy or pride as a common CT response they have when their clients made therapeutic progress.

Chapter Five - Results

Thematic Analysis: Managing and Utilising Countertransference Reactions.

This chapter presents the results of the thematic analysis of data pertaining to the ways in which therapists manage and utilise their CT. Therapists were asked to describe how they manage CT reactions that arise when working with their clients who present with BPD. Three main themes were identified which capture the ways therapists manage CT. These were: 1) trust in the DBT model; 2) talking with others; and 3) self-care (see Table 5). The therapists were also asked to describe and give examples of the ways they utilise their CT reactions in their work, if it all. Two key themes were identified that capture the ways therapists utilise their CT responses. There were: 1) naming or disclosing reactions; and 2) it depends – using CT reactions if helpful therapeutically.

These five themes and associated subthemes are presented in the following section. Quotes from the therapists illustrating examples of the themes are provided to demonstrate the theme and the therapists' views. The five subthemes are presented in in Table 5 including the number of participants that endorsed each theme.

Table 5

Managing and utilising their countertransference reactions – themes and subthemes

	Themes (N=13)	Subthemes
Managing CT reactions	Trust in the DBT model (N=12)	The DBT structure is containing DBT consultation team Using DBT skills
	Talking with others (N=13)	You can't beat good supervision My own therapy Debriefing with colleagues
	Self-care (N=12)	
Utilising CT reactions	Naming or disclosing reactions (N=13)	Awareness and I statements Naming to check in, problem solve or communicate limits
	It depends - using CT if helpful therapeutically (N=11)	

Managing CT Reactions

Theme One: Trust in the DBT Model

Twelve of thirteen therapists described using DBT as their main therapeutic approach when working therapeutically with clients diagnosed with BPD. These therapists emphasised the DBT framework as being crucial for assisting them in managing their CT, or emotional reactions. Three subthemes were identified: the DBT structure is containing; DBT consultation team; and, using DBT skills.

The DBT structure is containing.

Many therapists spoke about feeling anxious prior to learning DBT as they lacked a structure for working with complex clients, such as those diagnosed with BPD. One therapist explained her experience working primarily as a CBT clinician, prior to being trained in DBT,

> [I didn't] have a really clear idea about what to attend to in the session. So the client would come in for a session and we'd be trying to set some sort of agenda and there'd been so much that had gone on between the last session and this. So many social factors to need to sort out including perhaps some sort of crisis that was leading to wanting to self-harm in some way. And just not knowing what to deal with first. (P6)

The same therapist noted the structure of DBT helped settle some of her anxiety around "working with the chaos" (P6). Many therapists noted the DBT structure helped them feel contained in their work. As Participant 5 said, "DBT is such a structured form of therapy I find it very soothing and containing for myself". Other therapists said the structure of DBT helped them know what to prioritise in sessions. As one therapist said,

> The magic of DBT is that it does have a structure. It has a structure that tells you sort of what to do and a whole set of principles to help you figure out what to do and at the same time it says just be yourself and have a real relationship with the person … it helps me and the client get through chaos and so … it's just what I do now. (P8)

As well as the DBT structure proving to be useful in helping therapists know what to prioritise, some of the therapists described the benefits of working with a team who are speaking the same DBT language. One therapist described,

> All you needed was a small handful of borderline clients and the whole team were chaotic … Once we started talking the same language we all knew what we were talking about, it meant the interventions we were doing we consistent. They were consistent across all

> members of the team and then the language we spoke in consult group was the same language. (P11)

Several therapists spoke about the importance of using a therapy model that was specifically designed to treat people with complex problems, such as BPD symptomology. Some described DBT as being a model for therapy as well as a way of living. Participant 10 said "if you're gonna work in this field you need a therapy that's made for it". He further explained the ways DBT helps him manage the therapeutic work,

> People who used to burn out all over the place … were often doing therapies that didn't have these structures and systems in them and a framework for your own personal practice that would help you do the work … I do believe that one of the things that helps me to, in a sense manage the work is the treatment itself. Having a treatment that was specifically designed for this client group … and that also means if you're actually learning this stuff in your work, it becomes more of a way of seeing the world and, and moving through it. And it's just made my life easier. (P10)

This remainder of this section presents therapists' explanations of how certain aspects of the DBT model, such as the consultation team and using DBT skills support therapists to manage their CT reactions that arise when working with their clients who present with BPD.

DBT Consultation Team.

Nine therapists identified their DBT consultation team as being an important aspect of DBT that assists them in managing their CT reactions. Some therapists used words such as "containing", "effective", "helpful" and "reassuring" to describe their experiences being part of a DBT consultation team. Many therapists spoke about these meetings as a "safe" place, where "no decision is ever made individually" (P6) and "vulnerability" is encouraged. One therapist said "there's nothing I hold back. If I need help I go along and say that I need help" (P8). Another therapist spoke positively about the openness and support she experiences within her consultation team. She said,

> We talk about everything in consult. We talk about vulnerability, about feeling useless, about feeling very sure that this is the right way … everyone in the group shares their sense of vulnerability with the client. Or their sense of frustration, or their sense of feeling impressed or proud or whatever it is in consult. (P11)

One therapist noted "the main function of consult is to help us deliver the treatment in a way that maintains fidelity to the treatment model" (P12). Although consultation meetings do not involve talking about CT directly, some therapists described discussing reactions or burnout

in with consultation members, particularly if there are concerns they may interfere with treatment. For example,

> We rate our burnout every week … We don't draw a distinction like, burnout is life burnout or client burnout or whatever, we don't distinguish between them because the assumption is if you feel tired in your life that is gonna mean that you're less available for you patients. We want to see if there's a way we can help … if you're feeling really burnt out in relation to a particular patient, trying to elucidate what are the things that they are doing that are bothersome to you and how do we get those things to change … it's the team's job to assess whether there's a way they can help you do it or figure out how that clients need is going to get fulfilled in a different way. (P3)

Several therapists gave examples of the ways their consultation group members have helped them with specific CT reactions to their clients. One therapist described speaking with his DBT consultation team about his CT reaction of boredom, to ensure that these reactions did not become therapy interfering (Linehan, 2014). He illustrated this with the following example,

> I went to my team on and said, you know, 'I need help figuring out what to do about this person cos I'm actually just getting really bored. I'm getting really kinda like, it was frustrated but now I notice I'm just giving up. So help me with this'. And their job is to kind of assess that and make clever statements so I don't give up the treatment. (P10)

Similarly, another therapist emphasised managing burnout is essential in ensuring treatment can be carried out effectively. She described some of the ways that consultation meetings may assist her in maintaining empathy as well as observing and maintaining her limits. She explained,

> So we might come to consult and be like 'look I'm struggling having empathy for this client, I'm noticing lots of irritation, can you guys help me with this?' or it might be 'hey I'm noticing that I keep stretching my limits for this client' or 'I don't wanna stretch my limits for this client, I need help with that. (P12)

Several therapists described seeking "validation" or "reassurance" from consultation team members, often after difficult sessions with clients. As Participant 9 mentioned, "sometimes I go have a debrief and get some validation around what happened in session". Another participant spoke about her consultation team helping her manage anxiety that her client were to seek "retribution in some way" after finding out the therapist had made a report to child services. She said,

> I talked in consult and got some practical steps to take as well as just validating my concerns as well as little bit of reassurance you know that it's really unlikely, not impossible, but really unlikely – that her client will seek retribution. (P6)

Although majority of therapists spoke about consultation team meetings as helpful in assisting them in managing their CT or emotional reactions to clients, several therapists spoke about ways in which consult can be unhelpful. One therapist said consult can be less helpful when it "gets stuck", noting the importance of consultation members holding a balance between validating the therapist and helping them develop empathy for the client. This therapist further explained by saying,

> Sometimes consult members can swing to one side or the other too much too. So people might swing to just validating me if I'm feeling irritated, so if consult is feeling irritated too they might just do lots of validation rather than helping to develop empathy for the client or helping to figure out what to do about that irritation. So if consult can hold a balance of different sides and find a way forward it's really helpful but if consult gets stuck then it's less helpful. (P12)

Another therapist described a CT reaction of fear in response to his client being verbally abusive, and noted that he continued the treatment as recommended by his consultation team. The therapist explained how one of the "blind spots" in DBT may be not admitting when the treatment is not working. The therapist explained,

> The one thing the consult team hadn't considered was should you stop therapy. And I do think it is one of DBTs, from my point of view, one of DBT's blind spots is not being willing to admit when the treatment is not working. (P8)

Overall, these therapists described DBT consultation meetings as a safe and containing space whereby therapists can seek support regarding difficult aspects of the therapeutic work, such as CT. The therapists spoke about consultation meetings as helpful in assisting therapists manage their reactions in several ways. For example, consultation members may provide validation to the therapist, support therapists to develop empathy, or explore ways therapists can maintain their own limits. Several therapists noted that consultation meetings may be less helpful if the balance between validation of the therapist and developing empathy for clients is uneven.

Using DBT Skills.

