

**DPsych (post Chartered) Portfolio**

Section A: Preface **Abbie Kirkham**

Section B: Therapists with Clients Diagnosed with  
"Borderline Personality Disorder": An Interpretative  
Phenomenological Analysis  
**Student Number: 100011293**  
**Research Supervisor: Rosemary Rizq** (all contents page)

Section C: Professional **School of Social Science**

Section D: Systematic Review **City University**  
Critical Review: A Critical  
Reflection of the Impact and Utility of Evidence Based Practice on  
the Front Line: A Counselling Psychologists Perspective.

**Submitted in partial fulfillment of the requirement for the DPsych (Post Chartered) in Counselling Psychology, City University, 2013.**



**CITY UNIVERSITY  
LONDON**

**CityLibrary**  
Your space  
Your resources  
Your library

**THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN  
REDACTED FOR DATA PROTECTION CONFIDENTIALITY  
REASONS:**

**Section B: Appendices.**  
**Section B: Supplementary materials contents page**  
**Section C: Professional practice clinical case study.**

## **Contents**

**Section A:** Preface

**Section B:** Therapists Experiences of Working with Clients Diagnosed with 'Borderline Personality Disorder': An interpretative Phenomenological Analysis. (See section B for full contents page).

**Section C:** Professional Practice Clinical Case Study

**Section D:** Systematic Review of Literature/Critical Review: A Critical Reflection of the Impact and Utility of Evidence Based Practice on the Front Line: A Counselling Psychologists Perspective.

**Section A: Preface**

**Abbie Kirkham**

**Student Number: 100011293**

**Word Count (Excluding references): 1004**

**Research Supervisor: Rosemary Rizq**

**School of Social Sciences**

**City University**

**Submitted in partial fulfilment of the requirement for a DPsych (Post Chartered) in Counselling Psychology, City University, June, 2013.**

**Preface**

Counselling Psychology is a burgeoning profession in the UK as indicated by its increasing presence in the research, academic and psychotherapeutic communities. Central to the profession is the important role of the therapeutic relationship. Counselling Psychology is thus grounded in a humanistic value base that places emphasis on subjective experience and personal meaning. The profession therefore suggests the need for methods of research that reflect these underlying values. It is these principles of Counselling Psychology research and practice, which are considered to underpin my own motivations in conducting the following investigation. My aim was to develop a deeper understanding of the therapists' internal world when faced with a client considered to be highly ambivalent about emotional closeness.

This section aims to provide an overview of the three pieces of work that follow and make up my portfolio for the PsychD Counselling Psychology top up qualification. As set out below, each section has a distinct aim and purpose that emphasises different aspects of my role as a Counselling Psychologist, that is the researcher (section B), the practitioner (section C) and the final section that emphasises the relationship between the two (section D). All three sections were influenced by my experiences of working within an NHS Community Mental Health Team and were born out of my particular interest in the many facets that are 'Borderline Personality Disorder' (BPD). Referred to within a medical model framework, this complex area of mental health has stimulated much controversy, and debate, most notably concerning its authority as a diagnosis. Counselling Psychologists are well acquainted with these debates and the epistemological frameworks that underpin them. As illustrated in this thesis,

such tensions both directly and indirectly impact upon research and practice.

Each section of this thesis illustrates particular challenges concerned with the 'BPD' diagnosis that extends well beyond the person given the label and therefore inevitably impacts research and practice. Such challenges will be highlighted in the summaries of each section set out below.

### **The Counselling Psychologist Researcher (Section B)**

Section B consists of the research component of the thesis. The aim of this study was to investigate eight psychoanalytic psychotherapists' experiences of working with clients diagnosed with 'Borderline Personality Disorder' in an NHS Community Mental Health Service. Despite the extensive literature dedicated to 'BPD', there is virtually no qualitative research focussing on the experiences of working with this challenging client group within this particular type of service. The aims of this study to investigate these experiences in more detail was therefore considered particularly important given that the majority of clients receiving psychological therapy and support will do so from within community services. Furthermore, previous findings suggest that clients with a diagnosis of 'BPD' present particular challenges to clinicians and as such can often elicit negative responses and attitudes from those who are supposed to be helping. It was therefore considered essential to explore these potential challenges in more detail. Interpretive Phenomenological Analysis (Smith and Osborn, 2003) was considered the most appropriate method to analyse participant interviews and was considered particularly suited to the aims of the research, that is to explore these complex experiences in greater depth.

### **The Counselling Psychologist Practitioner (Section C)**

The aim of this section, that is 'The Professional Practice Clinical Case Study and Process Report', was to present my experience of working with a client I refer to as John. John was diagnosed with 'BPD' prior to attending therapy. However, my framework for working with him instead aimed to emphasize the person beyond the diagnosis. John came to therapy following a long history of relationship difficulties, low mood and suicidal ideation. His present difficulties were understood within a background of emotional neglect, and a frightening and abusive childhood with his mother. It was evident that John's early relationship experiences were greatly impacting on his current relationships. In view of this history, a psychodynamic approach was considered most appropriate to working with his difficulties. The process report in this section aimed to illustrate how the use of different frameworks, namely psychodynamic theory and the use of the therapeutic relationship, helped facilitate my understanding of John's difficulties and also illuminate my own challenges of working with his anger.

### **The Counselling Psychologist as Researcher-Practitioner (Section D)**

The final section aimed to critically consider the relevance of different types of research and their contribution to Counselling Psychology practice.

Furthermore, this paper aimed to consider the impact of working alongside different epistemological frameworks. My thinking about 'disseminating' my own research influenced this essay, as this is an important component of the

PsychD qualification. It made me think about the impact of different types of research and more specifically, how my own qualitative research would stand up

in the current evidence-based climate. On reviewing the literature, the mark of 'best practice' is not particularly clear. Within an Evidence-Based Practice (EBP) paradigm, research methods that fall short of empirical scrutiny are seen as the poor relation. As is discussed, the NICE guidelines mirror this perception and serve to overshadow other types of evidence and approaches to understanding and working with complex emotional problems. The EBP paradigm was considered in light of other sources of evidence including the utility of a Practice-Based Evidence paradigm and the view that 'best practice is, by definition, past practice' (Snowden and Boone, 2007). This paper argued a case for wider conceptions of EBP with an aim to increase its relevance to practitioners. I aimed to illustrate the challenges and debates discussed within this paper by reflecting on the impact of different types of evidence on my own day-to-day practice, including the utility of my own research.

### **References**

Smith, J.A. and Osborne, M. (2003). Interpretive Phenomenological Analysis. In: J.A. Smith (Ed.). *Qualitative Psychology: A Practical Guide to Methods*. London: Sage.

Snowden, D.J. and Boone, M.E. (2007). A leader's framework for decision making. *Harvard Business Review*, November, 1-8.



**Section B: Therapists Experiences of Working with Clients  
Diagnosed with 'Borderline Personality Disorder':  
An Interpretative Phenomenological Analysis**

**by**

**Abbie Kirkham**

**Student Number: 100011293**

**Word Count (Excluding references): 39, 240 words**

**Research Supervisor: Rosemary Rizq**

**School of Social Sciences**

**City University**

**Submitted in partial fulfilment of the requirement for a DPsych (Post Chartered) in  
Counselling Psychology, City University, June 2013.**

**Table of Contents**

	<b>Page Number</b>
<b>Acknowledgements</b>	<b>5</b>
<b>Declaration to City University Librarian</b>	<b>6</b>
<b>1. Abstract</b>	<b>7</b>
<b>2. Introduction</b>	<b>8</b>
<b>2.1 Aims and overview of introduction</b>	<b>8</b>
<b>2.2 Structure of Introduction</b>	<b>9</b>
<b>2.3 Positioning myself with a constructivist epistemology</b>	<b>10</b>
<b>2.4 Section 1: What is 'Borderline Personality Disorder'?</b>	<b>13</b>
2.41 Medical Model Definition of 'Borderline Personality Disorder'	<b>13</b>
2.42 The History of the 'Borderline' Construct	<b>15</b>
2.43 The relationship between hysteria and 'BPD'	<b>20</b>
2.44 The Emergence of the 'Borderline Construct'	<b>21</b>
2.45 Critique of the 'Borderline Construct'	<b>22</b>
<b>2.5 Section 2: Why Research 'Borderline Personality Disorder'</b>	<b>26</b>
2.51 The relationship between the medical model and Psychotherapy	<b>26</b>
2.52 Counselling Psychology, the medical model and the nature of evidence	<b>29</b>
2.53 Estimates of Incidence and prevalence rates	<b>33</b>
<b>2.6 Section 3: What can previous research tell us about the experiences of working with people diagnosed with 'BPD'</b>	<b>36</b>
2.61 Descriptions and Case Illustrations	<b>37</b>
2.62 Quantitative Research	<b>42</b>
2.63 Impact of the 'borderline label on clinician attitudes	<b>42</b>
2.64 Healthcare settings	<b>43</b>
2.65 Therapist reactions to particular client presentations	<b>44</b>
2.66 Qualitative Findings	<b>46</b>
<b>2.7 Conclusions</b>	<b>52</b>
<b>2.8 Research Aims</b>	<b>54</b>
<b>2.9 Research Questions</b>	<b>54</b>
<b>3. The utility of IPA for investigating therapists' experiences</b>	<b>56</b>
<b>4. A consideration of the researchers experience and preconceptions</b>	<b>60</b>
<b>5. Method</b>	<b>62</b>
<b>5.1 Design</b>	<b>62</b>
<b>5.2 Pilot Study</b>	<b>62</b>
<b>5.3 Self Interview</b>	<b>62</b>

**Table of Contents Continued**

	<b>Page Number</b>
<b>5.4 Participants</b>	<b>63</b>
<b>5.5 Recruitment</b>	<b>64</b>

5.6	<b>Method for data collection</b>	<b>65</b>
5.7	<b>Procedure</b>	<b>66</b>
5.8	<b>Ethical Considerations</b>	<b>67</b>
5.81	Confidentiality	67
5.82	Emotional Distress	68
5.83	Seeking ethical approval	68
5.9	<b>Data Analysis</b>	<b>68</b>
5.9.1	Cross Case Analysis	71
6.	<b>The Results Section</b>	<b>73</b>
6.1	<b>An overview of the results section</b>	<b>73</b>
6.2	<b>Table 2: Table of Master-themes and Sub-themes</b>	<b>74</b>
6.3	<b>Master-theme 1: Recognising the 'Borderline' Signature</b>	<b>74</b>
6.31:	Sub-theme 1: Identifying the 'Borderline' Client Through the Self: Special Rules Apply	<b>75</b>
6.32:	Sub-theme 2: The 'Borderline' Therapist: Losing Touch with the Self	
6.33:	Sub-theme 3: The Unforgettable Client	<b>81</b>
6.4	<b>Master-Theme 2: The 'Borderline Relationship': The Emotional Impact</b>	<b>84</b>
6.41:	Sub-theme 1: Feeling Inadequate in their responses	<b>84</b>
6.42:	Sub-theme 2: The Struggling Therapist: Managing the Self	<b>88</b>
6.43:	Sub-theme 3: Using the self to manage negative feelings	<b>91</b>
6.5	<b>Master Theme 3: Struggling within the working context</b>	<b>95</b>
6.51:	Sub-theme 1: Struggling within a multidisciplinary team	<b>96</b>
6.52:	Sub-theme 2: Providing therapy within an impoverished Mental Health Service	<b>100</b>
6.53:	Sub-theme 3: Struggling with the diagnosis	<b>104</b>
7.	<b>Discussion</b>	<b>109</b>
7.1	<b>Overview of Results</b>	<b>110</b>
7.2	<b>An Exploration of Selected Themes in light of existing findings</b>	<b>114</b>
7.3	<b>Master-theme 1: Recognising the 'Borderline' Signature, Sub-theme 1: Identifying the 'Borderline' client through the self</b>	<b>114</b>
7.4	<b>Master-theme 2: The 'Borderline' Relationship: The Emotional Impact, Sub-theme 1: Feeling inadequate</b>	<b>120</b>
7.5	<b>Master-theme 3: Struggling within the working context, Sub-theme 1: Struggling within a multidisciplinary team</b>	<b>123</b>
7.6	<b>Master-theme 3: Struggling within the working context, Sub-theme 2: Providing therapy within an impoverished Mental Health Service: Reconciling impossible opposites</b>	<b>125</b>
	<b>Table of Contents Continued</b>	
		<b>Page Number:</b>
7.7	<b>Negative Case Analysis</b>	<b>131</b>