Seven therapists described using DBT skills for themselves as a way of helping them "maintain their own wellbeing" (P10) and also manage CT reactions towards their clients with BPD. Some therapists referred to DBT skills as "life skills" (P2) that everybody should use. Examples of skills therapists emphasised as being important in managing CT or emotional reactions were mindfulness and the distress tolerance skill, radical acceptance. The latter refers

to a complete acknowledgement and acceptance of reality for what it is in that precise moment (Linehan, 2014). Several therapists described using mindfulness as a skill to notice what was happening for them in session, whilst others spoke about having a structured mindfulness practice. One therapist spoke about mindfulness skills as helpful when she feels overwhelmed by her clients' needs,

> The problems are so pervasive and complex that it can be a bit like, well fuck how am I gonna get on top of all of this? How can we get a handle on this when everything feels super important and risky and difficult? And so that can be really hard and that's when, for me, mindfulness saves my life because it's like, ok just one thing at a time. (P12)

Other therapists described how actively noticing is at the core of mindfulness. One therapist said "the first thing we wanna notice in mindfulness of course is noticing, allowing our experience rather than acting to either avoid it or change it or express it" (P10). Some therapists explained during therapy sessions, they actively notice thoughts they have and behaviours they engage in. One therapist described engaging in a "noticing mindfulness practice" during sessions whenever she feels a "pull to solve problems". She explained,

> I do this thing when I get this pull to solve problems, I notice myself leaning forward and get all keen and I have to just sit back in my chair and breathe. And that is super helpful for me. I have this mindfulness practice where I imagine myself letting go of thoughts and responsibilities. So I do a bit of that and I do a bit of a mindfulness practice around serving my own responses in session. That's probably the most helpful thing. Observing what's going on now? What's this urge that I'm having? Why am I feeling this kind of urgency? How come I'm leaning forward?" (P12)

As well as using mindfulness, some of the therapists spoke about using "radical acceptance of certain situations" (P11), themselves or their feelings. One therapist said "you just kind of make room for all sorts of feelings" and "radically accept it as what it is" (P9). Another therapist spoke about crying in response to his clients suffering and chronic self-harm. He explained that accepting his sadness and allowing himself to feel the reaction helped him manage it. He said,

> Just allowing myself to have the sadness and to cry cos that's what I do when I'm sad, is all I need to do. So sometimes it's just accepting the response as what it is and not needing to do anything else. (P8)

As such, DBT skills of mindfulness and radical acceptance were considered by these therapists as important skills that help them manage their CT reactions. Mindfully noticing thoughts and feelings, and radical acceptance of themselves and their reactions was described as helpful in managing such reactions.

Theme Two: Talking with Others

All therapists described talking with others to be an important way they manage their CT or emotional reactions to their clients who present with BPD. Three subthemes were identified: you can't beat good supervision; my own therapy; and debriefing with colleagues. The therapists described talking with others as being helpful in managing CT as this allows therapists to feel contained, to gain awareness of their experience, and process the effects of their work with the support of another person.

You can't beat good supervision.

All thirteen therapists discussed supervision as having a role in assisting them in managing their CT. One therapist said he is "religious about going to supervision once a fortnight" (P8), whilst another said "oh god I look forward to supervision so much, afterwards it just feels great" (P12). The therapists spoke about supervision as a space for "constant processing" (P11), with one therapist saying "you can't beat good supervision" (P11). One therapist spoke about supervision being important to ensure therapists are not holding things alone. She said,

> Supervision helps … Don't hold it alone ... working in this field is not something to hold alone ... you do the work for the client with the client. Don't torture yourself alone before or after. There's supervision for that, reflection space. (P2)

Many therapists said they tend to take "strong responses" (P5) or "reactions that stay around and have an intensity more than usual" (P9) to supervision. One therapist said her previous supervisors, who were "psychodynamically inclined", have helped her most with her CT. She said,

> I definitely think supervision has helped me to become aware of countertransference. Supervisors have asked me "how does that make you feel?" or "what happens to you?" or "what does this client do to you?" you know, stuff like that. So definitely it's helped me become aware of that. Um so I think it has in general also sensitised me more to my countertransference. I actually didn't realise that, but I think so, definitely. (P13)

Several therapists described the ways supervision helped manage specific CT reactions. One therapist said supervision was "really useful" and "contained" her, after feeling "hurt, upset and embarrassed" after being "fired by a borderline client" (P7). Another therapist highlighted the importance of speaking in supervision "to figure out how to cope" (P1) with feelings of frustration and anger towards his clients. Similarly, another therapist said

supervision helped her to her to learn a self-compassion strategy to implement whenever she feels frustration, anger, or guilt arise during sessions. She explained,

> My supervisor and I have come up with a kind of self-compassion or a compassion strategy. Which is, whenever feelings of frustration or guilt or anxiety come up, being able to sort of stop for a moment and connect to some sort of compassion that I have for the client, but then also some compassion that I have for myself in the moment as well. (P6)

Hence, regular supervision reportedly helps therapists manage CT as therapists are able to talk through their reactions in a way that facilitates self-awareness and exploration of ways to cope with difficult feelings.

My own therapy.

Five therapists spoke about their own experiences with therapy as important in managing their CT reactions towards clients presenting with BPD. Some therapists spoke about the importance of therapy for all therapists, as one therapist said that "everyone should have their own therapy at some point in their lives" (P9), particularly "if something has been triggered that is personal". She said,

> I think you actually really need to do that because to kind of get an external person that you're not linked to professionally to talk that through with because there are limits to what the supervision relationship is. Like, there are always elements of your personal experience and countertransference that can go there but there are some things that are more appropriate to talk elsewhere. (P9)

Several therapists described learning about themselves in therapy and understanding more about the nature of their CT as helpful for the therapeutic work. One therapist said she seeks therapy when she has strong personal reactions, which allows her to "travel back in [her] own history and make some connections" (P11). Another therapist said therapy has helped her be kinder to herself, which transfers to her work with clients. She explained,

> In the last 4 years I've done at least 2 years of personal therapy ... I know for sure it shaped my kindness and compassion to self, which I can assume has transpired in my work. And that I'm able to hold a more gentle stance with my clients when they go into 'I'm bad, I'm shameful, I'm hideous'. I can stay softer and warmer and when they do the behaviours that they are 'not supposed to do' I can also have more understanding and leniency and just be with that experience rather than yeah less judgement I guess. It does help a lot. (P2)

As such, accessing therapy was described as important for therapists, particularly when aspects of the therapists' history have been activated in the therapeutic relationship and would

be more appropriately explored in the context of therapy as opposed to in supervision. Moreover, learning about their CT in the context of their history was described as helpful for managing the therapeutic work.

Debriefing with colleagues.

Ten therapists noted "debriefing" with colleagues as valuable in managing or alleviating strong CT reactions. One therapist said debriefing with colleagues about "tricky reactions" at the end of the day is "extremely effective" (P4). Another therapist described having colleagues on site to speak with as she needs to as helpful. She said,

> I have no qualms in going and talking to colleagues if I needed to, especially if a client was acutely suicidal while I was seeing them. Then I would, if I was concerned about someone safety, I would pause the session and go talk to someone and then come back. And I find that helpful as well. (P5)

Several therapists highlighted the importance of discussing CT reactions with colleagues, to ensure they themselves are not "holding it alone" (P2). One therapist said "talking about [her] personal responses gets it out there and makes self-reflection a bit easier" (P6). Another therapist said "working with clients with borderline features or personality is work done in a team" (P2). She said "somebody needs to hold you as you hold the client. Doing it like that, feels manageable, feels good, feels doable, feels actually professionally sound". When asked about how she talks with her colleagues about CT, she explained,

> The clinician who brings the client for reflection talks a bit and as the person talks, the rest of the team just notices what is happening for them, what responses, what feelings, what memories or association content gets evoked and then the person, when they finish talking, we do a round of responses from the group. So, in that way, we are with the therapist as they are holding the client in mind and responding to the client we are responding to what the therapist is bringing. (P2)

In sum, debriefing with colleagues about strong CT reactions was described by many therapists as helpful in managing or alleviating their reactions to clients with BPD as therapists are able to reflect on their experiences with the support of another person.

Theme Three: Self-care

The therapists also spoke about self-care strategies they use to help manage the CT reactions they have toward their clients with BPD, often outside of work hours. Examples typically involved engaging in self-care activities unrelated to mental health, such as exercise,

meditation, watching TV, reading, music, dancing, singing, patting pets, and spending time with friends and family. Several therapists highlighted the importance of engaging in self-care in order to deal with the challenges of the therapeutic work, such as CT reactions. As highlighted in the following quotes,

> I really focus on self-care. I think if I didn't do that I wouldn't be able to stay as able as I am to deal with all these countertransference responses and emotions in the work … Um and I've never stopped paying attention to that. (P8)

> Sometimes they really piss me off. I think that my work with them requires a certain amount of discipline by me as a therapist. It requires me to really use what I have in terms of taking care of myself as a human being so that I am able to do this work. (P3)

Exercise such as yoga, walking, and running were described as assisting therapists in managing some of the effects of their work. One therapist said "every day when I leave work to catch the train that I catch I actually have to run to the station … so I put on my exercise gear and go for a run and I find that's me physically and mentally allowing myself to leave work at work and transition to going back to home" (P4).

Many therapists described the importance of engaging in "simple joyful experiences" (P2) that are "completely unrelated to mental health" (P10). One therapist spoke about the importance of "not thinking about work, booking holidays, doing things that are really different from work" (P12). Another therapist descried the activities she engages in,

> I spend a lot of time either making or listening to music. I go to some folk dancing groups and I sing in a choir. I have some good friends and we get together quite a lot. I go outdoors, you know tramps and exploring a bit. Um I try to connect with people who are far away from as well with Skype. I do that quite a lot. But it's good for me … Oh and I try to do some exercise. I walk and I swim sometimes and stuff like that. (P13)

Several therapists emphasised the need to see "the lighter side of life" (P9). One therapist said she tries to engage in activities that bring her joy and balance out some of the difficulties she experiences in her work. She said "I go home and I paint and I listen to music and I dance in my room and I cook myself a nice meal. Or I just go out with my partner, meet some friends, talk about little joys of life, just to balance it out" (P2).

As well as engaging in activities unrelated to work, several therapists spoke about the importance of structuring their work environment in such a way that allows them to manage the challenges of the work more effectively. When asked what she does to take care of herself to allow her to manage her CT or emotional reactions, one therapist said "it probably in a way

is just how I structure my day on the whole" (P6). She described having a before and after work structure, which she noted "allows me to a large degree for work to remain in work time and for me not to carry on after work thinking and feeling things" (P6). Another therapist described allowing time in between client appointments as important in allowing him to process emotions from the sessions. He said,

> I've always structured my work environment so I don't overwork. I'm quick to say 'I'm full, I can't see extra clients' … And I won't have anybody bullying me to see too many clients. And I leave half an hour between clients. (P8)

Overall, self-care strategies were emphasised as important in helping therapists manage some of the difficult aspects of their work, such as CT reactions. Engaging in non-mental health related activities and structuring the day was described as supporting therapists to feel effective in handling challenges that arise at work.

Utilising CT Reactions

Theme One: Naming or Disclosing Reactions

All therapists described naming or disclosing their CT reactions as being the primary way they utilise their reactions to clients with BPD. Some therapists used the term 'naming', and others used the term 'disclosing'. Several therapists who used the term disclosing, referred to the DBT concept of 'self-involving self-disclosure', whereby a therapist shares statements with a client about the therapists reaction to a client (Linehan, 1993). For these therapists, they highlighted the importance of disclosing their reactions as part of the DBT observing limits procedure, which encourages therapists to notice their limits and communicate these to clients once they have been crossed. This section presents the analysis of therapists' experiences of naming or disclosing their CT reactions to their clients and the reasons they name their reactions. Two subthemes were identified: awareness and I statements; and, naming to check in, problem solve or communicate limits.

Awareness and I statements.

Many therapists spoke about the importance of "being aware" of CT reactions, before utilising them. As one therapist noted "I just don't know how you'd do anything well especially not this kind of therapy without listening to how you're feeling about the client and your internal response" (P9). Another therapist spoke about using her CT "as a tool of responding

to ourselves and the client" (P13). She noted that "in order to do that you have to be very aware and pay attention to what is going on inside of yourself "(P13). The importance of awareness of reactions before utilising was highlighted by another therapist,

> I read through my responses, being aware of my responses as much as possible so that I can hold them in mind and not play into them. Because I might feel a response of, oh poor you you had such a hard week, and I might act into it if I am not aware. But if I am aware then I noticed, ah that is what I feel like doing, I wonder why. I wonder if that is what my client needs or what. And then I can voice it out. (P2)

Once aware of what they were experiencing, many of the therapists said they "name" or "disclose" their response to their client in session, often in the form of 'I statements' to illustrate ownership of the reaction. For example, one therapist reflected that she often feels disconnected and sleepy, whenever her clients are "dissociated or disconnected", and spoke about naming her response by saying to her clients "when you become disconnected I feel very disconnected and tired" (P7). Similarly, another therapist, who also discussed his CT reaction of sleepiness reported saying to clients, "I've figured out over the years if I get really sleepy and I know I've had a miserable night's sleep it's possibly because you've got some emotions you're trying not to feel and it's putting me to sleep" (P8). Another therapist gave an example of what she might say to name her CT response of frustration to her client using I statements,

> I notice that I am feeling this frustration and I am having this sense that you keep doing this thing over and over and I'm just feeling concerned about you as well, like, I'm nervous that if you keep doing this thing, the same thing is gonna keep happening and I know that that was really hard for you last time. (P5)

Several therapists discussed using I statements to name or disclose their fear about their clients' difficult situations. One therapist said he may disclose to his clients when he feels attacked by them. He gave an example, "you know, when you act in this way, when I ask you about your diary card, you know, I feel attacked and, and I notice that my willingness to work with you might diminish" (P10). Another therapist spoke about disclosing her response of fear with her clients,

> If I am scared about what's happening with a patient I say "look I am really afraid, I'm really afraid that if I let you leave here with four bottles of methadone after you've taken an overdose last week, that even though you're saying you're gonna return it to the dispensary, that you're actually not going to. So I think we've gotta figure out a way that this can happen. (P3)

As well as giving examples of how they would name or disclose their CT reactions in the form of I statements, the therapists also discussed the function of naming or disclosing their

reactions. Three ideas were identified which capture the therapists' rationale for naming or disclosing their reactions: checking in, problem solving with the client, and communicating therapists' limits.

Naming to check in, problem solve, or communicate limits

Twelve therapists identified naming or disclosing their CT reactions to clients to either "check in" with their clients, to problem solve with their clients, or to communicate their limits with their clients. For example, one therapist said, "I use a lot of my responses in therapy to check in with clients. Like, "I feel it has been quite a hard week for you and I feel like protecting you in some ways, is that what you would like?" (P2). The same therapist explained naming her CT reactions to check in with her clients so they can work together to figure out where the reaction stems from. She said,

> It comes down to that question of, is what I am feeling now - which might be anxious or nervous or - mine or is it in the room… That's helpful for me to tease out what's mine and what's in the room or specifically happening for the client right now … and then naming it. Because figuring out whose it is is only through naming. I can't assume. I can't say "oh I am feeling anxious it must be the client" (laughs). (P2)

Several therapists discussed using their CT response to "check in" with clients about factors impacting therapy. For example, one therapist said when her clients "come running in late" or "forget stuff they are supposed to bring", she notices that the invitation for her is to be critical in response. She said, "when I notice that invitation I think, that's a transferential thing. So what would be a therapeutic response here? … one of the things I do is I note my feeling and, and I then check in with them about what's just happened" (P11).

Many therapists spoke about naming or disclosing their reactions to their clients for the purpose of working together with their clients to problem solve a situation together. One therapist gave an example of using self-involving self-disclosure about her reaction of feeling worried, for the purpose of problem solving with a client. She described,

> I might say something like "you know I'm noticing, hearing you talk about this, that I'm feeling very worried about you. I'm feeling worried that I'm not seeing you do behaviours to solve this problem and I'm noticing I'm having this urge to step in and solve the problem for you. I don't think that's gonna be helpful. How can be work through this together? What do I need to understand? Or what am I missing? (P12)

Similarly, several therapists discussed naming or disclosing their CT reaction of tiredness towards their clients to problem solve how they can move forward together. One therapist shared an example and said "I'm noticing I'm feeling fairly tired all of a sudden. Is that what's happening for you right now?" (P11), followed by "so what should we do about that?" (P11). Another therapist said he finds himself "feeling like it's almost impossible to keep [his] eyes open" whenever his "clients don't wanna feel emotions" (P8). He said he then makes a plan with the client with how they can work through it next time it happens, he gave the following example of what he may say, tentatively, in session,

> So what're we gonna do next time that happens? Next time that happens can you tell me or can I check in with you? Can I say 'hey are you trying not to think right now?' … and when I bring it in I always offer it very tentatively 'I noticed this, I was wondering, I wanna check this out with you, this may not be accurate it all, please feel free to tell me a different view on this'. I always do it in that way. (P8)

Several therapists described disclosing their reactions to clients with BPD as part of the DBT "observing limits procedure", which requires therapists observe the client behaviours that interfere with therapists ability or willingness to continue therapy, and then communicate their limits with clients in an honest and genuine manner (Linehan, 1993). One therapist explained that the observing limits procedure serves to protect the therapy,

> So in a sense making use of my emotional experience I have a procedure to ensure that I can protect the therapy, cos if you don't protect the therapy and yourself in the therapy you're gonna burn out. So in DBT, that's the observing limits procedure. That's why DBT's so fantastic. But it kinda seriously is, because without that you're fucked (P10).

Several therapists described communicating their limits with their clients in such a way that is "humane and human, like one human being speaking to another" (P3). One therapist highlighted an example where she felt the urge to stretch her limits and see her client in her lunch break. She explained how she would disclose her urge to stretch her limits to a client,

> I'll say "look I'm having the urge to schedule you over my lunch break and I actually think when it comes to that day that that's gonna be problematic for you cos I will be hungry and irritated and less able to pay attention to you, so I think we might need to skip that week and schedule you next week". (P12)

As well as observing and disclosing limits prior to being crossed or pushed, some therapists also spoke about the importance of setting limits after they had been crossed, or after they themselves had "burnt out". One therapist spoke about carrying out phone coaching "7 days a week 7am till 9pm". He said he eventually had to change his limits around phone

coaching timeframes after one of his clients with BPD contacted him so much he felt like he had "no downtime". He said,

> She went into crisis so often it was sometimes 2 or 3 calls in an evening, and then over the weekend … And if she couldn't get hold of me she would then start text bombing. I once left my phone in the car for an hour and there was something like 76 texts waiting for me when I got back. And it just felt like, you know, ahh really, I just don't have any life. So, of late I've actually changed it so that I am not available after hours and on weekends. (P1)

Several therapists spoke about becoming more aware of their limits with time, which has helped them protect the therapy and also avoid burnout as their limits become "tighter". One therapist said she used to "tolerate a lot of therapy interfering behaviours" when clients would become "aggressive or abuse". She said she now feels more confident in disclosing her limits before she reaches burnout. She gave an example of her limits changing regarding risk and suicide,

> Especially things around suicide and risk like I had a client who used to call and leave a message with reception saying that if I didn't call her back within a certain period of time that she would die and that would be my fault … now I wouldn't have such a tolerance for that. About what my personal limits are for being drawn in and taking that responsibility. My limits are different now. (P9)

Hence, therapists described naming or disclosing their CT or personal reactions to their clients with BPD as the primary way they utilise their CT. The therapists spoke about the importance of being aware of their reactions before naming them, and said they would name them by using I statements, to take ownership of their reactions. Therapists described naming or disclosing their reactions for the purposes of checking in with clients, problem solving with clients, or as part of observing and communicating their own limits to clients.

Theme Two: It Depends – using CT if helpful therapeutically

When asked about whether they use their CT reactions, many of the therapists said "it depends" whether using them is helpful or unhelpful for the therapy. Specifically, nine therapists spoke about utilising their CT only if they believed it would be therapeutically helpful. The section presents therapists' explanations and examples of how utilising CT is dependent on the client and the context.