<b>7.8</b>	<b>Concluding comments of discussion of results</b>	<b>133</b>
<b>7.9</b>	<b>Critical and Reflexive considerations</b>	<b>136</b>
7.91	Reflecting on my personal positioning	137
7.92	Quality and Validity	139
7.93	Sensitivity to Context	140
7.94	Commitment and Rigour	140
7.95	Transparency and Coherence	141
7.95	Impact and Importance	142
<b>7.10</b>	<b>Limitations of the study</b>	<b>142</b>
<b>7.11</b>	<b>Conclusions</b>	<b>146</b>
<b>8.</b>	<b>References</b>	<b>148</b>
<b>9.</b>	<b>Appendices</b>	
	Appendix 1: Recruitment Sheet	169
	Appendix 2: Participant Information Sheet	170
	Appendix 3: Consent Form	173
	Appendix 4: Debriefing form	175
	Appendix 5: Full transcript taken from participant 4	178
	Appendix 6: List of Emergent Themes taken from participant 4	191
	Appendix 7: Table 3 indicating the number of participants that contributed to each sub-theme.	195
	Appendix 8: Table of cross case themes with supporting extracts	196
	Appendix 9: Interview Schedule	213
	<b>List of Tables</b>	
	Table 1: Displaying basic demographic participant information	67
	Table 2: Summary of Master-themes and sub-themes	78
	Table 3: Indicating the number of participants that contributed to each sub-theme	195
	Table 4: Table of cross case themes and supporting extracts	196
<b>10.</b>	<b>Supplementary Materials Contents Page</b>	

### **Acknowledgements**

**With sincerest thanks to those of you who took the time to share, so openly your time, experiences and insights. I would also like to thank my research supervisor; Dr Rosemary Rizq for the encouragement, support and guidance you provided.**

**Declaration to City University Librarian**

**I grant the powers of discretion to the City University Librarian to allow the thesis to be copied in whole or in part without further reference to the author.**

## **1. Abstract**

This qualitative investigation aimed to explore the experiences of eight psychoanalytic psychotherapists' work with clients diagnosed with 'Borderline Personality Disorder' (BPD) in an NHS Community Mental Health Service. Previous quantitative research indicates that working with this client group is challenging and can lead clinicians to harbour negative feelings towards their clients. Few qualitative studies exist focussing on the way in which practitioners cope and manage working with this challenging client group. Interpretative Phenomenological Analysis (IPA) was used to analyse participant interviews. Findings revealed three main themes: a) Recognising The 'Borderline' Signature - referred to the experiential ways in which participants detected the presence of 'BPD'; b) The 'Borderline'

Relationship; The Emotional Impact - referred to the strong feelings evoked in the therapist and his/her attempts to manage these intense experiences; c) Struggling Within The Working Context - referred to the impact of working within an impoverished Mental Health Service. In line with previous research, this study revealed inherent difficulties involved in working with 'borderline' clients. However, it also highlighted additional challenges relating to working alongside different frameworks, professional relationships with colleagues and working within an impoverished Mental Health Service. It is hoped that this research will inspire other clinicians to reflect upon the impact of their work.

## **2 Introduction**

### **2.1 Aims and overview of Introduction**

The aim of this study was to investigate therapists' experiences of working with clients diagnosed with 'Borderline Personality Disorder' (here after referred to as 'BPD'), employing Interpretative Phenomenological Analysis (here after referred to as IPA) (Smith and Osborn, 2003). Currently, there is significant academic and clinical interest in 'BPD'. This area of mental health has created considerable controversy and debate, most notably

in terms of its authority as a diagnosis. In this introduction, I will start by introducing these debates and the difficulties surrounding the 'BPD' diagnosis by drawing on different epistemological positions. It follows that this research will argue for a framework capable of representing the experiential concerns of participants. In addition, I will consider existing research focussing on the experiences of working with clients diagnosed with 'BPD'. Despite extensive literature in this area, there is a paucity of research representing the lived experience of therapists working with clients labelled as 'BPD'. However, it is increasingly acknowledged that exploring the experiences of identified groups can offer alternative and valuable insights into various areas of health. This is reflected in an increasing number of IPA publications (e.g. Benner, 1994). Discussion of the literature will then lead to a consideration of this research in light of these existing debates and research findings.

It has been long established that the relationship between therapist and client is central to treatment outcome (e.g. Steering Committee APA; 2002). However the complex nature of this relational process remains poorly conceptualised. Understanding this process in the context of working with individuals diagnosed with 'BPD' is particularly important given the interpersonal nature of the client's difficulties. Previous research examining health care professionals' experiences of working with individuals diagnosed with 'BPD' has largely focussed on them working in high security settings or inpatient hospitals. The work of community-based practitioners have received less attention. However, this increasingly occupies an important area of enquiry in response to government initiatives aiming to increase community provision for personality disorder services. The acknowledgement from the Department of Health (2003) pointing to inconsistent and inappropriate service responses highlights the need for a greater understanding and consistency when working with this client group.

This study aims to research and evidence the subjective experiences of psychoanalytic psychotherapists working with people diagnosed with 'BPD'. This group of participants are of particular interest given that 'BPD' is rooted in the psychoanalytic discipline.

Furthermore, Secondary Care Services specialising in working with clients diagnosable with 'BPD' tend to operate from a psychoanalytic perspective and yet there is virtually no qualitative exploration of how practitioners cope with, or manage with such challenging clients.

The rationale for this research is not to offer a framework for working with clients diagnosed with 'BPD', but rather to represent the experiential concerns and meanings taken from this particular group of therapists' accounts of their work. It is hoped that this research will inspire other mental health professionals to reflect on the impact of their work, and on their personal and professional selves in light of these findings.

## **2.2 Structure of introduction**

This introduction is divided into three main sections. Firstly, it will focus on the question: 'What is 'BPD'?' This question will be considered in the context of different epistemological positions that underpin many of the debates and controversies surrounding the 'BPD' diagnosis. The next section will focus on a related question: 'Why research 'BPD'?' This section will consider the need to research an already highly investigated area of 'psychopathology'. The third section of this introduction will review existing research that has focussed on clinicians' experiences of working with people diagnosed with 'BPD'. Finally, issues discussed in these sections will be used to form a rationale for pursuing the current research enquiry. Prior to moving onto the first section, the following aims to define two main epistemological positions from which the 'BPD' construct will be considered.

## **2.3 Positioning myself within a Constructivist Epistemology**

The purpose of this section is to outline the positivist epistemological position from which the medical model diagnosis of 'BPD' arose. Following this description, a social constructionist framework will be defined. This perspective will subsequently feature as an alternative framework for understanding and investigating the phenomenon under study. Within this review, it will be argued that this alternative paradigm may provide scope for understanding an area of psychological distress that remains greatly misunderstood.

These alternative positions will also be outlined, given that they underpin many of the debates and controversies at the centre of the 'borderline' diagnosis. These debates hold particular relevance to the current research enquiry given that the paradigms used to define emotional distress have had such a powerful impact on the way such difficulties are described, made sense of, investigated and responded to. This introduction will illustrate the impact by outlining the historical origins of the 'BPD' diagnosis. It will explore the influence these underlying paradigms have had on the individual, and in particular women, the professional and also the impact on culture (see section 2.42 entitled: 'the history of the 'borderline' construct').

Regardless of the epistemological position one subscribes to, it is difficult to see how the medical model with its positivist underpinnings cannot impact on one's therapeutic work with clients diagnosed with 'BPD'. This is particularly the case when working within an NHS context, given that the medical model represents the dominant framework for describing and responding to its service users. Or, to borrow from a medical model perspective, to 'diagnose' and 'treat' 'patients' with a 'mental illness' such as 'BPD'.

In addition to its influence in clinical practice, the positivist framework has occupied a dominant position within the research community. To date, this framework makes up a growing body of evidence establishing the effectiveness of psychological approaches for the treatment of 'BPD' (e.g. Bateman and Fonagy, 1999).

The positivist epistemology rests on the assumption that there is one objectively discoverable truth that can be established via experimentation and/or observation. This implies that this universal reality can be accessed through a scientific approach characterised by objectivity and detachment. Within this framework, objects of enquiry are seen in isolation and independent of the observer and of the social context one occupies. Within the context of practice, this framework would assume a person with a diagnosis of 'BPD' to have an 'illness' that is located within them and that could be treated with a predetermined set of clinical responses.

Research methods aligned to this approach include the so-called 'gold standard' of randomised controlled trials. These approaches are commonly favoured among funding bodies and research publications in the UK, reflecting a continuing dominant presence in the scientific and healthcare community. This current study will argue that this epistemology is not an adequate framework to understand therapeutic practice. In particular, the idea of the practitioner as detached observer is heavily contradicted by a vast body of evidence pointing to the significant contribution of the therapeutic relationship to treatment outcome (Norcross, 2011).

The present research will therefore take a critical stance towards a positivist framework, arguing instead for an epistemology located in a constructivist philosophy (Neimeyer and Mahoney, 1995; Neimeyer and Rood, 1997; Neimeyer and Raskin, 2000). In contrast with a positivist framework, a constructivist position holds that there is no objectively discoverable truth. Instead, there exists a variety of realities informed by social psychological constructions. From this perspective, values facilitate an understanding of knowledge. In contrast to the detached observer, practitioners become 'collaborators' by engaging in the person's subjective world. Understanding the complex nature of this

interaction represents an important area of concern within this framework. The use of qualitative methods is considered particularly appropriate to investigate specific phenomenon in this way.

IPA (Smith and Osborn, 2003) adopts a flexible epistemological position, in that 'it is congruent with traditional applied psychological research traditions in acknowledging the existence of a social world independent of human understanding' (Bailey, 2011:49) whilst also allowing for wider interpretive meaning arising out of the individuals subjective experience. In this way, IPA is informed by both social constructivism and positivist approaches 'as the text of an individuals perceptions can be analysed both in itself and scrutinised for wider interpretive meaning' (Bailey, 2011:49) With this in mind, IPA is particularly suited to the current study with its aims to investigate a specific group of therapists (psychoanalytic) working within a specific context, that is an NHS Community Mental Health Service. These theoretical and contextual factors will inevitably feature in the way participants make sense of their experience. It is argued that the use of such a specific group makes it possible to access insights into particular experiences.

## **2.4 Section 1: What is Borderline Personality Disorder?**

### **2.41 Medical Model Definition of 'Borderline Personality Disorder'**

The aim of this section is to outline the medical model definition of 'BPD' and introduce the positivist framework from which this concept arose. This framework will then be considered in view of other perspectives.

'BPD' is a psychiatric diagnosis that emerged from the medical model. The model takes the view that a person experiencing psychological or emotional difficulties has an illness that is to be treated with medication or with a medical intervention. A diagnosis can be made on the basis that a patient fulfils a set of criteria or symptoms as set out in the Diagnostic and Statistic Manual (DSM) of Mental Disorders (DSM –III; American

Psychiatric Association, 1980). 'BPD' has appeared in every subsequent edition of the DSM [DSM-III-R 1987 p. xxiii; DSM-IV 1994 p. xxii; DSM-IV-TR 2000 p. xxxi].

The most recent edition, The Diagnostic and Statistical Manual of Mental Disorders 5th Edition, Text Revision (DSM-V) describes Borderline Personality Disorder as '*a pattern of instability in interpersonal relationships, self image, affect and marked impulsivity*' (APA, 2012). For an adult to receive a diagnosis of 'BPD', five of the following nine criteria (p. 654) must be satisfied and must feature for a substantial length of time. These criteria are as follows:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships.
3. Markedly and persistently unstable self-image/sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging.
5. Recurrent suicidal ideation/attempts or self-mutilating behaviour.
6. Affective instability due to marked reactivity in mood.
7. Chronic feelings of emptiness/worthlessness.
8. Inappropriate anger.
9. Transient, stress related paranoid ideation or dissociation.

Within this framework, each diagnosis is defined by a set of observable signs and symptoms. This model has the advantage of classifying a person's difficulties in a way that enables any changes to be observed and measured (Sackett & Rosenberg, 1995). It is argued that this enables health care providers to empirically establish the efficacy of their services, a condition increasingly expected of health care providers if they are to secure financial support from commissioning bodies (Monk, 2002; Roberts, 1997).

Although the DSM has been widely criticised (see section 2.45), the publication has generated widespread interest and attention, promoting increased research in this area. A particular benefit of the medical model identified by Sadock and Sadock (2001) is that the diagnostic language provides a useful way to exchange information across a diverse group of professionals involved in the care of people labeled as 'BPD'. However, McDonald, Pietsch and Wilson (2010) highlighted the discomfort of many practitioners within the psychotherapeutic profession in entering into discussions using psychiatric terminology. It is argued that such discussions can often compromise any attempt to understand a person's unique predicament. Regardless of one's preferred theoretical framework, practitioners working within the NHS will inevitably be confronted by a system governed by the medical model. This predicament presents particular challenges for many non-psychiatric colleagues.

Given my own background as a counselling psychologist employed in the NHS, I am aware of these epistemological clashes that all too often create tensions between mental health colleagues. These challenges will be discussed further (see section 2.52 entitled: Counselling psychology, the medical model and the nature of evidence) by highlighting some general difficulties that mental health professionals can experience when working within alternative theoretical and epistemological frameworks.

Firstly, this introduction will consider the 'borderline' construct. Any attempt to understand the complex nature of the 'BPD' diagnosis cannot be made without first briefly reflecting on some historical origins of the diagnosis and the role of the medical model on the evolution of the concept.

## **2.42 The History of the 'Borderline' Construct**

*'At one outpatient clinic, the category 'borderline' was taught through the 'meat-grinder'*

*sensation: the chief resident explained to the others that if you were talking to a patient and felt as if your internal organs were turning into hamburger meat (you felt scared; you felt manipulated by someone unpredictable; still, you liked her), that patient most likely had borderline personality disorder.’ (Luhrmann, 2001:113)*

This extract serves to illuminate some of the inherent problems associated with diagnosing a person as 'Borderline Personality Disordered'. Particular difficulties include the stigma associated with 'BPD', the validity of the diagnosis and its clinical utility. These issues have stimulated widespread attention and controversy among psychiatric academic and psychotherapeutic professions and will be introduced here and further on in this introduction. In particular, this section will focus more specifically on the historical origins of the 'BPD' diagnosis and the professional legitimacy of a questionable construct.

Understanding current practices of working with, and diagnosing people with 'BPD' cannot be achieved without first reflecting on earlier representations of psychological distress. It is argued that these earlier notions of distress have contributed greatly to our current understanding and approaches to emotional difficulties. Throughout time, societal responses to distress have primarily reflected cultural conceptions (Szasz, 1961). It almost seems absurd that up until the 1970s and 1980s (and around three centuries prior to this), the predominant response to those experiencing emotional difficulties was to confine them to institutional care (Foucault, 1967; Porter, 1987; Skill, 1981). The relatively recent shift to the provision of community based mental health services marks a significant change in the way in which people are perceived and helped. However, these historical responses to emotional difficulties have continued to exert influence on professional and cultural perceptions of distress largely because the paradigms used to describe earlier notions of emotional difficulties continue to dominate our discourses about distress in the twenty first century.

During the nineteenth century, 'madness', and 'hysteria' were among the favoured cultural narratives used to describe individuals experiencing emotional difficulties. Both constructs share a similar history particularly in terms of the way in which they have shaped perceptions around women and femininity. Each will be discussed in turn here.

As was the case up until the 1970s, those attracting the 'madness' label were largely removed from mainstream society and placed in institutions. For Foucault (1971), 'madness became imprisoned in a *'moral world', which successfully delineated the world of reason from unreason'*. Attributing 'madness' with others also helped maintain distance from one's own sense of internal disturbance (Foucault, 1971). Women are of particular relevance here, as since the nineteenth century, they have made the greatest use of services for emotional issues. Furthermore, Widiger and Frances (1989) said that three times as many women as men were given the 'BPD' diagnosis. Similarly, Showalter (1985) referred to 'madness' as the *'female malady'* of the nineteenth century. The relationship between 'madness' and women was further endorsed via the culturally constructed notions of femininity of the time. Women seen to be deviating from their feminine roles were considered within this pathological framework. The legitimisation of psychiatry as a medical specialism further promoted this relationship as a reality (Walkerdine, 1990). In line with this, Ussher, (1992:13) wrote:

*'the discourses which regulate 'femininity', 'women', and 'the mad' are irrevocably linked to a fantasy, seen as a fact and experienced as 'real' by individual women; and located in the material world in which both 'madness' and 'women' act as important signifiers'*

These powerful discourses and cultural responses to distress inevitably influenced the way in which women experienced and made sense of their difficulties. 'Madness' was understood as arising from within the person given the label and not, as others (e.g.

Szasz, 1961) subsequently proposed, as arising from the sociocultural discourses of a given era. This distinction is potently illustrated when looking back even further to sixteenth century notions of distress and the impact of prevailing narratives of that time on those labelled. During this period, a particular conception of distress was instead understood within a framework of theology and philosophy. From this perspective, female 'madness' was for some, conceptualised as witchcraft (Ussher, 1992), and therefore seen as driven by forces of 'evil'. Any woman labelled as a 'witch' carried the burden for her affliction. Here, society was seen as vulnerable and in need of protection. As science gained popularity, it began to supercede existing theories of distress. Within this expanding field of

expertise, intentional deviancy was instead considered within a framework of 'illness' (Ussher, 1992). Writing from a feminist's perspective, Becker (1997:2) points out '*control of women through allegations of witchcraft came gradually to be replaced by another potent means of social control – psychiatric diagnosis*'.

The notion of 'madness' and in particular its strong association with women and femininity shares many features attributed to another early conception of distress, namely 'hysteria'. Loudis (2011:1) wrote;

*'since antiquity, the word hysteria has served as a bellwether for societies' relationship to women and medicine, revealing more about attitudes than any specific medical condition'*.

For the ancient Greeks, hysteria was associated with women who had unfulfilled sex lives and a delay in producing children. A number of other theories were proposed for the cause of hysteria. These reflected favoured ideologies of the time. One effort to list all known symptoms spanned 70 pages. '*Excessive emotionality*' and '*a predilection for drama and deception*' were among those descriptions identified (Hustvedt, 2011:53).

Loudis (2011:1) observed;

*'Diagnosis and treatment was unquestionably gendered: vibrators and Victorian fainting couches were considered acceptable medical options'*

Among the first to systematically investigate hysteria, Jean-Martin Charcot (1885), famously studied 430 patients residing in the Salpetriere, an asylum renowned for accommodating those considered insane. According to Charcot (1885:142), for every male with hysteria there were twenty females. From his observations, he concluded that hysteria was:

*'...caused by the effect of violent emotions, protracted sorrows, family conflicts and frustrated love upon predisposed and hyposensitive persons'.*

During the second half of the nineteenth century, hysteria became particularly associated with middle class women, an increasing number of whom identified with a role characterised by fragility and mental weakness. When diagnosing during this period, doctors continued to associate the condition with women's sexual organs and *'even less carefully scrutinised beliefs about the social and psychological nature of femininity and its roles and responsibilities in their society, beliefs which coloured their attitudes towards the illness of their female patients'* (Wood, 1973: 34). It was not to be until the early twentieth century that hysteria began to lose its hold and authority as a diagnosis. This came during the introduction of psychoanalysis and a turning away from the physical theories that were seen as failing to provide an adequate explanation or treatment for patients with the diagnosis.

#### **2.43 The relationship between hysteria and 'borderline personality disorder'**

Although conceptualisations of distress could be seen as having undergone considerable revision over time, it is argued that subsequent approaches to distress have continued to

exert great influence on the way in which it is understood, and the way in which those given the label make sense of their experience. Becker (1997) illustrated this point. She argued that the way in which 'hysteria' was conceptualised, and the manner in which such difficulties were responded to during its popularity as a diagnosis, shared many features with current notions of 'BPD', particularly in the way in which '*these two 'women's diseases' and the women who suffered from them are viewed*' (Becker, 1997:19). She argued that in both cases, symptom lists have broadened across time to account for a greater number of women. In line with this, Manning (2000: 264) argued that the 'borderline' construct is a label that serves to account for a '*heterogeneous group of patients that do not fit elsewhere*'. Central criteria once regarded as vital in making a diagnosis are now applied less stringently. Professionals' difficulties in working with, and attitudes towards, nineteenth century 'hysteria' patients and twenty first century 'borderline' patients are also considered similar (Becker, 1997). Research investigating the attitudes of health care professionals working with people diagnosed with 'BPD' tends to be negative (see 2.63 for further discussion on clinicians attitudes). Patients are generally perceived as manipulative, attention seeking and difficult to treat (e.g. Lewis and Appleby, 1988). These views runs parallel with professional attitudes towards patients diagnosed with hysteria with one such professional describing his hysterical patients as '*a vampire who sucks the blood of the healthy people around her*' (Mitchell, Fat and Blood: And How to make to Make Them, quoted in Ussher, 1992:76).

The historical account of the diagnosis and handling of women given the label 'hysteria' marked the transition from physical medicine (a framework from which such ailments were understood in the late nineteenth century) to the beginnings of psychiatry and psychoanalysis as a legitimate specialism within medicine and science and claiming a more coherent framework from which to understand emotional difficulties. It is argued (Becker, 1997) that this exclusively male profession permitted its members to command

authority over the nature of reality, through the discourse of diagnosis, treatments and cures. For Ussher (1992: 66) '*science itself emerged as a singularly male enterprise*' for which women became the greatest consumers. The difficulties women presented to their male physicians were understood within this emerging framework.

Overall, It is argued that 'BPD' represents a blueprint for these earlier notions of distress, such as 'hysteria', with respect to its negative impact on those given the diagnosis and its favourable relationship with professionals serving to maintain its authority as a legitimate framework for understanding emotional difficulties.

#### **2.44 The emergence of the 'borderline' construct**

The dominance of the emerging medical model approach to psychotherapy also brought with it early uses and conceptualisations of the 'borderline concept'. Psychodynamic approaches were among the first to conceptualise 'borderline' phenomenon. Stern (1938) initially used the term 'borderline' to refer to patients who appeared to ignore conventional boundaries common to psychotherapeutic practice. Neither did they appear to correspond to any diagnostic classification, a system that at the time classified people under neurotic or psychotic categories. This group of patients were referred to as having '*a mask of sanity*' (Clerkley, 1941) which seemed to dissolve in the presence of emotional arousal, triggered especially in the context of interpersonal relationships. The use of 'borderline' construct only began to gain recognition in 1953 in response to Robert Knight's paper on '*borderline states*'. He associated the borderline condition with that of a brief psychotic state in people normally considered as 'non-psychotic'. Knight considered this state to emerge following a pattern of early trauma, interpersonal difficulties and stress in the person's present life situation. Interestingly, Knight did not characterise the 'borderline' state as a problem within the structures of personality organisation.

In contrast, Kernberg (1975), who contributed significantly to this area, conceptualised the 'borderline' entirely within the context of character structure. He used the more general term, Borderline Personality Organisation (BPO) and proposed this to be a third form of personality organisation that fell between the healthier neurotic and the more severe psychotic personality spectrums, thus reflecting the degree of dysfunction. Kernberg considered BPO to be characterised in part by a difficulty managing emotional states and also in an inability to hold constant representations of self and others, resulting in poor interpersonal functioning. During the 1970s and 80s, a number of significant theories on the etiology and treatment of 'BPD' were proposed. What seemed to unite psychodynamic theories was an emphasis on the person's early life experiences, and the impact of significant relationships during this critical phase of emotional development. For example, Object Relations Theory (Adler and Buie, 1979) described patients with 'BPD' as having difficulty drawing on soothing experiences to regulate themselves. They proposed that these deficits arose from early experiences with caregivers who were largely unempathic, unavailable and rejecting of their needs as children.

Psychoanalytic descriptions of borderline presentations led Gunderson and Singer (1975) to devise a diagnostic tool to assess patients - the Diagnostic Interview for Borderline Patients. From their research, a set of characteristics was identified and used to formally categorise 'BPD' within the medical model paradigm. From 1980, 'Borderline Personality Disorder' was to be given its own axis in the Diagnostic and Statistical Manual (DSM) of Mental Disorders (DSM –III; American Psychiatric Association, 1980).

#### **2.45 Critique of the 'Borderline' Construct**

Despite considerable revision of the 'borderline' construct, there remains a lack of consensus about the validity of the concept as well as disagreement regarding the etiology of 'Borderline Psychopathology'. It is argued, and perhaps evident from the discussions so

far, that the various ways in which the borderline construct has been used, described and understood, makes it:

*'rife with ambiguities, unresolved questions, inconsistencies, and limitations...and because these meanings lie on different planes of discourse reflecting different notions of illness and etiology, they are totally unreconcilable' (Aronson, 1985: 209)*

Although the DSM-V aimed to classify 'BPD' in a way that attempted to overcome such ambiguities, there remains extensive disagreement within the field of psychology, psychiatry and academic circles. During the 1960's, in view of such widespread disagreement, Menninger proposed to withdraw the system of classification deeming it unworkable. The diagnosis itself has been criticised for being too general. Stone (1991) identified ninety-three combinations of the diagnosis using the DSM-IV criteria. However, it is argued that the DSM publication marked a move from this broad categorisation to a more specific type of disorder comprising observable symptoms and behaviours in order to improve overall reliability. Furthermore, this system improved the ability to measure the effectiveness of treatments via the diminishment of symptoms. However, this diagnostic system has been criticised in relation to its conceptual framework and scientific claim. For example, Masterson (1990: ix) argued that:

*'the diagnostic approach based on symptoms was misleading in that it focused on the most puzzling, paradoxical, and superficial aspects of the disorder...[telling] us more about the complexity of the problem to therapists than about the patient'*

Others (e.g. Coles 2011) questioned the reliability of a diagnosis which rests fully on the clinician's take on the client's description of their problem, and which cannot rely on measures utilised when making a medical diagnosis (e.g. biological indications of ill health). A further problem with this classification is reflected in Alnaes and Torgersen's

(1988) findings following a review of the literature. These findings showed that 97 per cent of personality disorder participants occupied axis one categories thus indicating a high rate of comorbidity.