For instance, one therapist was speaking about her CT reaction of frustration to clients who present with BPD and her beliefs about whether she would name her reaction. She said

"depending on the context and depending on the person. Especially if I had been working with them for a while, yeah I think I would. Definitely, especially if they were doing something that was really self-sabotaging." (P5). Another therapist said she has no rules as to whether she uses her CT reactions, though emphasised the importance of determining whether expressing her response would be therapeutically helpful before doing so. She said,

> I don't have a strict rule for myself that if I experience countertransference I have to interpret it fully or I don't have to. I try to respond to what I'm sensing. And I try to make it useful in the therapy. I try to ask myself 'could it possibly be useful for my client's process that I interpret this? (P13)

Some therapists discussed the need to "be careful" using CT reactions, "particularly with borderline clients" (P9). One therapist spoke about being careful about naming her reactions with these clients by saying,

> Self-disclosure is always on the table with borderline clients and you know wanting to switch roles and wanting to rescue you and know about you and your personal life and build a personal relationship with you rather than a therapy relationship … So yeah I'm careful. (P9)

Another therapist said "I'm probably very careful about kind of expressing any form of anxiety with clients unless I think it's helpful to say so" (P6). Another therapist spoke about how he feels he has to be careful expressing any reactions of frustration or judgement toward his clients with BPD, as many of them are sensitive. He said "so many of my clients are so ultra-sensitive to judgments I am really reluctant to say "you know I am feeling really judgemental about you" (P1). Similarly, another therapist said she is careful to monitor her reactions of frustration. She explained,

> I am more likely to try and be aware of and monitor and regulate my emotional response when I am in the room with a client if it's negative. So particularly frustration. I guess because if it was to come out in a way that I didn't want it to, it's most likely to have a detrimental impact on the relationship. But there has been times when I've said "oh I'm feeling really frustrated with how this is going. (P6)

Some therapists described naming their CT reactions to benefit the therapeutic relationship. One therapist described the ways this can be beneficial, saying, "I think it's getting the person and I on the same page … I guess it can break down that barrier of, you know cos that's their protective layer. So I have found it powerful to name what is coming up in the room" (P4). Another therapist explained, although "it depends", naming CT can strengthen the therapeutic relationship. She said,

> I think [naming CT reactions] certainly has the capacity to strengthen the relationship. Because it's bringing more of myself into the relationship, I think it can make it stronger. Even if it's like a 'I am feeling frustrated about this', it makes me feel like I am being genuine and maybe it makes me more invested in the treatment in some way. Yeah so I think it can strengthen, but I think it depends on the person and the situation. (P5)

Another therapist used a case example to illustrate how interpreting her CT can be helpful to identify relationship patterns she believed were being repeated in the therapeutic relationship. She described a client who thought she was "an awesome client" and then one day became "angry" and told the therapist it was their last session together because she was angry the therapist and Mental Health System had let her down. The therapist noted she felt scared at the time, though tried to validate her client whilst expressing her reaction of discomfort in the situation to try assist her client in identifying the relational pattern that was being replayed in the therapeutic relationship. She said,

> With her I really tried to listen, to let her vent and talk about it. Eventually at some point I just acknowledged her frustration with the system and with me and acknowledged how it could have made her feel. And also recognising her transference and interpreting that and eventually I asked her "I was wondering if this kind of dynamic also happens in other relationships? Like other therapists, romantic relationships, colleagues". And then she recognised it and she said "oh this has happened before". So that was helpful. I didn't interpret that it was scary to be at the receiving end or be the object of the splitting. I think I used some description of discomfort that I felt but I tried to get her to recognise the pattern, and she could. (P13)

Hence, therapists described utilising their reactions by naming or disclosing them, but only if they thought it would be of therapeutic benefit. Some therapists expressed caution naming their reactions to clients with BPD because these clients often want to know more about therapists, or are sensitive.

Summary: Managing CT

The therapists described various ways they manage their CT towards their clients with BPD. All of the therapists who practice from a DBT model spoke about the DBT framework as being crucial for assisting them in managing the emotional impacts of their work. These therapists described DBT consultation meetings as being an important aspect of DBT in supporting therapists to feel validated, whilst also helping the therapists make decisions, in an attempt to avoid burnout. Some therapists spoke about using DBT skills such as mindfulness and radical acceptance help them manage their own wellbeing, and the emotional effects from the work. All therapists described talking with others – in the form of supervision, therapy, or

informally with colleagues – as helpful in managing their CT reactions. Many therapists highlighted talking about strong reactions, or reactions that linger, to seek support in managing them. Lastly, all therapists described engaging in self-care activities unrelated to mental health as being a common way to take care of themselves, to ensure they have the capacity to manage their CT and feel effective in their work.

Summary: Utilising CT

All therapists described naming or disclosing CT reactions as the most common way they utilise their CT. The therapists described the importance of being aware of their CT reactions before naming or disclosing reactions as well as using I statements such as 'I notice' when expressing their reactions. Reasons for naming CT to clients included checking in with clients, problem solving with clients, and communicating therapists' limits to clients. Although naming responses was common for all therapists, the majority of the therapists emphasised naming their CT, only if they believed it to be therapeutically helpful. The therapists described the importance of waiting and being cautious with their responses, before expressing them. Some therapists noted that utilising their CT can strengthen the therapeutic relationship and help the client increase their awareness. The therapists said they do not name or disclose their reactions if they do not think it would be therapeutically helpful to do so.

Chapter Six – Discussion

This qualitative thesis study examined therapists' experiences of CT when working therapeutically with clients diagnosed with BPD. In particular, it sought to develop an understanding of the types of CT reactions that therapists experienced when working with clients with BPD, including the clients' behaviours, therapists' sensitivities and therapy circumstances that gave rise to the therapists' reactions. This study also examined the ways therapists' conceptualised their CT reactions from different therapeutic orientations. It also aimed to gain insight into the ways therapists managed and utilised their CT reactions.

Twelve of thirteen therapists in this study were using DBT or DBT informed therapy when working with clients with BPD, which may reflect the current evidence that DBT is the most effective treatment at reducing severity of BPD symptomology (Storebø et al., 2020), and the predominance of cognitive behavioural based treatments in New Zealand training programmes and practices (Kazantzis & Munro, 2011). The results of the thematic analyses, presented in the previous three chapters, suggest that the therapists experienced a range of CT reactions, and conceptualised their reactions through psychodynamic and/or dialectical-behaviour therapy ideas. Therapists also described several ways they managed and utilised their CT reactions. This chapter addresses these findings in light of the existing research and clinical writing. This is followed by a discussion of the implications of the results for therapists and training programmes. Lastly, limitations of this study and future research directions are discussed.

Therapists' Countertransference Reactions with Borderline Personality Disorder

The therapists in this study reported strong CT reactions when working with clients with BPD, irrespective of therapeutic training background. An examination of the literature revealed that no published qualitative studies have used the term CT to examine the in-depth nature of therapists' reactions to clients with BPD. Indeed, much of the literature in this area either does not use the term CT, or does not capture the contextual factors of therapists' reactions, including client behaviours, therapist sensitivities and therapy circumstances. Consequently, the present findings will be discussed in relation to research that uses terms such as 'personal reactions' or 'responses' as well as research that has examined therapists' CT reactions relevant to characteristics of BPD, such as therapists CT reactions to suicidality. The present study identified six types of CT reactions through the thematic analysis, including:

frustration and anger with ongoing challenges; anxiety and fear amidst chaos; sadness with suffering; disconnecting when the client disconnects; hopelessness and despair with ongoing self-harm and suicidality; and joy and pride with progress. Frustration and anger was the most commonly experienced, followed by anxiety and fear.

Frustration and anger with ongoing challenges.

Therapists in this study described frustration and/or anger when working with clients with BPD as arising in relation to clients slow or no apparent progress; in response to clients verbally attacking or pushing therapists' limits; and/or, in response to clients engaging in self-harm or suicidal behaviour. Both clinical writing (Linehan, 1993) and research (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012) indicate that clients with BPD often make very slow progress in therapy compared to clients with other disorders, resulting in therapists frustration or impatience (Bieke-Rapske, 2016; Koerner, 2011). Similarly, therapists' feelings of frustration or anger in response to clients' attacking behaviour (Kernberg, 1985; Rossberg & Friis, 2003) or suicide attempts/behaviours is well documented (Putrino, Casari, Mesurado, & Etchevers, 2020; Treloar, 2009). In support of the findings from the present study, several interview studies have found that therapists reported feelings of frustration and annoyance in relation to clients with BPD repeatedly engaging in self-harm and suicidal behaviour (Putrino et al., 2020; Treloar, 2009).

Anxiety and fear amidst chaos.

Therapists in this study reported experiencing fear or anxiety associated with the chaos they perceived in their clients lives and clinical presentation. This was particularly relevant for the therapists early on in their careers. Although it is established that therapists may report feeling overwhelmed in response to their clients' emotion dysregulation and complex presentation early on in their careers (Cartwright et al., 2014), there is no research that has examined the qualitative nature of therapists early career CT experiences working with clients with BPD. The therapists in this study reported feeling fear in response to the perceived chaos and unpredictability of their clients' lives and clinical presentation during therapy. In particular, they described their clients' impulsive behaviours, heightened distress, and suicidal threats as overwhelming. For some therapists, this resulted in thinking about clients outside of session and feeling uncertain about how to proceed therapeutically as they felt they did not have any structure or direction for working with this client group.