In addition to these concerns about the overall reliability and utility of the DSM, the diagnostic system has also been criticised for only representing observable behaviours signs and symptoms and excluding other important indicators of distress. In particular, the experiences of practitioners and patients have not been incorporated into this system of classification. It is argued that this is due to on-going efforts to improve DSM V's overall reliability.

Research (e.g. Miller, 1994) investigating the value of subjective experiences supports the need for additional methods for investigating and understanding complex phenomena and highlights some of the limitations of adopting an exclusively positivist framework. It is argued that the exclusion of subjective experiences of clients could reveal important information about their internal worlds that is otherwise difficult to capture objectively. This concern was shared in a study by Miller (1994). He investigated the experiences of patients diagnosed with 'BPD'. Via participant interviews, he identified important differences between the way in which experiences were described and the objective descriptions set out in the DSM-IV. An example of this discrepancy concerned the emotional aspect of participants' difficulties. This is described in the DSM-IV as 'chronic feelings of emptiness' and 'affective instability due to a marked reactivity in mood'. In Millers (1994:1217) study, he concluded that:

*'the sense of emotional pain conveyed by these patients was overwhelming ... much of the impact [of their words] may be lost without hearing the pain in their voices or experiencing the redundancy of such comments in their narratives.'*

These findings highlight the value of accessing subjective measures of a person's distress. This appears essential to any practitioner aiming to develop an understanding of their client's difficulties. It also highlights the limitations of objective measures. It is argued that an objective approach only captures a partial view at the expense of developing an understanding of a person's internal experience. Miller went further, in line with his findings, to suggest that the diagnostic and statistical manual provides a distorted view of his participants' subjective experiences.

Similarly, Luhrmann (2000) offered support for the implementation of subjective measures when diagnosing patients. He suggested that this would serve to enhance the quality of a patient's experience and move away from diagnostic interviews led by professionals attempting to identify symptom clusters. This approach would further facilitate a wider understanding of the client, thus taking into account a 'biopsychosocial' view of the person's life. Brandchaft and Stolorow (1984) highlighted the importance of thinking about the person's life situation over a focus on symptoms. They suggested that a narrow focus runs the risk of communicating that the person has an 'illness'. This can undermine an approach that serves to facilitate the person's whole life situation as valued and valid. In other words, this narrow view may marginalise a person who already feels marginalised and misunderstood. A viewpoint that embraces a subjective exploration of the person's predicament could further facilitate the development of empathy, a central ingredient to improved outcome (Gehrs & Goering, 1994). Given the accessibility and utility of the DSM-V manual within the health care community and its leading presence in the NHS, it seems regrettable that the subjective experiences of patients are excluded. Yet these alternative views have contributed greatly to this vast and complex area.

Many psychological practitioners share the view that the medical model conceptualisation of 'BPD' runs the risk of overlooking the person's unique experience of psychological

distress. Despite these compelling shortcomings, the medical model continues to feature as the dominant model used to describe emotional difficulties and to inform practice. Its relationship with psychoanalysis, outlined in the following section, further illustrates its past and continued influence on the theory and practice of psychotherapy. This discussion holds particular relevance given that the current study seeks to investigate the way in which psychoanalytic psychotherapists endeavour to make sense of their experiences of working with clients diagnosed with 'BPD'. The relationship between the medical model and psychotherapy will now be evaluated by drawing on humanistic and constructivist perspectives.

## **2.5 Section 2: 'Why research 'Borderline Personality Disorder' ?'**

### **2.51 The Relationship between the Medical Model and Psychotherapy**

The emergence of the borderline construct can be traced back to the relationship between the medical model and psychotherapy. This period was significant in that the influence of these related approaches further endorsed the field of 'BPD' as a concept rooted in the psychoanalytic discipline. This association is subsequently indicated by the vast body of theoretical work on 'BPD', which has in the main come from the psychoanalytic approach.

Freud was one of the first physicians to apply principles of the medical model to psychotherapy during his efforts to find an effective treatment for hysteria and from which emerged a '*talking cure*' (Breuer & Freud, 1893-1895/1955). In line with the medical model, this emerging approach, referred to as psychoanalysis, was predicated on the same principles used to respond to physical illness. Bohart and Tallman (1999:5) illustrated the relationship between the medical model and the practice of psychotherapy in the following quote:

*'In the medical model the therapist is analogous to a physician. He or she is an expert on*

*the nature of the client's problems and on how to remediate those problems. He or she forms a diagnosis of the client and then prescribes treatment. Treatment consists of applying interventions appropriate to that diagnosis. These interventions cause change in the client, thereby alleviating the symptoms.'*

However, since the inception of psychoanalysis, many psychological practitioners have argued that the medical model is not adequate in describing the practice of psychotherapy. Carl Rogers (1951), a humanistic psychologist was particularly influential in his opposition to the medical model. In its place, the medicalised term '*patient*', associated with a person coming to have something done to them, was replaced by '*client*' who came to therapy, not because of an afflicted illness needing a cure, but to engage in a relational process with a view to facilitate self understanding and personal growth. Within this framework, clients were seen as bringing, to the therapeutic encounter, their own unique experience that was distinctive and could not be reduced to clusters of symptoms or groupings. A person's difficulties were considered as an understandable response to difficult life situations that may have arisen following a breakdown in coping.

As mentioned earlier, the humanistic position stood at odds with a medical model perspective to psychotherapy, which located the problem within the client, who was to be labelled as having a 'mental illness'. Thomas Szasz (1978), suggested that many psychological practitioners often took the medical model's view of psychological distress too literally, believing that their clients' presentation was an illness. Rather than providing a useful framework to understand a person's difficulties, he argued that the medical model perpetuated this 'confusion' between the literal and the metaphorical. Despite these inherent concerns about the medical model's hold on psychotherapy, Elkins (2012:73) suggested:

*'...the medical model has remained the dominant descriptive system for psychotherapy, not because it offers the most accurate description of what actually occurs in therapy, but, rather, because the model's association with medicine and science gives psychotherapy a level of cultural respectability and economic advantages that other descriptive systems do not.'*

It is this association between science and psychotherapy, referred to here by Elkins (2012), that has subsequently placed positivism firmly at the centre of psychological enquiry. It is argued that the strength of this relationship is particularly the case given the long history of its association. Orlans and Van Scoyoc (2009) dated this back to as early as the sixteenth century to Francis Bacon, an advocate of the scientific method and founder of empiricism. This approach was based on the assumption that knowledge could only be accessed through experimentation and observation. This emphasis on the objective and scientific examination of a given phenomenon continues to lay claim to being the most credible of approaches, particular given its notable utility for investigating medical science. However, its appropriateness for investigating complex human experiences has been heavily challenged (e.g. Bohart, 2005; Elkins, 2007; Morrall, 2008; Corrie, 2010; Rapley, Moncrieff & Dillon, 2011).

Despite these concerns, research investigating psychological therapy is increasingly dominated by research methods aligned to a positivist epistemology. Many factors appear to be driving the influence of positivism. It is argued that evidence is embedded in historical, economic, and political agendas. This is at the exclusion of other methods (e.g. qualitative approaches) which emphasise the value of investigating psychological processes. Corrie (2010: 52) highlighted a limitation of quantitative approaches within the profession of psychotherapy and counselling;

*'Gold standard evidence is essentially 'product focused' whereas practitioners are 'person*

*focused', less concerned with global statements about effectiveness than how information can inform the subtleties of what they do.'*

## **2.52 Counselling Psychology, the medical model and the nature of evidence**

The debates about the nature and utility of scientific research discussed here represent particular challenges within the counselling psychology profession, which aims:

*'...to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing' (British Psychological Society, Division of Counselling Psychology, 2006).*

As indicated in this quote, counselling psychologists endeavour to negotiate between different and often opposing philosophical positions. Of particular concern within the profession, is a pursuit to engage in the personal meaning of experience. Within this humanistic framework, it is these multiple constructions of reality that form the basis for 'knowing' or making sense of experience. This endeavor represents the core values underpinning counselling psychology. However, these values directly contradict the core principles underpinning the medical model and a positivist epistemology, which assumes one way of knowing. Lane and Corrie (2006: 17) suggested that a defining feature of counselling psychology is:

*'a respect for the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment, as well as a pursuit of innovative, phenomenological methods for understanding human experience.'*

According to Brown (2002), embracing these two philosophically opposed positions represented an '*epistemological contradiction*'. Attempts to reconcile these conflicting frameworks represents a particular challenge for the profession. However, Strawbridge

and Woolfe (2003: 5) believed such a *'dichotomy is not unbridgeable and that a great deal depends on what we mean by 'science' and the notion of the 'scientist practitioner.'*

What Strawbridge et al (2003) implied here is that such tensions become more pronounced when the notion of science is viewed within the constraints of positivism.

Thus, they argued for a need to revise existing conceptions of 'science', 'research' and 'evidence' beyond the scope of the medical model in a way that becomes appropriate and relevant to counselling psychology practice.

Regardless of one's philosophical position, it is likely that all psychological practitioners will encounter the influences of the medical model when working within an NHS context. With this challenge in mind, Bury and Strauss (2006: 56) asked;

*'How, if at all, can the use of diagnostic labels in practice be reconciled with counselling psychology's humanistic value base?'*

Writing from a humanistic perspective, Golsworthy (2004) suggested a need for counselling psychologists to reflect on their own relationship with a diagnostic framework so as to think about the impact this has in their work with clients. This, Hage (2002) suggested, is particularly crucial in an NHS context where the perspective taken on clients' experiences centres more around 'illness' and less on growth and human potential, more typically associated with a counselling psychology approach. The concern indicated here is that the identity of the counselling psychology profession in the NHS risks becoming diluted by the dominant medical model and its associated medicalised discourses that centre around concepts such as mental illness.

In a climate where practitioners are increasingly under pressure to justify their competence and effectiveness, it is difficult to see how counselling psychologists and others, aligned to different philosophical positions, cannot be affected by the medical model in a way that

may make it more difficult to debate, question, disagree and reflect. Elkins (2009) implied that psychological practitioners in general, who work within a context dominated by the medical model, are particularly subject to this unquestioning position. He suggested that:

*'Freud and others have become so accustomed to describing psychotherapy in medical model terms that it is difficult, if not impossible, to remove the medical model 'grid' to see the process of psychotherapy as it actually is.'* (Elkins, 2009: 71)

Elkins referred to clinicians' sense of 'professional guilt' when working with clients who do not adequately fit the diagnostic classifications, as they consider this to be beyond the scope of their remit. He suggested that the guilt experienced by practitioners reflects the impact of the medical model, that psychotherapy is for 'ill' people not those hoping to gain self-understanding.

Many psychological practitioners share the view that a positivist approach is not an adequate framework for investigating complex human experiences via psychological research and clinical practice. Donald Schon usefully illustrated the limitations of what he referred to as the technical rationality model using the following metaphor:

*'A high ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research based theory and technique. In the swampy lowland, messy confusing problems defy technical solution...[But]...in the swamp lie the problems of the greatest human concern.'* (Schon 1987:3)

Here, the 'swampy lowlands' represent what is uniquely experienced in a room with a client. An objectivist framework, according to Schon (1987), fails to equip practitioners in responding to these uncategorised subjective experiences. Instead, this framework centres on a quest to find solutions in a way that distracts from engaging with a person's distress. Failing to acknowledge the phenomenological experiences of a client's distress

can risk creating a barrier to understanding. This acknowledgement parallels the values endorsed by counselling psychology. Within this framework, a person's difficulties are viewed as an attempt to cope with their life situation rather than seen as a set of symptoms that constitute an 'illness'. This understanding is facilitated by the relationship between therapist and client.

Overall, it is argued that studies that take a more phenomenological focussed view on human experience can offer additional ways in which to understand complex experiences. With regards to the current research, it is argued that an approach with this focus will provide insights and contribute to our understanding of how the therapist experiences a client diagnosed with 'BPD'. Before reviewing how different methods of research have addressed and informed this current study, the remainder of this section will consider the case for pursuing this enquiry by setting out current prevalence rates of a problem that has been conceptualised as 'BPD'. It will then review some important policies that have attempted to stimulate changes in the way in which services respond to this widespread difficulty.

### **2.53 Estimates of incidence and prevalence rates.**

'BPD' is described by the NICE Guidelines (National Institute of Clinical Excellence, 2009: 3) as being:

*'...characterised by significant instability of interpersonal relationships, self image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide.'*

Given the association with self-harm and suicide, 'BPD' has increasingly occupied an area of concern within the health care community. 'BPD' is said to affect 2-3 per cent of the population (Swartz, 1990). The diagnosis is primarily attributed to women (between 75-80 per cent (Leib et al, 2004). Around 75 per cent of people diagnosed with 'BPD' attempt suicide (Soloff et al, 1994) with completed suicides at a rate of 9.4 per cent (Stone, 1989), rendering this as an important area of enquiry. 'BPD' patients have been found to make up 15 per cent of hospital admissions (Widiger and Weissman, 1991). This may indicate something of the struggle these individuals have in managing themselves in the community or being adequately supported within a community setting.

People with a diagnosis frequently report sexual abuse (Yen et al 2002). For example, Paris (2005) found 25 per cent of diagnosed individuals had been subjected to sexual abuse. Other traumatic experiences have also been reported. For example, Bandelow et al (2005) identified that 94 per cent of people with the diagnosis had experienced a trauma.

Bland et al (2007) identified between 41-70 per cent of inpatients having experienced abuse during childhood. There is increasing evidence to suggest that repeated exposure to these kinds of experiences could lead a child to develop 'borderline' features in adulthood. This is supported by Gunderson (2008), who identified abuse as a potential feature in the development of 'BPD'.

Over the past ten years a number of important policies have been published in many cases, in response to the inconsistent and inappropriate service responses to people with a personality disorder. These papers include; Personality Disorder: No Longer a Diagnosis of Exclusion (2003), Breaking the Cycle of Rejection: The Personality Disorders

Framework (2003), Reaching Out: An action Plan on Social Exclusion (2007), The NICE guidelines (2009), The Personality Disorder Knowledge and Understanding Framework (2008) and Recognising Complexity: Commissioning Guidance for Personality Disorder (2009). These policies emphasise different issues but are united in their aims to change the way in which services respond to people with a diagnosis of personality disorder. Further, they aim to challenge the perceptions that people, in particular clinicians, have towards those experiencing difficulties associated with personality disorder diagnosis (see 2.63 below for attitudes towards people diagnosed with 'BPD').

The policy: Personality Disorder: No Longer a Diagnosis of Exclusion (2003) highlighted inconsistencies in the way services responded to people with a diagnosis. This paper further aimed to address the difficulties people thus diagnosed had in accessing appropriate Mental Health Services, and proposed that working with this client group should be central to the work of Secondary Care Services. It stated that clients' needs should be addressed from a multidisciplinary team perspective. Despite this important publication, five years later, the implementation of service changes remained *'patchy and, in some areas, rudimentary'* (NCCMH, 2009: 32). These responses similarly mirror the challenges encountered in changing the perceptions of clinicians working with clients presenting with complex needs. This led to the publication: Breaking the Cycle of Rejection: The Personality Disorders Capabilities Framework (2003) which aimed to address the importance of staff training in personality disorders. A more recent policy: The Personality Disorder Knowledge and Understanding Framework, 2008 similarly highlighted the importance of educating clinicians. These publications have indicated how a lack of training and education may impact negatively on service users' experiences of those who are supposed to be helping them.

This section has aimed to address the question: 'Why research 'borderline personality

disorder?'. In an attempt to answer this complex question, I have argued that research methods aligned to a positivist approach, that have dominated the research surrounding 'BPD', are not adequate to investigate the subjective experiences of therapists working with clients diagnosed with 'BPD'. In making this argument, I propose a need to consider wider conceptions of evidence that embrace research methods capable of investigating subjective meaning.

This section has also aimed to consider the uneasy relationship between two philosophically opposed paradigms. This was considered particularly necessary given that the current phenomenological research enquiry aims to investigate a construct taken from the positivist framework. This discussion has considered the challenges a positivist approach may present to psychotherapy research and practice based on available literature.

Finally, this section has attempted to capture relevant statistics that serve to indicate the problems associated with service users diagnosed with 'BPD'. It is hoped that these prevalence rates coupled with shifts in service provision in recent years provides further argument to investigate this area. The following section aims to consider existing research and highlights a paucity of research specific to the current study.

## **2.6 Section 3: What can previous research tell us about the experiences of working with people diagnosed with Borderline Personality Disorder?**

Within the literature, it is widely agreed that there are specific issues and difficulties experienced by clinicians working with clients diagnosed with 'BPD'. These specific difficulties have been represented within clinical descriptions and case illustrations as well as being empirically investigated with a particular focus on the reactions of clinicians towards this client group. This section will present the available findings from clinical

illustrations followed by quantitative and qualitative research findings.

Firstly, this section will focus on clinical descriptions and case illustrations of working with clients diagnosed with 'BPD'. Although, these illustrations are offered from a broadly psychoanalytic perspective, it is noteworthy that a number of other approaches have established themselves as effective in working with clients diagnosed with 'BPD'. These approaches include Cognitive Analytic Therapy (Ryle, 1990) and Dialectical Behavioural Therapy (DBT) (Lineham et al, 1991). However, on reviewing the literature, most of the theoretical work in the field comes from the psychoanalytic approach. As is indicated here, the psychoanalytic profession has had a great deal to say about 'BPD'. It is argued that this contribution supports the rationale for exploring, in depth, psychoanalytic psychotherapists' clinical work. The fact that practitioners working within a broadly psychoanalytic perspective are at the forefront of service delivery for clients with a diagnosis of 'BPD' also supports the rationale for investigating these particular clinicians. Further on, this section will consider existing quantitative and qualitative evidence. Given that there is virtually no exploration of how psychoanalytic practitioners respond and cope with their work, this will further support the rationale to investigate this area.

## **2.61 Descriptions and Case illustrations of the psychotherapy relationship with clients diagnosed with 'BPD'**

Within the literature, psychoanalytic writers have extensively described the implications of working with clients diagnosed with 'BPD' as well as using direct experiential accounts to illustrate these claims. Within this approach, therapists' subjective experiences are broadly referred to in terms of 'transference' and 'countertransference'. Although these concepts are specific to the psychoanalytic approach, the terms are increasingly used and becoming established concepts across a number of other therapeutic approaches including Cognitive Behavioural Therapy and Systemic Therapy.

Within this psychoanalytic framework, a number of writers (Holmes, 1994; Kernberg, 1975; Greben, 1977; Adler, 1975; Stolorow, 1995; Gabbard, 2005) have described the implications of working therapeutically with clients diagnosed with 'BPD'. Practitioners working within this framework describe the frequent use of 'projective identification'. This refers to a process whereby the client unconsciously pushes unacceptable and overwhelming feelings into the therapist. The therapist is then nudged into a position of experiencing these disowned feelings as if they belong to him/herself. As such, the therapist is likely to experience intense feelings of anger, anxiety and repulsion. The patient is likely to be highly ambivalent in the therapeutic relationship, for example, alternating between highly dependent behaviour (e.g. clinging) to extreme emotional avoidance (e.g. detached and apathetic). In response, the therapist is likely to oscillate between feeling that the client is being helped or alternatively made worse by the therapy and that he/she is subjecting the client to an experience he/she could do better without.

According to Holmes (1994) who wrote from an attachment perspective, the therapist may feel 'paralysed' in this situation. Despite feeling invalidated and unhelpful, the therapist is likely to face intense opposition in response to any efforts to end therapy. Holmes (1994) suggested that the therapist must be vigilant to the elusive ways in which he/she can be nudged into traumatic re-enactments with the patient and that despite the patient's ambivalence, should assume an approach characterised by consistency, empathy and emotional availability.

Also writing within a psychoanalytic framework, Kernberg (1975) described the prominent feature of working with clients diagnosed with 'BPD' as a rapid onset of intense feelings towards the client. Describing his own work with a client, he similarly referred to an inability to respond to his patient, in his own words, feeling 'paralysed'. He considered this

to indicate something of his patient's early relational experiences. Kernberg (1977) also described a strong inclination to prescribe medication or refer the patient to hospital in response to his 'acting out' behaviours and indicated how these typical responses can risk repeating earlier abandonment experiences for the patient.

According to Kernberg, regardless of experience, therapists are likely to feel deskilled, to be questioning of self and to anticipate a threat of disapproval by others. He suggested that these responses reflect the patient's internal world and subsequently impact on the therapist. The therapist may attempt to protect him/herself by emotionally retreating thus giving rise to a lack of emotional availability and responsiveness.

A further countertransference issue he described, was when the therapist attempted to collude with the patient by directing his/her aggression outwards. He/she takes in some of the patient's aggression believing this reflects his/her commitment. Kernberg illustrated these defensive responses through his own case illustrations. The following is his work with a 20-year-old 'borderline' patient:

*'As long as I did not contradict him openly, he maintained an amused and friendly security in the hour. Open challenge brought about attacks of rage against me, the intensity to which I at first found almost frightening. I gradually realised that the main intent of his rage was to shuttle any view of himself or reality that contradicted the way he saw them, and that if I remained silent his rage diminished. I had rarely experienced a more effective control over my psychotherapeutic efforts in the treatment of a non psychotic patient'* (1975:13).

This passage highlights the appeal for therapists to seek refuge in the face of intense emotions. Kernberg found safety from his '*almost frightening*' feelings in his silence. He found himself in a position of treading carefully, so as not to arouse his patient's rage, and

yet needed to challenge the patient's view of himself. This is similar to what Greben (1977) referred to as the *'double edged sword'*. He used this term to describe the necessary conditions of therapeutic change for the treatment of patients with 'BPD' (e.g. empathy) but pointed out how these necessary conditions serve to evoke intense primitive emotions in the client.

Adler (1975) also described particular therapist reactions with 'borderline' patients by suggesting the need of the therapist to be aware of retreating in response to strong emotions from the client. He suggested that this might lead the therapist to want to 'rescue'. Another response he referred to was feelings of apathy and detachment provoked by a client presenting as indifferent. Adler (1975) emphasised the need for the therapist to constantly reflect on his/her felt experiences, as this would largely determine the effectiveness of therapy, and the client's opportunity to renegotiate 'separation-individuation'.

Stolorow (1995) and Gabbard (2005) identified two distinctive patterns of interaction in the therapeutic relationship. The first was one that resembled early attachment experiences. Within this mode, the patient was likely to experience the therapist as harsh and rejecting and would be likely to respond with anger and 'acting out' behaviours. Accordingly, this dynamic would risk bringing about the very conditions the patient was striving to avoid, that is rejection from the therapist (e.g. premature termination). The second mode of relating was characterised by a desire for the therapist to be the good parent the patient never had. The nature of this interaction thus placed the therapist in an idealised role. The therapist as ideal could quickly oscillate to a denigrated position should he/she fail to fulfill those hopes of the patient. For example, if the therapist was late for a session, this could be experienced as rejecting and punitive. Within these attachment activated situations, Kernberg (1989) suggested that the patient may struggle to consider alternative

explanations to account for the therapist's lateness other than to reinforce these internal representations of self and other.

The strong reactions experienced by clinicians and described here reflect something of the emotional demands placed on the therapist working with clients diagnosed with 'BPD'. Wilson and Lindy (1994) suggested that the demands of the client could impede the therapist's capacity to adopt an empathic approach. Crucially, the therapist must continually reflect on his or her own contribution to the relationship in an endeavour to gain an insight into the client's relational difficulties (Gabbard, 1995). This is particularly important given the evidence to suggest that the therapist's reactions and his/her response to these reactions in the therapeutic interaction are crucial features to the effectiveness of psychotherapy (Gelso and Hayes, 2002; Strupp, 1980).

The accounts offered by psychoanalytic writers serve to provide some insights into the experiences likely to be encountered within the therapeutic relationship with a client diagnosed with 'BPD'. The advantage of these accounts is that they are specifically relevant to the experiences likely to be encountered by therapists. As will be illustrated when reviewing quantitative and qualitative studies, few have been conducted that specifically focus on therapists' experiences. At the same time, it may be difficult to generalise these descriptions across other therapeutic modalities and across different working contexts. However, Betan, Heim, Conklin and Western (2005) argued that regardless of the preferred therapeutic approach, striking similarities in terms of therapists' reactions exist. Upon reviewing the literature, it is argued that due to a paucity of research, these claims are yet to be established specifically for therapists working with this group of clients. And yet, as Ginot (1997) pointed out *'the growing importance attached to the analysts world and use of self, exploring possible ways in which we can understand and operationalize it has taken on a new sense of urgency'*. Although there is a lack of

research in this area, a number of studies have been conducted confirming distinct variations between different client and professional populations, lending some support of these findings. These empirical studies are described in the following section, which aims to consider the contribution made by quantitative studies.