Outside of early career experiences, reactions of anxiety and fear were also described by the therapists in this study in response to feeling threatened or tested. This is partially aligned with literature that suggests therapists experience anxiety in response to clients with BPD whenever they feel they have done something wrong (Gabbard, 2001b). The therapists also described fear that their clients may end their life by suicide. For some of the therapists, this resulted in a sense of responsibility and pressure to ensure their clients' safety paired with doing more than they usually would, such as extra phone calls. Feelings of fear in relation to concerns clients with BPD may attempt or complete suicide is well established in both clinical literature (Gabbard, 1993; Maltsberger & Buie, 1974) and research studies (Fritz, 2012; Pope & Tabachnick, 1993). Indeed Pope and colleagues (1993) found that 97% of therapists in their study reported feeling afraid that clients would die by suicide. In a previously mentioned study, Bieke Rapske (2016) found that strong CT reactions of fear and anxiety that clients with BPD would harm themselves, resulted in therapists reporting a strong desire to keep their clients safe. This latter finding is consistent with the present study in that therapists reported wanting to engage in certain behaviours to ensure their clients safety. Unique to the present study, some therapists described experiencing physiological symptoms such as dizziness, sweating and panic attacks when feeling anxious and afraid their clients may attempt suicide. This suggests that clients' threats or attempts of suicide in the context of BPD symptomology can be frightening for therapists and have the potential to impact therapists' overall wellbeing.

Sadness with suffering.

Working with clients who present with trauma histories can also bring up strong feelings for therapists (Hesse, 2002). Some therapists in the current study reported feeling sadness towards clients who had shared their early life experiences of trauma and were seen by therapists to be suffering as a consequence of that trauma. For some therapists, this resulted in a desire to save, rescue or protect their clients. This relational pull is consistent with descriptions from clinical writing that posit that therapists may experience rescue fantasies towards clients with BPD who present as needing to be rescued and have things done for them (Gabbard, 2001b). Cartwright and colleagues (2014) also found that therapists experienced feelings of sadness and a desire to make things better when working with clients who were sad, traumatised, or struggling to overcome problems, although the focus in this study was not on BPD. That therapists experience reactions of sadness and a desire to rescue clients in response to hearing or knowing about clients' trauma is well-established (Cavanagh, Wiese-Batista,

Lachal, Baubet, & Moro, 2015; Fixsen, Ridge, & Evans, 2020). However, research into CT and BPD discussed previously did not draw attention to sadness or urges to rescue as experiences reported by therapists working with this client group. The depth of the current study may have allowed the therapists to talk about such relational patterns or pulls in a way that is not captured by questionnaire studies. Moreover, it may be hypothesised that because the therapists in this study were experienced working with this client group and had established therapeutic relationships with their clients, they may have experienced a greater degree of empathy for their clients, which allowed them to better understand their clients' challenging behaviours in the context of their suffering and experiences of trauma.

Disconnecting when the client disconnects.

Feelings of disconnection were also experienced by therapists as arising in relation to clients disconnecting from themselves, the therapist or the therapy. Notably, clients' avoidance of their own emotions was described as causal of therapists feeling bored, disconnected or sleepy, particularly when clients carried themselves in a theatrical or animated way. This is consistent with clinical writing which suggests that therapists can experience strong CT reactions of boredom and sleepiness when clients with BPD do not take responsibility for themselves (McHenry, 1994). Past research supports the notion that therapists may experience boredom or difficulties staying awake then their clients talk about things that are boring (Williams, Polster, Grizzard, Rockenbaugh, & Judge, 2003) or feel disengaged when clients intellectualise and struggle to express their emotions (Cartwright et al., 2014).

Hopelessness and despair with ongoing self-harm and suicidality.

Clients' chronic suicidal ideation and suicidal behaviours can evoke intense feelings of hopelessness in therapists (B. Richards, 2000). Therapists in this study described CT reactions of hopelessness or despair when working with clients with BPD, often in relation to clients' chronic suicidal ideation, self-injurious behaviours, and own sense of hopelessness. Some therapists spoke about feeling hopeless when they felt like nothing they were doing was making a difference to their clients' behaviours. Linehan (1993) noted that clients with BPD often feel hopeless about themselves, their relationships and their lives, and that it is common for therapists to experience hopelessness when working with these clients (Koerner, 2011; Linehan, 1993). Several quantitative research studies (Colli et al., 2014; Tanzilli et al., 2016)

have also found that emotional responses of helplessness and inadequacy are common for therapists working with BPD.

Joy and pride with progress.

Finally, some therapists described feelings associated with joy and pride in relation to clients' therapeutic progress and achievements. Machado and colleagues (2014) conducted a review study to identify the main findings of studies that investigated CT in adult psychotherapy. As is consistent with the findings from the present study, the researchers found that more positive CT reactions are often in response to positive outcomes such as symptom improvement. Bieke-Rapske (2016) also found that some therapists experienced feelings of pride towards clients with BPD when their clients made progress and when therapists felt connected to their clients. Consistent with the present study's findings, participants in Bieke-Rapske's (2016) study spoke about clients with BPD making progress as a rewarding experience, because majority of the time, therapy is slow, consisting of many challenging client behaviours, such as suicide attempts, which can largely impact therapists' emotional states and wellbeing. Moreover, Fritz (2012) explored the CT reactions, attitudes and feelings of eleven therapists towards clients with BPD and found that there appeared to be a change overtime whereby therapists often reported not liking their clients with BPD at the start of therapy, but grew to like them as time progressed. These findings are broadly consistent with the present study's findings, in that therapists often experienced challenging, negative feelings towards clients with BPD when therapy was challenging, however, over time, they felt pride and warmth when their clients overcame challenges and made positive changes in their lives.

Therapists' Conceptualisations of Countertransference Reactions

The development of the concept of CT has a long history and it is widely used across psychotherapies to refer to therapists' cognitive-affective reactions to clients during therapy (Gabbard, 2004). The results of this study revealed that majority of therapists understood their reactions to be a joint creation, involving contributions from both themselves and their clients. The therapists in this study referred to psychodynamic concepts and/or DBT concepts to describe the ways they conceptualised their reactions towards clients with BPD.

Psychodynamic Conceptualisations.

Some of the therapists in this study understood their reactions to be evoked or invited by their clients; to arise from their own personal history; and/or from a combination of the two. The notion that clients pull, invite and/or evoke various reactions within therapists was discussed by many therapists, most of whom had training or interest in psychodynamic therapies. These conceptualisations appear consistent with several views of CT. For instance, the complementary view (Kiesler, 2001; Levenson, 2004) of CT suggests that therapists' CT reactions are a complement to a client's style of relating whereby a therapist responds certain interpersonal "pulls" from a client. Some therapists' in this study reported sadness and a desire to rescue clients whom had experienced trauma and were seen to be suffering. This therapist response could be an example of complementary CT to a client's want to be rescued and saved by the other. Moreover, some therapists described experiencing responses that could be likened to the notion of concordant CT (Racker, 1957), whereby a therapist resonates or identifies with a client's emotions. Indeed, some therapists in this study described feelings of hopelessness and despair in relation to their clients' hopelessness and continuous attempts to end their lives. In this sense, the therapists' emotional responses appeared to mirror the affective states of their clients, consistent with concordant CT (Racker, 1957).

The idea that CT reactions can be influenced by both client and therapist contributions was a common view held by the therapists, and is consistent with the CT literature (Gabbard, 2001a). Some therapists in this study used psychodynamic terms such as 'objective' or 'global' to refer to responses towards their clients with BPD that were also experienced by other clinicians working with the same client. This is consistent with Winnicott's (1949) idea of objective CT. Related to this, some therapists in this study also spoke about how their CT responses served to inform them about their clients' past and current relationships. They shared the belief initially espoused by Heimann (1950) that CT can be used as therapeutic tool to gain access about a client's interpersonal world.

Some of the therapists in this study also spoke about the ways in which their own histories and personal experiences played a role in their reactions to their clients. Some therapists described these as "subjective" or "unique" responses. This is consistent with the concept of subjective CT (Kiesler, 2001; Winnicott, 1949). It is noteworthy that the therapists who used the terms objective and subjective CT, reported having completed a CT training in

New Zealand (Cartwright, Barber, Cowie, & Thompson, 2018) that introduces psychodynamic conceptualisations of CT – such as objective and subjective CT – and their application to a range of therapeutic modalities.

Dialectical-Behavioural Therapy Conceptualisation.

Some therapists, who practiced primarily from a DBT model, spoke about their reactions to their clients as arising out of a "transaction" whereby both therapist and client mutually influence each another. This is line with clinical writing in DBT that posits the therapeutic relationship is a transactional relationship whereby both therapist and client influence one another over time through a series of reciprocal interactions and shared experiences, which subsequently give rise to various behaviours (Koons et al., 2001; Linehan, 1993; Swales & Heard, 2007). It is important to note that, from a DBT perspective, behaviour includes any activity, functioning or reaction of a person, conceptualised by three modes of behaviour: motoric, cognitive-verbal, and physiological (Linehan, 1993). Furthermore, Linehan (1993) notes that emotions are integrated responses of a whole system involving behaviours from all three mentioned modes of behaviour. With that in mind, it appears that some of the DBT therapists in this study conceptualised CT reactions or emotional responses as behaviours that arise out of a transaction between therapist and client within the therapeutic relationship.

To use or not to use the term CT.

Despite the therapists in the study reporting an interest in the therapeutic relationship and the reactions they have toward their clients, none of the therapists reported using the term CT in their work places or with colleagues. Therapists who had training or interest in psychodynamic paradigms described not using the term CT as they felt cautious about it, given the term is used within psychoanalytic and psychodynamic paradigms, and the Mental Health system in New Zealand primarily lends itself towards Cognitive-Behavioural therapies. Some of these therapists with psychodynamic training, who also used DBT when working with BPD, conceptualised their CT reactions based on their psychodynamic knowledge, but used DBT specific terms such as behaviours or emotional responses when discussing their experiences with others. Other therapists who had training in cognitive-behavioural paradigms and practiced primarily from a DBT model spoke about not using the term CT because they feel it

belongs to psychoanalytic and psychodynamic therapies and is "too conceptual" or "not relevant" for them as behavioural therapists.