## **2.62 Quantitative Research**

This section has been divided up by sub-headings reflecting the particular focus these quantitative studies have taken in their research. However, there is overlap and therefore relevance between these sub-headings.

## **2.63 Impact of the borderline label on clinician attitudes**

Several quantitative studies have shown that working with clients diagnosed with 'BPD' sponsors negative feelings in healthcare staff (Lewis and Appleby, 1988; Radley, 1994; McIntyre et al, 1998; Feather et al, 2001; Markham et al, 2003; Markham, 2003; Commons Treloar et al, 2008; Cleary et al, 2002; Johnstone, 1997; Alston et al, 1997; Gallop et al, 1989). Research to date has focussed on particular aspects of working with clients diagnosed with 'BPD'. For example, a number of studies have focussed on the impact of the 'BPD' label on various groups of mental health workers. Lewis and Appleby (1988) examined the perceptions of psychiatrists in response to descriptions of clients with or without a diagnosis of 'BPD'. They revealed that patients with a diagnosis were more often seen as *'manipulative, difficult to manage, unlikely to arouse sympathy, annoying and not deserving of [National Health Service] resources'* (Lewis and Appleby, 1988:8). The authors proposed that these negative views were born out of the psychiatrists' beliefs that clients diagnosed with a personality disorder were in control of their difficulties (e.g. self harming). In another study, Feather and Johnstone (2001) investigated the attitudes of nursing staff towards clients diagnosed with 'BPD' and those with a diagnosis of schizophrenia. Clients with a 'BPD' diagnosis were more likely to be blamed for their

behaviour. In a separate study, these reported negative attitudes led mental health nurses to emotionally withdraw (Markham and Trower, 2003). These findings are particularly concerning given the evidence that negative attitudes, including the view that clients with a 'borderline' diagnosis may not be deserving of treatment, are influential in treatment decisions (Radley, 1994). These attitudes also run the risk of clinicians overlooking the events and traumas that are often present in this client group. In line with these concerns, Suzi in Shaw and Proctor (2004:12) wrote:

*'I cannot understand how the vast majority of perpetrators of sexual violence walk free in society; whilst people who struggle to survive its after effects are told they have disordered personalities'*

It is interesting to note from a review of previous studies (Reynolds, 2000) that as well as a lack of training, a lack of empathy among nursing staff was cited as accounting for their difficulty in understanding the experiences of clients. These findings were also reflected in service user accounts of professional attitudes by the National Collaborating Centre for Mental Health (2004:28). They found that:

*'Service users describe contact with health services as often difficult, characterised by ignorance, negative attitudes and, sometimes, punitive behaviour'.*

## **2.64 Healthcare settings**

Whilst these studies have examined the impact of the diagnosis on clinicians' attitudes, other studies have focussed on the experiences of clinicians working in particular mental health and healthcare settings (Miller et al, 1994; Herman, 1992; Fraser and Gallop, 1993; Lancee et al, 1995; Commons Treloar et al, 2008; Bowers, 2002). For example, a large number of studies have focussed on the experiences of health care professionals working in inpatient settings. These studies generally reported negative attitudes towards clients

diagnosed with 'BPD'. For example, Bowers (2002) documented highly critical views among nurses working within an inpatient forensic service. In another study (Benham, 1995; Crowe, 1996), nursing staff reported feeling ineffective and incompetent in response to working with their clients. These negative feelings were seen as a barrier in developing a therapeutic relationship. It is noteworthy that many of these studies were conducted in the early 1990s, perhaps reflecting the type of services in place at that time. More recent studies have emerged focussing on the experiences of clinicians working in various community services thus reflecting the shift in service provision.

Amongst these studies, Commons Treloar and Lewis (2008) compared the attitudes of clinicians working in an emergency department with those employed by mental health services. Those working within an emergency setting were consistently more negative in their attitudes towards clients diagnosed with 'BPD'. The context of work was found to be the greatest predictor of attitudes. However, research examining the perceptions of clinicians working in Community Secondary Mental Health Services also revealed negative attitudes including the view that clients diagnosed with 'BPD' were difficult to treat (James and Cowan, 2007).

### **2.65 Therapists' reactions to particular client presentations**

Of particular relevance to the current research, a small number of studies have examined therapists' experiences (Fraser et al, 1993; McIntyre et al, 1998; Piner et al, 1984).

McIntyre and Schwartz (1998) used the Impact Message Inventory and Stress Appraisal Scale to measure the reactions of 155 psychotherapists towards clients with a diagnosis of Major Depression and 'BPD'. Results showed that participants identified distinct reactions between the two groups of clients. Therapists reported powerful feelings towards clients diagnosed with 'BPD' including hostility and wishes to retaliate or undermine their clients. Fears of being criticised by others and emotional distancing were

also reported.

In another study, Betan, Heim, Conklin and Western (2005) presented case vignettes to assess therapists' countertransference reactions. Consistent responses were identified irrespective of the participant's therapeutic orientation (i.e. Cognitive Behavioural or Psychodynamic approaches). These results suggest that clinician reactions are not necessarily influenced by their theoretical framework. Such findings led Annemarie et al (2007) to argue for an '*empirically supported*' framework of therapists' responses to specific client difficulties. The identification of common reactions may provide a focus for therapists from which to develop helpful responses. However, until further research is conducted in this area, it would appear difficult to collate anything substantial in terms of clinicians' reactions. Although there remains a lack of research, a number of studies have been conducted confirming distinct variations between different client and professional populations lending some support to these proposals. For example, one study (Commons et al, 2008) identified large discrepancies in the attitudes of psychologists, social workers and occupational therapists when compared to psychiatrists and nursing staff, with the latter two groups expressing more negative responses.

Overall, very few studies have focussed on therapists' experiences. Furthermore, no quantitative studies were found focussing specifically on psychoanalytic psychotherapists' experiences of working with clients diagnosed with 'BPD', and/or using this kind of sample in a Community Secondary Care Mental Health Service.

More generally, quantitative research findings are somewhat limited in their capacity to investigate experiences of clinicians in any depth. The difficulty in investigating the processes underlying such attitudes and experiences represent a major constraint with this research methodology. A further constraint to these findings concerns the level and type of contact practitioners have with clients diagnosed with 'BPD'. For example, nurses working

within emergency departments are likely to encounter their clients in crisis. This would call for a particularly focussed response centred on the immediate presentation of the client. This would potentially contrast with the nature of contact with therapists, which would likely be more consistent (e.g. weekly contact) and give rise to a more in depth experience. Despite the limitations of the available research, these findings confirm the presence of difficult and often negative feelings towards clients diagnosed with 'BPD'. Furthermore, results indicate differences between health care professionals in their perceptions towards clients diagnosed with 'BPD'. This would suggest that general findings are not easily applied across professional populations. These quantitative studies may provide a framework from which to explore these themes in more detail, through the use of qualitative research methods.

## **2.66 Qualitative Findings**

Qualitative studies examining the experiences of therapists working with clients diagnosed with 'BPD' are scarce. However, there is increasing use of qualitative methods to explore, in more depth, the reactions and experiences of a variety of healthcare professionals to particular client difficulties. These studies include an investigation into: Doctors' reactions to self-harming patients (Hadfield et al, 2010); Psychotherapists' experiences of working with suicidal clients (Richards, 1999); Therapists' reactions to self perceived difficult situations (Annmarie et al, 2007); Therapists' experiences of working with clients they consider as self deceptive (Westland et al, 2009); an exploration of therapists' own feelings of incompetence (Therriault et al, 2008).

Among these studies, Hadfield et al (2009) used IPA to investigate doctors' responses to working with self-harming in patients within an emergency setting. Three main themes were identified from interview transcripts. Addressing the physical needs of the patient occupied the focus of treatment for this group of practitioners. Doctors perceived the

emotional needs of their patients to be an area beyond the remit of their professional competency. This theme, labelled as '*treating the body*', revealed how in part treatment was determined by participants' moral views about self-harm. The second theme; '*silencing the self*' referred to doctors' efforts to cope with difficult feelings associated with their work, for example by minimising the person's self-harming. This is similar to previous quantitative research (e.g. McIntyre and Schwartz 1998) revealing clinicians' attempts to emotionally withdraw in response to difficult feelings arising in their work with clients diagnosed with 'BPD'. Interestingly some participants also feared losing emotional control if they were to engage in the client's distress. A more understanding approach was seen in participants with indirect personal experiences of self-harm. The final theme: '*Mirroring Social and Cultural Responses*' referred to the impact of the medical model and societal values in treatment responses. This influential paradigm focussed on the physical treatment of self-harmers, and in turn, was seen as restrictive to intuitive responses. This further reinforced a feeling of ineffectiveness in doctors' approaches to self-harm. This study differs from the present study in terms of the type of professionals employed, the working context and the focus on a specific behaviour that may or may not apply to people diagnosed with 'BPD'. However, with its use of IPA, this study gives rise to a deeper understanding of the processes underlying participants' responses that has not been possible using quantitative methods. Of some interest here, are the findings revealing the reported restrictive influence of the medical model on practitioners' responses to their clients. Again, a common theme arising from this study, in line with previous research, were participants feeling ineffective about what they could offer their clients.

In a separate study, Smith et al (2007) similarly identified feelings of ineffectiveness among 26 therapists who were asked about their experiences of working with clients they

considered as challenging. In addition, participants also described overcompensating responses triggered by feeling deceived by their clients. A limitation of this study is that participants were employed in a variety of working contexts. It would therefore be difficult to draw comparisons with therapists' experiences of working in Secondary Care Services. However, these findings illustrate the presence of powerful emotions in the face of challenging work with clients, as well as a tendency for the therapist to respond in particular ways.

In line with these findings, therapists working with suicidal patients also reported profound feelings of emotional discomfort (Richards, 1999). This research focussed on the transference-countertransference issues for therapists. One hundred postal surveys and 5 interviews were conducted and revealed intense reactions towards suicidal clients, including despondency, anger and hopelessness. Within this study, countertransference responses were explored. These responses included: a) the therapist thinking that the client would more likely benefit from seeing someone else; b) feeling angry to the extent that the therapist wanted to stop seeing the client; c) urges to assault the client (likened to that of an 'abusive parent'); d) becoming overbearing in the relationship thus attempting to take responsibility on the client's behalf. This was similar to Smith et al's findings, in particular with regard to the tendency for therapists to overcompensate in response to challenging situations. Participants made sense of their experiences as indicative of, or resembling, the client's perception of others as hostile and unempathic. Making sense of their experience in this way served to facilitate understanding in the relationship.

Richards (1999) also found that therapists experienced intense and powerful feelings when working with this client group. These feelings were seen to impact therapists on both a personal and professional level. Therapists were said to struggle to monitor their countertransference under such intense conditions and use it as a source of information

about the client and the relationship. Respondents acknowledged the use of their countertransference to be a crucial tool, but if left unchecked could jeopardise the therapeutic relationship, including risking premature termination of therapy. Participants felt that these clients should be seen within a more containing service as opposed to private practice. They highlighted the need for good supervision, support within a multi-disciplinary team and well-defined boundaries within the therapist-client relationship.

Richard's (1999) study is considered particularly relevant to the current investigation, as participants were made up of therapists who were described as either psychodynamic or psychoanalytic in their approach. However, the interview schedule that made up part of the qualitative component of this study asked participants to think about their suicidal clients in the context of the transference relationship. This focus differs from the current research aims, which do not ask participants to make sense of their experience within a particular framework. However, Richards (1999) study may illustrate the influence of a practitioner's theoretical model on the ways in which they make sense of their experience. This study also used content analysis, which differs from IPA in its emphasis on the phenomenological.

Similar themes were revealed by Westland (2009) who looked at therapists' experiences of working with clients they considered as 'self deceptive'. This broadly referred to clients who held two contradictory beliefs about themselves, who were reluctant to consider alternative viewpoints, including those introduced by the therapist, and who exhibited aloofness and detachment in the therapeutic relationship. IPA was employed and four main themes were identified. Themes included intense responses felt by the therapist (e.g. frustration towards the client) and therapists doubting their competence to work with their clients.

Overall, it may be difficult to draw general conclusions from these studies about therapists'

experiences of working with clients diagnosed with 'BPD'. Crucially, none of the above qualitative studies specifically focus on clients diagnosed with 'BPD'. However, studies have focussed on particular client presentations that may be of relevance to the current research. For example, as already discussed in this introduction, clients diagnosed with 'BPD' are more likely to self-harm, present with suicidal behaviour and be experienced by a variety of health care professionals as '*manipulative*' and '*difficult to treat*'. Similarities exist across qualitative studies. These studies tell us that clients can evoke strong and often difficult feelings in participants including feeling incompetent. In addition, participants generally struggle to respond to their clients in a way that they consider to be helpful. In some cases (e.g. Smith et al, 2007 and Richards, 1999), therapists report uncharacteristic ways of responding to their clients (e.g. overcompensating) that they perceive as unhelpful.

Limitations of these studies are that none specifically focus on the experiences of psychotherapists working in Secondary Care Mental Health Services. On reviewing the literature, two studies were found that have focussed on practitioners experiences of working with clients diagnosed with 'BPD'. Themes identified from these studies share some similarities with previous qualitative findings. However, there are some important differences.

In one study, Commons Treloar (2009) used thematic analysis to investigate the responses of 140 practitioners' experiences of working with clients diagnosed with 'BPD'. Four main themes were identified. Themes included the experience of 'uncomfortable feelings' evoked in workers. The following was a common response:

*'I have found people with BPD to be manipulative and I wonder if ...BPD is just an excuse for bad behaviour and nastiness'* (taken from Commons Treloar, 2009:31).

A further theme identified concerned particular behaviours exhibited by clients that led clinicians to feel inconsequential in their efforts to help. This included the tendency for them to take up a lot of time. Finally, participants pointed to an insufficient service provision for the care of 'BPD' clients. The authors concluded that attitudes might arise, in part, from clinicians feeling inadequately trained, informed or resourced to respond effectively. This may indicate contextual influences in the development of negative responses among clinicians. The authors also highlighted the need for deeper exploration, in an attempt to gain greater clarity about these reactions using qualitative methods. It may be difficult to draw conclusions from this study given that the participants were largely made up of nurses, occupational therapists, social workers and psychiatrists. Only a small number were made up of psychologists and none were psychotherapists. Further, the study focussed on a variety of health care settings and was not specific to Secondary Mental Health.

In a more recent study, Rizq (2012) explored the experiences of primary care counsellors working with clients who they considered could meet a diagnosis of 'BPD'. In line with previous research, 'feelings of inadequacy' were identified as a central experience and concern for counsellors who despite their efforts to respond to the needs of their clients, felt personally limited in what they could offer. Another finding that has not arisen in previous research, labelled as '*managing dilemmas in the context of primary care*', referred to counsellors' concerns that were specific to working with clients in a primary care setting. For example, the dilemma of time limited working with clients perceived to have greater needs. An important implication of these findings is that there are likely to be concerns and experiences reported by clinicians that are specific to their context of work. These results highlight the need to consider the impact of context on experience and therefore further highlight a need to investigate experiences specifically within a secondary

care context.

Overall, research tends to reveal that working with clients diagnosed with 'BPD' is experienced as difficult and emotionally demanding for a variety of practitioners working in a variety of healthcare settings. Given the lack of research focussing specifically on psychotherapists working with clients diagnosed with 'BPD' in a Secondary Mental Health Service, it is difficult to draw any conclusions beyond the scope of these findings.

However, there is certainly evidence to suggest that the working context is likely to impact on reported experiences (e.g. Rizq, 2012).

## **2.7 Conclusions**

The aim of this introduction has been to consider the 'borderline' construct from a positivist epistemological position from which the term arose. Then, to consider the term from a broadly social constructionist perspective. By tracing the origins of the 'borderline' construct, it is hoped that this introduction has illustrated the influence of early labelling and the subsequent impact of psychiatric diagnosis on the way in which emotional distress is described, understood, responded to and investigated. From this discussion, a number of limitations associated with a positivist framework have been outlined, and an argument is put forward for the need for alternative ways in which to explore complex phenomenon.

This introduction has also discussed existing research with a view to considering how different methods of research have contributed to current insights about 'BPD' and what they have revealed. In particular, quantitative studies have shown that the term in itself influences the way in which clients with the label are perceived and treated by a range of healthcare professionals and across various healthcare settings. However, there are also some differences between professional attitudes. These results indicate an inconclusive picture from which it is difficult to draw conclusions about the experiences of clinicians working within Secondary Care Mental Health Services. These mixed results further

highlights a need to research this area.

It is argued that it is particularly important to investigate the working context, given that Secondary Care Community Services are responsible for the provision of 'BPD' services, and in view of government policies aiming to increase community provision for these. In line with this service remit, it is also the case that the majority of clients given the label receive the greatest input of therapeutic intervention from these services. It is therefore of central importance that we understand how clinicians are responding and coping with the challenges presented to them when working with this client group in this working context.

Given that there are virtually no qualitative studies investigating healthcare workers' and therapists' experiences of working with clients diagnosed with 'BPD' and none existing that focus specifically on psychoanalytic psychotherapists working within Secondary Mental Health Services, it is argued that this type of research enquiry has taken on a particular sense of priority. The rationale for choosing this group of participants is as follows:

- 1 Most of the theoretical work in the field of 'BPD' seems to come from this perspective
- 2 The aim of this study is to explore therapists' clinical work in depth. Given that psychoanalytic psychotherapists work with clients at least once a week, tend to be highly self reflective in their approach and tend to focus on the role of the therapeutic relationship, they are in a good position to reflect on and describe their experiences in a way that is likely to generate rich, detailed and nuanced descriptions.
- 3 Most practitioners working with clients diagnosed with 'BPD' in these services tend to adopt a broadly psychoanalytic approach and yet there is virtually no qualitative exploration of how these practitioners cope and manage such difficult clients.
- 4 There are specific services within secondary care (e.g. The Therapeutic Community

Model) which operate within a psychoanalytic approach and where such research would be wholly relevant.

In conclusion, despite the attention 'BPD' has received from the research community, there

remains widespread disagreement and controversy regarding the diagnosis, and on how best to respond to people with the diagnosis. Although there is evidence to suggest that particular psychotherapeutic approaches are effective for this client group (e.g. Batemen et al, 2006), research discussed in this review confirms that professionals continue to feel confused, hopeless and incompetent when working with clients given this label. These inconclusive results suggest an overall need to investigate this area in more depth. It is anticipated that this current study, with its aim to explore the experiences of a smaller number of participants in greater depth may reveal insights into existing findings. These experiences potentially serve to make an important contribution to the current evidence base. It is anticipated that investigating therapists' experiences, using semi-structured interviews will facilitate an exploration of these challenges in more depth.

## **2.8 Research Aims**

It is the aim of this research to investigate the lived experience of Psychoanalytic Psychotherapists working with people diagnosed with 'BPD'. By using IPA (Smith et al, 2003) it will be possible to investigate the specific experiential concerns that participants have in their work with this client group, within the context of an NHS Community Mental Health Service.

## **2.9 Research questions**

The main research question that participants will be asked in this study is:

**How do psychoanalytic psychotherapists experience working with clients diagnosed with BPD?**

In conjunction with this main question, participants will be asked to think about specific experiences that may have evoked powerful thoughts and feelings in the therapy situation. Also, they will be asked how they made sense of what was happening. The aim of this semi-structured interview is to help participants to explore their experiences in depth. In order to facilitate this exploration, participants will be prompted by questions such as: 'How did you feel then?'; 'What did you do then?'; 'What sense did you make of that?'; 'What made you say that?'.

Chapter three will consider the utility of IPA for investigating therapists' experiences.

### **3. The utility of IPA for investigating therapists' experiences.**

IPA (Smith and Osborn, 2003) is an established qualitative approach, which aims to investigate the lived experiences of participants and to examine the ways in which participants make sense of these experiences. IPA is a phenomenological approach (Giorgi and Giorgi, 2003) given its interest in participants' experiences of important areas of concern. However, it acknowledges the role of the researcher who inevitably imposes his/her own interpretation when making sense of a person's account. This activity therefore aligns itself with the hermeneutic approach (Palmer, 1969). The important ideas, that Smith (2003) has brought together within this approach, are discussed further here.

It is proposed that IPA lends itself to the research question (refer to 2.9) as its aim is to focus on the meaning of a person's experience. It provides a systematic means of interpreting first person accounts. Existing research has been dominated by empirical methods. These approaches are predominantly concerned with '*what happens*' and within the context of this current area of research, would be focussing on investigating effective approaches to working with 'BPD'. This differs from the current research, which instead aims to investigate '*the meaning of what happens*'. It is thus grounded in phenomenological enquiry, as it aims to access the meaning people make of their experience. For this reason, a review of those ideas central to this enquiry will be considered.

This relatively recent approach draws from ideas within the realms of phenomenology, hermeneutics and idiography. Phenomenology refers to the study of being. What unites the various positions within this philosophical approach is an interest in human experience and in particular, when one experiences something of self-significance. Within this approach, Husserl (1927) proposed that we should '*go back to the things themselves*'. He wrote:

*'when we are fully engaged in conscious activity, we focus exclusively on the specific thing, thoughts, values, goals or means involved, but not on the psychological things as such, in which these things are known as such. On reflection reveals this to us' (Husserl, 1927: para. 2)*

Husserl endeavoured to get to the core of a person's experience by reducing and 'bracketing off' cultural, historical and contextual assumptions that he saw as blocking the 'essence' of a lived experience. An ultimate aim of this pursuit was to identify potential shared structures among different people. It is this area of Husserl's contribution to phenomenology that has been of particular relevance for researchers using IPA, i.e. the importance of a person attending to, and reflecting on, their experience in order to access an understanding of a given phenomenon. However, Husserl did not prescribe any procedure with which to systematically capture a person's *'lived experience'*. Subsequent writers (e.g. Heidegger, 1927/1962 and Merleau-Ponty 1962) have argued that it is not possible to bracket off our contextual, cultural and historical assumptions and further, that it is these features that make an experience meaningful. For Heidegger, to separate the person from the world would jeopardise the meaning that constituted the lived experience and that both were crucial to accessing an understanding of experience. IPA has drawn from the particular assertions proposed by Heidegger, in that meaning emerges from ourselves in relation to others and the world. Furthermore, interpretation is an inevitable and implicit activity when seeking to make sense of a person's experience. This point also highlights a somewhat misleading quote referring to IPA as attempting to access *'an insider's perspective'* (Conrad, 1987). Instead, the researcher can only realistically aim to access a person's experience and provide a third person account of this experience.

Another influential feature of IPA concerns idiography. An idiographic approach focusses at an individual level of understanding and is therefore different to a nomothetic approach,

which endeavours to access more general claims about a given phenomenon. This is an approach that continues to dominate psychological enquiry. IPA takes from this a dedication to understand the nuances that encompass the experience of an individual. IPA facilitates a detailed analysis of a person's account. An idiographic approach is adhered to via a systematic approach to analysing the accounts of a group of participants to a particular phenomenon. This method moves from an appreciation of a specific experience to more general claims encountered within a small sample of participants. These broader claims are made with great carefulness and caution in order that such richness is not lost. IPA serves to facilitate caution by representing both convergent and divergent accounts that emerge within those accounts offered. These unique experiences remain captured within the analysis via verbatim quotes from which the reader can engage in their own inter-subjective process in relation to participants' accounts.

Finally, central to IPA is the concept of interpretation referred to as hermeneutics. This concept is concerned with human beings' need to understand the meaning of experience. Failure to make sense leads to powerlessness, and so the activity of making sense persists via a process of negotiation through conversation 'to get to the things themselves'. IPA seeks to gain an understanding of a person's experience and within a hermeneutic framework, inevitably entails a process of interpretation. Thus, bringing about understanding demands a thorough engagement with what is being said. At the same time one has to acknowledge one's own relationship with the world, and with this in mind, the inevitability that what is understood as being a product of interpretation. Smith and Osborne (2003) refer to this as a '*double hermeneutic*', where the researcher is making sense of the participant making sense of their experience.

IPA has taken from these approaches the importance of accessing the richness of a person's experience to access an understanding of a given phenomenon but also

acknowledges the inevitability of interpretation within this activity. As Smith et al (2009) wrote:

*'without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen'.*

In conclusion, this chapter has outlined the philosophical underpinnings of IPA. Thus, IPA is an attempt to represent and utilise ideas offered by these branches of philosophy into a useable method for accessing the meaning of everyday life experiences. Although it is never possible to access actual experience, the aim of IPA is to get as close to a person's experience as possible, otherwise referred to as 'experience close'. This chapter has also highlighted the dynamic process involved in IPA and thus the role of the researcher who attempts to engage as closely as possible to the participant's world. Given that the researcher's own preconceptions will inevitably feature in the way in which experience is made sense of, it is important to be transparent about the nature of possible assumptions held. Therefore, the aim of the chapter 4 is to consider the author's personal and professional background and motivations to conduct this area of research.

#### **4. A consideration of researcher's experience and pre-conceptions**

As mentioned above, IPA is a dynamic process and as such, when an interview is conducted or a transcript read, the way in which the listener or reader will make sense of the material will depend on their own preconceptions about a given phenomenon.