The variety of opinions provided by the therapists in this study are consistent with an enduring theoretical discussion in the research and clinical literature on CT. Although the term CT originates from psychoanalysis, and CT as a phenomenon is considered a crucial part of the therapeutic work among many psychodynamic and psychoanalytic schools, there are some cognitive-behaviourists who believe that the term CT also has a place in cognitive-behavioural therapies (Leahy, 2007; Newman, 2013; Prasko & Vyskocilova, 2010). Conversely, there are cognitive behavioural therapists who believe it is best not to use the term CT (Beck et al., 2015; Kazantzis, Dattilio, & Dobson, 2017; Kimerling, Zeiss, & Zeiss, 2000). Indeed, Aaron Beck and colleagues (2015) preferred to use the term the 'therapist's emotions' so as to not confuse cognitive behavioural concepts of CT with the psychoanalytic concept of CT. Similarly, other researchers who practice from psychoanalytic and/or psychodynamic paradigms have expressed their concern regarding the increased use of the term CT by cognitive behavioural therapists (Craig, 2020; Ivey, 2013). They argue that the cognitive behavioural conceptualisation of CT does not adequately accommodate the Freudian unconscious (Ivey, 2013) which underlies the understanding of CT within psychoanalytic praxis (Craig, 2020; Najavits, 2000). Moreover, paying attention to therapists' conscious feelings about a client does not equate to sufficiently working with CT as CT reactions are not always decipherable (Craig, 2020; Ivey, 2013; Najavits, 2000). This school of thought concludes that cognitive behavioural and psychoanalytic/psychodynamic therapists are referring to different things when they speak about CT.

Debates around the use of the term CT notwithstanding, the findings from this study suggest that therapists experience common reactions when working with clients with BPD, regardless of therapeutic orientation. Although therapists had different ways of describing their CT or emotional responses, most therapists identified that both client and therapist contributed to their reactions. It appeared that therapists in this study who work with BPD solely from a DBT model, were acknowledging and working with CT, though they preferred to use behavioural language to describe their experiences, such as behaviour or emotional responses. Therapists who were trained in or had interest in psychodynamic approaches did think about their CT reactions using psychodynamic ideas, and were able to modify their language when working from a DBT model or within services that prefer behavioural paradigms. It could be

proposed therefore, that exposure to various therapeutic models and conceptualisations of the therapeutic relationship resulted in increased flexibility among experienced therapists. Indeed, in this study, therapists appeared able to conceptualise their emotional reactions towards clients in therapy from a variety of therapeutic perspectives.

Therapists' Management of Countertransference Reactions

The therapists in this study described a number of ways they manage their CT reactions towards clients with BPD. For many therapists, managing their reactions involved using aspects of the DBT model, such as consultation meetings and DBT skills. All therapists described talking about their CT experiences either in supervision, in their own therapy, or with their colleagues to help manage their reactions. Therapists also reported engaging in self-care strategies unrelated to mental health to manage the emotional impacts of the work.

As mentioned, twelve of thirteen therapists in this study were using DBT or DBT informed therapy when working with clients diagnosed with BPD. Thus, it is unsurprising that therapists spoke about aspects of DBT as important in assisting them in managing their CT reactions. Many therapists described their early career experiences working with BPD as CBT trained therapists. These therapists described heightened anxiety and fear trying to both manage their clients' emotion dysregulation and work effectively with the perceived chaos and unpredictability of their clients' lives. They described not knowing what to attend to or prioritise in therapy because of the ongoing changes and numerous crises. The therapists then spoke about feeling contained and more confident working with clients with BPD after being trained in DBT and working as part of a DBT team within their mental health services. The therapists described the structure that DBT provides to be "soothing" and "containing" as DBT has a framework for working with challenging and suicidal behaviours, which helps therapists manage their own fear and anxiety. This finding sheds light on the importance of having a structure for managing clients with this clinical presentation, as this helps clients feel more contained and therapists feel more contained and less anxious in the therapeutic work.

The therapists in this study described talking about their reactions in DBT consultation meetings as helpful in managing their reactions as therapists were able to seek validation and support from their DBT consultation colleagues. Two prior studies support the notion that DBT consultation teams can support therapists to manage their emotional responses towards clients with BPD (Kim & Sweeny, 2015; Walsh, Ryan, & Flynn, 2018). Walsh and colleagues (2018)

interviewed 11 DBT therapists about their experiences of their DBT consultation team meetings to determine their usefulness. The findings revealed that therapists reported DBT consultation teams had an important role in supporting the emotional impact of working with BPD. Specifically, therapists reported that emotions such as frustration, doubt and anxiety were regulated by consultation team members, validating the therapists' emotional experiences. Moreover, they described that the consistency of support from consultation meetings helped therapists feel more motivated to continue their challenging work with clients with BPD (Walsh et al., 2018). Similarly, in a mixed methods thesis study, Kim and Sweeney (2015) found that consultation groups were useful in assisting therapists to process feelings such as frustration and anger whilst also learning new skills to better manage these feelings. The therapists reported that consultation meetings helped support therapists to reduce their own issues being activated in the therapy relationship. Moreover they reported them helpful in identifying reactions that therapists themselves may have been unaware of prior to seeking support from the consultation team (Kim & Sweeny, 2015).

Some therapists in the present study described using DBT skills such as mindfulness and radical acceptance as ways of helping them maintain their own wellbeing and manage their CT reactions towards their clients with BPD. The therapists spoke about using mindfulness skills to pause, notice, and proceed one step at a time, particularly when feeling overwhelmed or wanting to solve clients' problems. Radical acceptance of certain situations and the therapists' own feelings was also described as helpful for managing CT, as it allowed therapists to make room for challenging situations or emotions. This is broadly consistent with two studies that examined the relationship between DBT and burnout found that therapists reported decreased burnout and stress after utilising aspects of the DBT model, such as DBT skills (Carmel, Fruzzetti, & Rose, 2014; Jergensen, 2014). For instance, the therapists in Jergensen's (2014) study reported that DBT mindfulness skills and emotion regulation skills were the most common skills used by therapists. There is further evidence that using mindfulness helps facilitate CT management for therapists, irrespective of client diagnosis (Davis & Hayes, 2011; Fatter & Hayes, 2013; Guest & Carlson, 2019).

All therapists described speaking with their supervisor, own therapist and/or colleagues as being helpful for assisting them in managing their CT reactions to clients with BPD. The therapists in this study reflected that talking to supervisors, personal therapists and colleagues them to feel contained as they are able to gain awareness of their reactions and process the

effects of the work with the support of another person. Past research supports this (Coster & Schwebel, 1997; Harrison & Westwood, 2009; Wyman, 2008), suggesting that it is common for therapists to find talking about their CT reactions with others to be helpful.

Engaging in self-care strategies were also described as helpful in managing difficult reactions, and also as being a vital part of daily routine to ensure therapists felt they were able to be successful in their work. Examples of self-care strategies the therapists described included exercise, meditation, watching TV, reading, music and dancing. Past research supports the effectiveness of self-care in assisting therapists in managing the emotional impacts of the therapeutic work (Bush, 2015; K. Richards, Campenni, & Muse-Burke, 2010). For instance, Tudury (2020) found that therapists engage in a diverse range of self-care strategies such as, reading, exercise, music, playing with kids, arts and crafts to help maintain their own mental health in order to feel effective in both their work and personal life.

Therapists' Utilisation of Countertransference Reactions.

As well as strategies to manage CT, some therapists in this study also spoke about the ways they used their reactions to clients with BPD in the therapeutic work. All therapists in the present study described naming or disclosing their CT reactions to be the primary way they utilise their CT reactions for the purposes of checking in with clients, problem solving with clients, or to communicate their limits to their clients The therapists described the importance of needing to be aware of CT reactions, before being able to make use of them. However, most therapists expressed caution about this approach and said they would only use CT in this way if they felt it would be helpful for the client, the therapeutic relationship, and the treatment.

Past research on therapist self-disclosure appears to focus on therapists' disclosure of their own lives or past experiences and the implication of disclosure for clients, as opposed to examining therapists' disclosure of emotional reactions towards clients (Audet & Everall, 2010; Hanson, 2005; Levitt et al., 2016). Immediacy (Im) is a term used in the literature which refers to therapists disclosing or inquiring about immediate feelings about a client, disclosing their own feelings in relation to a client, or about the therapeutic relationship (Hill et al., 2014). In a recent meta-analysis, Hill and colleagues. (2018) found that therapist Im was often followed by positive and beneficial therapeutic processes, such as clients opening up and gaining more insight. Similarly, Hill et al. (2020) examined the effects of deliberate practice training focused on Im for trainee therapists. Qualitative findings indicated that deliberate

practice training in Im increased therapist awareness and management of their emotions and CT. In addition, the trainee therapists described feeling more confident in their work, as they felt more able to use Im in sessions to work with CT and address problems in the therapeutic relationship. Together, these findings indicate that Im is a way therapists can make use of their feelings in therapy, which can have positive effects for the therapists confidence and ability to regulate and manage their reactions to clients.

Sturges (2012) posits that one aspect of Im are self-involving statements, which involve therapists sharing their honest reactions to a client in therapy for the purpose of benefiting the client or the therapeutic relationship. This appears consistent with the DBT strategy of self-involving self-disclosure (Linehan, 1993), a therapeutic technique in DBT, which was discussed by several therapists in the present study. Most of the therapists in this study described disclosing their reaction to clients with BPD by describing a particular client behaviour, followed by a disclosure of its impact on the therapist. For instance, one therapist described disclosing to his client that, when the client acted in a certain way, the therapist felt attacked and less willing to work with that client. As mentioned previously, one purpose of self-involving self-disclosure is that it allows the client to understand the contingency between their behaviour and its effects on the therapist (Koerner, 2011; Linehan, 1993).

Several therapists in the present study described disclosing their reactions to communicate their limits to the clients. As described, the DBT observing limits procedure requires that the therapist notice the client behaviours that interfere with the therapists' ability or willingness to continue therapy as they arise during therapy and then communicate their limits to their clients (Linehan, 1993; Van Dijk, 2013). Some therapists discussed communicating their limits in a way that is humane and validating, which is consistent with clinical writing in this area that highlights therapists need to validate the client whilst communicating their own limits, as clients often have their own wants and needs that need to be acknowledged (Lindenboim et al., 2017; Van Dijk, 2013).

All therapists in the present study said they would only utilise their reactions by naming or disclosing them in therapy if they felt doing so would be beneficial for the client and the treatment. This is consistent with clinical writing about DBT, which suggests that whilst self-disclosure is helpful and necessary, therapists must always think about what would be most helpful to the client and the therapeutic relationship (Van Dijk, 2013).

Summary of findings

The thirteen therapists who took part in this thesis study reported a range of CT reactions when working with clients with BPD, regardless of therapeutic orientation. Some therapists experienced strong reactions early on in their career towards clients with BPD as they often felt less in control of their therapy planning, clinical interventions and/or ability to manage CT. Psychodynamic and/or DBT conceptualisations of CT were described by the therapists. A number of strategies for managing CT were highlighted, such as debriefing with colleagues, supervision, therapy, and self-care, as these can combat difficult aspects of the work. Moreover, the structure that DBT provides around working with risk and managing challenging behaviour and support from consultations teams were described as helping therapists manage CT and feel more contained and confident in the therapeutic work. Naming or disclosing reactions was the main way therapists described utilising their CT in therapy. This was most often for the purpose of therapists checking in with clients, problem solving with clients, and/or communicating their limits to clients.

Clinical Implications

The findings of this thesis study add to the research in the field of CT and BPD and have a number of clinical implications. The findings point to the importance of therapists' awareness and management of their CT reactions in relation to clients with BPD. Based on the present findings, there appear be a number of strategies or approaches that therapists may find helpful in assisting them with their CT. Therapeutic models that provide a structure for both therapists and clients as well as support for therapists may be effective in assisting therapists to feel supported and contained in the therapeutic work. For instance, models such as DBT and MBT both require the use of consultation team to support therapists. Alternatively, peer supervision groups may serve a similar function for therapists in terms of accessing support, validation, and assistance problem solving. Regular mindfulness practice or training can also help therapists increase awareness of their experiences and stay present in the moment. Lastly, therapists engaging in regular self-care strategies is vital in increasing therapists resiliency thereby ensuring therapists are in the best position to manage any effects of the therapeutic work.

Additionally, the findings discussed above highlight the need for psychology and psychotherapy training programmes to prioritise teaching on CT, in order to prepare training

therapists for acknowledging, understanding and managing CT when it arises in the clinical work. This is particularly important given most training programmes in New Zealand and Australia provide training in cognitive-behavioural models (Kazantzis & Munro, 2011) and thus do not typically offer training in CT. It seems important that training programs concentrate on the challenges of working with clients that therapists experience strong CT reactions towards, such as those with BPD.

Training centred on utilising reactions and addressing problems in the therapeutic relationship would also be beneficial as this assists therapists in managing their emotions and CT, as demonstrated in a recent study on deliberate practice focussed on trainee therapists' use of immediacy (Hill et al., 2020). Alternatively, training programs in New Zealand could consider incorporating self-practice/self-reflection training, a programme developed for CBT practitioners, to support trainee therapists to gain insight into therapist processes (Chigwedere, Thwaites, Fitzmaurice, & Donohoe, 2019). Moreover, training programmes could incorporate reflective practice using Hayes' (1995) five component model of CT (origins, triggers, manifestations, effects and management), which has recently been found to be useful for guiding trainee therapists reflections of CT and CT management (Cartwright, Hayes, Yang, & Shires, 2021).

Finally, the findings of this thesis study also provide valuable implications for Mental Health Services (MHS) in which therapists are treating clients with BPD. In New Zealand, it is understood that of those engaged with MHS with a personality disorder diagnoses, more than half of (55.9%) have a diagnosis of BPD (Newton-Howes, Cunningham, & Atkinson, 2020). Moreover, these clients utilise a significant amount of resources compared to other client groups, such as more inpatient stays, more crisis contacts, and more service contacts. Thus, it seems vital that all staff working in MHS have some understanding of the types of reactions they may experience when working with BPD. In addition, given the emotional reactions can be so strong, it is important that all mental health staff have ways of managing these, such as seeking support from their team. For instance, manager awareness of the impact of working with this client group may assist in facilitating a safe environment whereby staff can seek support as required. This could result in them feeling more able to speak freely about their CT experiences and gain the appropriate support, which may ultimately reduce burnout.

Limitations

This thesis study has several limitations. Whilst this study sought a range of participants representative of therapists in New Zealand (age, years of experience), the lack of ethnic diversity is a limitation. All therapists interviewed were of European descent, and therefore the findings of this study may not be relevant for therapists from other cultural groups, such as Māori, Pasifika, or Asian peoples. In particular, it may be that therapists from other cultures, particularly those who hold non-Western views of therapeutic models and the therapeutic relationship, report different CT experiences and ways of understanding these experiences. This is noteworthy given CT as a phenomenon is generally associated with Western therapeutic models.

Moreover, despite seeking therapists from a range of therapeutic modalities, most therapists in this study were trained in cognitive/behavioural paradigms and all therapists except one used DBT or DBT informed therapy as their main approach with clients with BPD. As such, this study is most informative about DBT therapists, most of whom had training backgrounds in CBT. This is important to acknowledge as CT is conceptualised and utilised differently in psychoanalysis and psychodynamic therapies. Also, the fact that all therapists self-selected to take part in the research may indicate that they have an interest in CT, which is likely as majority of the therapists had some type of training in CT.

Interviews as a means of data collection may be a further limitation as they rely solely on recall of the therapists. For instance, memory bias is a factor to consider as in some cases, considerable time had elapsed between treating clients and participating in the interview. In addition, it is possible that therapists were only reporting reactions they felt comfortable disclosing and not sharing those they felt uncomfortable sharing. Furthermore, CT reactions that were shared were based on the conscious recollection of the therapists. Thus, the CT reactions that were identified by the therapists do not represent the full range of reactions, given unconscious responses are unable to be recalled.

Lastly, whilst the data collected was enough to address the research aims, the sample size was small, focussing on the perspectives of only thirteen therapists. Hence, considering the above, it cannot be assumed the views and experiences of the therapists are representative of other therapists working with BPD in New Zealand.

Future Research Directions

Given the findings and limitations of this study, there are a number of important areas that warrant exploration in future research. Firstly, there appears to be a gap in the literature as to how indigenous therapists experience, conceptualise, and manage CT. As such, future research could seek to explore CT experiences of a more ethnically diverse sample size of therapists. Moreover, the majority of therapists in this study were trained in cognitive behavioural approaches, and all except one therapist acknowledged DBT as the main therapeutic approach they used with clients with BPD. Future research could explore the CT experiences of therapists working with BPD from psychodynamic approaches - such as MBT - as this would allow for the voices of psychodynamic therapists to be more thoroughly represented. It could also be instructive to interview both DBT and MBT therapists about certain common aspects of the models that support therapists to manage their own personal reactions. For example both treatment approaches comprise of individual sessions, skills group, and consultation meetings for therapists.

Lastly, many therapists in this study spoke about utilising their reactions by naming or disclosing them to their clients, providing it would be therapeutically helpful to do so. Because it was not within the scope of the study to capture clients' perceptions of therapists disclosing their reactions, it is unknown as to whether clients with BPD experience this as helpful in the same way therapists do. Future research could interview clients with BPD about their experiences of their therapists' immediate responses and emotional reactions during therapy to gain understanding of the interactions clients find may find helpful or unhelpful. Such research would provide more insight into the impacts of therapists' use of immediacy or disclosure in therapy for clients with BPD.

Conclusion

This thesis study sought to examine the CT reactions of therapists working with clients with BPD in New Zealand. Six main types of CT reactions were found within the study, including: anxiety and fear amidst chaos; frustration and anger with ongoing challenges; sadness with suffering; disconnecting when the client disconnects; hopelessness and despair with ongoing self-harm and suicidality; and, joy and pride with progress. Most therapists conceptualised their reactions to involve contributions from both client and therapist, and this was discussed using psychodynamic and/or DBT concepts. Moreover, the therapists considered

their reactions as providing important information about clients' current and historic relationships. Therapists emphasised the importance of being aware of their reactions in order to manage them effectively. Given most therapists worked with BPD using DBT, aspects of the DBT framework were described as helpful in assisting therapists in managing their CT and other challenges of the work. Talking with others and engaging in self-care were also seen as vital for wellbeing and being able to manage CT. Finally, the therapists spoke about utilising their CT in the form of naming or disclosing reactions in session only if they felt it would be of therapeutically helpful.

Appendix A: Advertisement

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

SCIENCE
SCHOOL OF PSYCHOLOGY

Science Centre
Building 302, Level 2
22 Symonds St, Auckland
T +64 9 373 7599
E psych.auckland.ac.nz
School of Psychology
The University of Auckland

Are you a therapist working with individuals diagnosed with borderline personality disorder?

My name is Kristin Reilly am I am a Clinical Psychology Doctoral student at The University of Auckland.

As part of my research, I will be interviewing therapists about their **experiences of countertransference** when working with clients diagnosed with Borderline Personality Disorder.

Your experience will contribute to training in this area.

The interview will take been 50 and 90 minutes and be conducted in a location of your choice.

I am seeking therapists from psychodynamic, CBT, DBT and/or integrative perspectives, with at least 3 years' experience as a psychologist or psychotherapist.

For more information, please contact Kristin Reilly at krei739@aucklanduni.ac.nz

This study is being conducted by Clinical Psychology Doctoral Student, Kristin Reilly (krei739@aucklanduni.ac.nz) and is supervised by Dr Claire Cartwright (c.cartwright@auckland.ac.nz) at The University of Auckland.

Approved by the University of Auckland Human Participants Ethics Committee on 7th June 2018 for three years. Reference number 021316.

Appendix B: Participant Information Sheet

SCIENCE
SCHOOL OF PSYCHOLOGY

Science Centre
Building 302, Level 2
22 Symonds St, Auckland
T +64 9 373 7599
E psych.auckland.ac.nz
School of Psychology
The University of Auckland

PARTICIPANT INFORMATION SHEET

Title of project:

Therapists' experiences of countertransference when working with clients who have a borderline personality disorder diagnosis.

Primary Investigator/Supervisor:

Dr Claire Cartwright
School of Psychology, University of Auckland

Student Researcher:

Kristin Reilly, Clinical Psychology Doctoral Student

Researcher introduction

My name is Kristin Reilly and I am Clinical Psychology Doctoral student. For this project, I am supervised by Dr Claire Cartwright at the School of Psychology, The University of Auckland.

Project description and invitation

Countertransference is commonly understood as the therapist's cognitive-emotional responses to the client, which involve the therapist's thoughts and feelings. This study aims to understand more about the countertransference experiences of therapists working with individuals diagnosed with borderline personality disorder, in order to better understand the nature of countertransference when working with this client group. This study will explore the types of countertransference reactions of therapists working with borderline personality disorder. This study will also attempt to ascertain how therapists from different treatment modalities both conceptualise, utilise and, subsequently, manage the countertransference reactions they have to clients with borderline personality disorder.

Participants in this study will be 15-20 therapists whose therapeutic orientation is psychodynamic, cognitive-behavioural, dialectical-behavioural and/or integrative. Participants

need to have at least 3 years' experience post-graduation and need to be currently working with a client/clients with borderline personality disorder.

We believe it is important to understand more about countertransference as previous research has found that countertransference is a common reaction for therapists working with borderline personality disorder and that countertransference is a factor in therapy that can affect the therapeutic process. However, no past research has explored differences in countertransference reactions with borderline personality disorder across a variety of therapeutic modalities or explored how such reactions are processed by therapists.

You have been sent this Information Sheet as you have shown interest in the study. If you are a therapist with experience working with borderline personality disorder, are trained within a psychodynamic, cognitive-behavioural, and/or dialectical-behavioural paradigm, and have at least three years post qualifying experience, we invite you to take part in this study. However, you are under no pressure to take part in this study, as all participation is voluntary.

Project Procedures

If you do decide to take part in this study you will complete a single interview in a location of your choice or via skype/zoom. Interviews will likely last between 50 and 90 minutes. Fifteen to twenty therapists will be interviewed. During the interview, you will be encouraged to talk about your experiences of working with individuals who have a diagnosis of borderline personality disorder. I am interested in your understanding of the experiences you may have had and how you managed these experiences. If you discuss experiences working with clients, care will be taken to ensure that no client's names or identities are revealed. It is also a possibility that you may experience distress when speaking about your experience. If this happens, we can stop the interview at any time if you wish.

Data storage/retention/destruction/future use

The interviews will be digitally recorded, however, you can request the digital recorder be turned off at any time, without needing to provide a reason. All interviews will be transcribed by a professional transcriber who will sign a confidentiality agreement. Your name will not be used on the recording and your identity will be protected. Your participation in the study will also be confidential. Each recording will be assigned a number and the identity of the numbers will be stored in a separate location so that individual recordings cannot be identified. If you decide to withdraw from the interview, you can do that and you can also withdraw your data up to a month after the interview.

If you do take part in the study, the recordings will be stored on a locked University of Auckland computer that is password protected. Transcripts will be stored in a locked cabinet at the University of Auckland by Kristin Reilly. The data will be kept for ten years. All data will be destroyed when ten years have passed. The results from this study will be published in Kristin Reilly's doctoral thesis (which will take three years to complete) and in a scientific journal. However, no individuals will be identifiable. If you take part in the study, you can request a summary of findings and this will be sent to the contact address that you provide on the consent form.

Right to Withdraw from Participation

You have the right to withdraw from participation at any time without giving a reason. You also have the right to withdraw your data from the research up to one month after the interview. If you desire, you will be sent the transcript of the interview once it has been transcribed and will have up to one month to decide if you want to remove sections or all of the data. At this point, you will also be able to include clarification of anything included in the transcript if you desire, however you will not be able to make changes to the transcript past this.

Contact details

You may contact the researchers or Head of Department at any time if you require more information about the study.

Researcher	**Supervisor**	**Head of Department**
Kristin Reilly School of Psychology University of Auckland E: krei739@aucklanduni.ac.nz	Dr Claire Cartwright School of Psychology University of Auckland E: c.cartwright@auckland.ac.nz Ph: +64 9 923 6269	Dr Kerry Gibson School of Psychology University of Auckland E: kl.gibson@auckland.ac.nz Ph: +64 9 923 8556

For any concerns regarding ethical issues you may contact the Chair, the University of Auckland Human Participants Ethics Committee, at the University of Auckland Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz

Approved by the University of Auckland Human Participants Ethics Committee on 7th of June 2018 for three years. Reference number 021316.

Appendix C: Participant Consent Form

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Science Centre
Building 302, Level 2
22 Symonds St, Auckland
T +64 9 373 7599
E psych.auckland.ac.nz
School of Psychology
The University of Auckland

CONSENT FORM

THIS FORM WILL BE HELD FOR TEN YEARS

Title of project: Therapists' experiences of countertransference when working with clients who have a borderline personality disorder diagnosis.

Principal Investigator/Supervisor:
Dr Claire Cartwright
School of Psychology
University of Auckland

Student Researcher:
Kristin Reilly, Clinical Psychology Doctoral Student

I have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have had them answered to my satisfaction. I agree to take part in this research.

- I agree to take part in this research.
- I understand that I am free to withdraw my participation at any time, and to withdraw any data traceable to me up to one month after the interview date.
- I agree for the interview to be recorded digitally, however, I can request for the recorder to be turned off at any time, without needing to provide a reason
- I understand that a third party who has signed a confidentiality agreement will transcribe the recordings.
- I understand that all of the data collected will be treated confidentially and that my information and anonymity will be protected.
- I understand that all data will be stored in a secure location at The University of Auckland by Kristin Reilly, under the supervision of Dr Claire Cartwright
- I understand that all data provided by me will be kept for ten years, after which it will be destroyed.

- I understand that the results of this study will be published in Kristin Reilly's doctoral thesis and in a scientific journal.

- I wish / do not wish to receive the summary of findings. Please provide an email address if you wish to receive a summary of findings.

Name: _____

Signature: _____ Date: _____

Approved by the University of Auckland Human Participants Ethics Committee on 7th of June 2018 for three years. Reference number 021316.

Appendix D: Participant Demographic Form

DEMOGRAPHIC FORM

Instructions: Please provide a response for each of the following:

1. Gender: _____

2. Age: _____

3. Ethnicity: _____

4. Professional training: _____

_____

5. Years working as a therapist/clinician: _____

6. Years working with clients with BPD diagnoses: _____

7. Number of clients worked with who have BPD diagnoses (general estimate): _____

8. Therapy approaches trained in for working with clients with BPD diagnoses:

_____

_____

9. Current treatment setting: _____

10. How long in current setting: _____

11. Please outline any training you have had in countertransference: _____

_____

Appendix E: Interview Schedule

Therapists' experiences of countertransference when working with clients who have a borderline personality disorder diagnosis.

INTERVIEW SCHEDULE

I am interested in hearing about your experiences of countertransference when working with clients with BPD. I do have some questions to guide that, but as we go please feel free to talk about other areas that I haven't asked you about. I will ask you about your general experiences of countertransference, and I will also ask you to think about some specific examples of therapy and clients, without giving names, to illustrate what you're saying and give us a clear picture of your experiences. Do you have any questions before we get going?

To start with, when did you begin working with clients with BPD?
What has your general experience been like working with this client group?
Can you remember your first client with BPD? Can you tell me about what it was like?
Which therapeutic modalities do you use when working with BPD?

CT and BPD

What is your understanding of countertransference? Or, what comes to mind when you think of CT?
I am not expecting you to talk about this in any depth, but do you think your own life experiences come into your CT reactions?
What are the main types of reactions you have had to clients with BPD?

Specific reactions

What is the specific reaction you remember having with a client?
What was happening during therapy with this client that lead to this reaction?
Did you experience any thoughts and feelings (about yourself, the client, and the situation)?
Behaviour and body sensations?
How did you make sense of the reaction at the time? What made you think that?
How did your reaction/s impacts the therapeutic process or relationship?
Can you think of examples when countertransference reactions have helped you or got in the way of therapy?
How do your reactions to clients with BPD differ to clients without BPD?
Are there any other types of reactions that you have encountered that you would like to share?
Thinking about the experiences we just talked about and the ones from earlier in your career, how do you think your experiences of CT changed over time with these clients?
How would you say CT has affected you?

Utilising the reaction

Generally speaking, do you utilise your CT reactions in your work?

How to you use CT reactions in sessions?
How do you understand this from a X perspective?
Do you ever find your CT reactions useful? Tell me about a time…

Supports and management

There is little research on how people manage CT. I am wondering, how do you manage your reactions to clients with BPD? What strategies do you use?
Client example.
How do you look after yourself in this line of work? What supports do you have?
What do you do for your own supervision? Does this involve talking about countertransference?
How/does your workplace/team talk about CT?

Impact of countertransference

Looking back, what impact has working with these clients had on you? (either challenging or positive)
Your work?
How has the emotional reactions to the work impacted upon your wellbeing?

Training

What would you have liked to learn more about with regards to CT in your training?

I think that is everything I had to ask you to talk about. Have you got anything else you'd like to say or any things you'd like to follow up that I haven't asked you?

Approved by the University of Auckland Human Participants Ethics Committee on 7th of June 2018 for three years. Reference number 021316.

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