Interpretation is inevitable in any IPA analysis. However, in order to give voice to the participant, it is important to recognise and set aside those thoughts, feelings and concerns that belong to the listener. I therefore include some of my own experience on which I have reflected, and that I have needed to be aware of since initiating this research enquiry.

I became a qualified counselling psychologist four years ago. However, my interest in relationships and my pursuit to help people change the way they felt about themselves, and others, was an activity I have engaged in for as long as I can remember. I believe my clinical training, personal therapy and supervision have enabled me to direct my fascination with other peoples' emotional difficulties in a more healthy and sustainable way and also helped me to put my empathic abilities to good use. In retrospect, it seems no surprise that I was drawn to work with people with such complex difficulties in view of my history. I initially worked and trained in an alcohol service, which at first I idealised. The service was predicated on the relational model and placed great importance on the therapeutic relationship. This service also afforded the luxury of open-ended contracts. During my time in this role, I began to work with clients who, I would subsequently understand within a psychiatric framework, to be labelled as clients with 'BPD'. They stood out to me as clients I took to supervision every week, and often tried to talk about with my colleagues out of supervision, as I found my experience with them extremely difficult to bear. I would tend to experience myself as unhelpful and on at least one occasion seriously considered leaving my relatively new profession. Three years into my role, I sadly left what was an extremely rewarding and nurturing experience to work within a psychological department of a Secondary Mental Health Service. I was immediately aware of the differences, not necessarily in the type of clients I was seeing, but the diverse frameworks I was encountering, as one might expect in a multi-disciplinary team. I was

also aware that I had been indulged in my previous role with open-ended contracts and little need to think about, or experience, many endings. I was also interested in the experiences of other staff members who often seemed quite despairing when describing their experiences of working with clients diagnosed with 'BPD'. I tended to experience a similar degree of helplessness and unhelpfulness when faced with my colleagues and supervisees seeking my advice about their own clients, as I was with my clients. I was struck by these challenges and struggles within my clinical practice and those of my colleagues, and it was these experiences, coupled with a lack of research focussing on the experiences of therapists specifically working with this client group, that has motivated my interest to pursue this area of research.

## **5. Method**

### **5.1 Design**

Interpretative phenomenological analysis (IPA) (Smith & Osborne, 2003) was selected to examine participants' experiences of working with people diagnosed with 'BPD'. This qualitative approach provides a robust method for investigating participants' experiences of this chosen area and was particularly appropriate given the complex nature of this

relational process under investigation.

## **5.2 Pilot Study**

Prior to the main study, a pilot study consisting of one semi-structured interview was carried out in order that the design of the interview could be considered.

During this interview, the participant was asked if they would have liked to have changed any aspect of the interview or be asked any other questions by the researcher. From this pilot study, it was decided that participants would be asked to think about specific experiences that may have evoked powerful thoughts and feelings in the therapy situation, and how they made sense of what was happening. This information would be provided via the participant information sheet (see appendix two) prior to interview. The aim of the interviews was therefore to follow those aspects of participants' experiences that were important to them and from which such experiences could be explored in greater detail.

## **5.3 Self Interview**

Prior to conducting interviews, a self-interview was carried out by the researcher as a way to identify any preconceptions that might have arisen and that could serve to impact on subsequent findings. Through this process, the researcher was able to identify her own preconceptions and be mindful of these during interviews and the process of analysis.

## **5.4 Participants**

Eight psychoanalytic psychotherapists (four male, four female) took part in the study all with at least five years experience of working with clients diagnosed with 'BPD', within the context of providing psychological therapy. Psychoanalytic therapists were selected as it was anticipated that, given their training, they would be highly reflective about their experiences. This stance would be particularly complimentary to the aims of the study.

Furthermore, within the Community Mental Health Service (CMHT), psychological

practitioners are required to consider and work within the NICE guidelines for the treatment of 'BPD' (June, 2008). Although other approaches are recommended and indeed used (e.g. DBT), there are fewer practitioners specialising in these approaches across the services under study. Guidelines include recommendations that therapeutic approaches should not be brief (any less than three months). Psychodynamic approaches are amongst those most frequently employed when working individually with clients diagnosed with 'BPD' in this particular trust. These approaches are selected, in part, because they are particularly suited to longer-term work.

In line with IPA procedures, it is suggested that a homogeneous group of participants should be employed in order to access insights that are meaningful. Based on these recommendations, it was necessary to recruit a group of practitioners working within the same orientation rather than a disparate group where it would be more difficult to determine the nature of their concerns.

IPA methodology provides a robust method for investigating a small number of participants' experiences. The specific number of therapists selected for interview in the study would ensure that the richness of data being generated could be adequately captured. It is recommended that up to a maximum of ten participants should be used when employing this method. Smith et al (2009) pointed out that the predominant interest in IPA, is making sense of an individual's experience and would agree with the proposed number of participants being used in this study.

Participants were all employed by Kent and Medway NHS Social Care Partnership Trust and worked within Psychological Services Departments of Community Mental Health Services Across East Kent. When using IPA, Smith and Osborne (2003) suggested purposive sampling. This was therefore used, with an aim to access a group of people

(co-researchers) to whom the area under investigation would also be of importance.

Finally, all participants were professionally known to the researcher in the capacity of fellow employee to the trust. Specifically, I am employed as a Counselling Psychologist within a particular locality of Psychological Services. All participants worked within other localities and I have therefore had minimal previous contact with them. However, given that participants were aware of my role, it was important to reflect on the possible implications of this. One possibility would be that participants might have assumed that I was aware of particular issues given my background. Furthermore, participants may have chosen not to share particular information. Given my dual role, it was important to reflect upon these possible implications throughout the research process (See 7.10: Limitations of the study).

## **5.5 Recruitment**

Participants were enlisted via a recruitment information sheet (see appendix 1) displayed in the staffing areas of psychological services. This information sheet provided information about the study and contact details of the Chief Investigator (the author of this thesis).

Participants were also recruited via email. In these cases, information about the study and an invitation to participate was given.

In all cases, participants were given detailed information about the aims of the study and the procedure involved in their participation. Recruitment information, participant information (appendix 2), consent (appendix 3) and debriefing information (appendix 4) were given to prospective participants prior to interview. Basic demographic information is set out in the table below. Names have been changed to protect the identify of those taking part in the study.

Participant Number	Participant Name	Sex	Years of Experience working with 'BPD'
1	Tony	Male	23
2	Jeanette	Female	9
3	Jon	Male	14
4	Linda	Female	7
5	Jan	Female	24
6	Arthur	Male	14
7	Robert	Male	11
8	Jo	Female	22

Table 1: Table displaying basic demographic participant information.

## 5.6 Method for data collection

A semi-structured interview was the chosen method for data collection. This was considered the most useful approach as it was anticipated that the research topic would provoke conversation that was highly sensitive and personal to participants. This approach was favoured over a focus group interview format given the personal nature of the topic under study. Furthermore, a group discussion may have limited self-disclosure and diluted the voices of some participants. Therefore, potentially some important experiential concerns could have been lost.

## 5.7 Procedure

Those who were interested in participating and who made contact with the Chief Investigator were invited to be interviewed on a convenient date.

All participants were interviewed in their place of work in various locations across East Kent. Participants were sent all information relevant to the study prior to interview. This

included information reminding participants that interviews would be recorded via a digital voice recorder. Participants were invited to think about specific experiences that may have evoked powerful thoughts and feelings in the therapy situation and how they made sense of what was happening.

Prior to the start of each interview, participants were asked to read and sign the consent form. They were reminded of their right to withdraw at any stage of the interview. Upon commencement of the interview, they were asked about their experience of working with people diagnosed with 'BPD'.

Throughout the interview, participants were prompted by questions such as: 'How did you feel then?'; 'What did you do then?'; 'What sense did you make of that?'; 'What made you say that?' This interview schedule (see appendix 10) enabled the interviewer to follow those aspects of each experience that was felt to be important to them, and to explore these in greater detail.

Once the interview had come to an end, participants were debriefed and invited to ask any questions. They were thanked for their participation and asked to sign the debriefing form. A total of eight interviews lasting between 50 and 70 minutes were conducted.

Data was then transcribed and analysed using qualitative analytic procedures appropriate to IPA as detailed by Smith (1995).

Participants were then invited back to a meeting where an opportunity to read through their interview and offer feedback on an initial analysis was given. They were informed prior to the initial interview that this was optional, and intended to provide participants with an opportunity to check for confidentiality and provide feedback.

## **5.8 Ethical Considerations**

Prior to conducting both the pilot and the main study, it was necessary to consider the ethical issues. The main ethical issues identified were confidentiality and emotional distress.

### **5.81 Confidentiality**

During the interviews, participants were likely to reveal personal information about themselves and their clients. In order to minimise the risk of breaking confidentiality, a number of measures were taken. Participants were given all relevant information prior to interview, i.e. that interviews would be recorded, transcribed and analysed. Furthermore, participants were asked not to disclose anything that could jeopardise patient confidentiality (see recruitment information). In addition, they were informed that all interview recordings would be held in the strictest confidence. Any identifying features were removed from transcribed interviews. Participants were advised that direct quotes would be seen by the Chief Investigator's supervisor, those involved in the examination of the dissertation and in any future publications. Also names would be changed to protect the identify of those involved. Participants were informed of the limitations of confidentiality, for example if they shared any information that posed a risk to themselves or others. Finally, participants were invited to attend a further interview to check their transcripts for confidentiality.

### **5.82 Emotional Distress**

An additional ethical consideration concerned the possibility that participants could become emotionally distressed when reflecting on their work. If participants became distressed at any stage of the process the following measures were taken to manage this. Firstly, participants were reminded of their right to withdraw from the study. Under these circumstances, the interview would be stopped. Information would be given detailing appropriate support (e.g. supervision and counselling resources, see supplementary

materials section). Finally participants would be invited to contact the Chief Investigator to discuss any issues arising from their participation.

### **5.83 Seeking Ethical Approval**

An application for ethical approval was initially submitted to the NHS Ethics Committee (see supplementary materials section) and subsequently approved (also refer to supplementary materials section for letter confirming ethical approval). A second application was then submitted to CITY University Ethics Committee and approved.

## **5.9 Data Analysis**

The method for conducting IPA was taken from Smith, Flowers and Larkin (2009). This approach does not propose a definitive process of analysis. Instead it provides a flexible approach to navigating the various stages of analysis, which can therefore be tailored depending on the aims of the research. Given that the researcher's own perspective is active throughout the process of investigation to interpretation, reliability will be demonstrated by setting out the process by which themes were identified. It is therefore the aim of this chapter to provide the reader with an in depth understanding of the findings and how these came about through the stages of analysis.

The procedure used in this study started by taking and reading each transcript in turn a number of times and any areas that appeared important and of significance were noted in the right hand margin. This process enabled the researcher to submerge herself in each interview and promoted increased familiarity with what was being said. The transcript was then revisited and examined in more detail. This time initial notes were taken and more specific expressions were noted in the right hand margin. Eatough and Smith (2006: 490) suggested that *'at this stage of analysis caution is essential so that the connection between the participants own words and the researchers interpretations are not lost'*. Here

the level of analysis requires that the researcher provide a description of the meaning she took from a section of the transcript. These references were referred to as emergent themes. This further enabled the researcher to manage the sheer volume of data, whilst retaining the essence of the participant's account through the lens of the researcher. An illustration of this process is given here for participant four (see appendix six for list of emergent themes and supporting quotes identified for participant 4). The transcript appears on the left of the page and emergent themes are present in the right hand margin:

<i>'I had to work with her ambivalence all the time about</i>	managing closeness/
<i>being attached to me, that was a big theme in the work</i>	distance
<i>so I suppose I learnt with her to accept her coming and</i>	learning from the
<i>going, so I offered flexibility'</i>	patient

When this process was complete, all emergent themes were recorded on a separate word document, labelled with the participant number, page number and line number and its corresponding quote. For participant four, 62 emergent themes were identified. Each emergent theme was then enlarged and printed so that they could all be seen and physically moved around. One could then see where groups of themes began to form and where they shared a particular theme. These were then moved into piles and are set out below for participant four as an example:

**Cluster 1:**

Learning from the patient

The intuitive therapist

The Emotional Impact

Regulating closeness and distance

**Cluster 2:**

Different rules for 'BPD'

The accountable therapist

Deskilled therapist

Intrigued therapist/person

### **Cluster 3:**

Working with other colleagues

The working context and 'BPD'

These clusters were then relabelled as master themes, at this stage forming a single case analysis. For participant four, the master themes identified were as follows:

Master Theme 1: The Task of Therapy

Master Theme 2: Recognising the Borderline Signature

Master Theme 3: The Working Context

This procedure was repeated across transcripts giving rise to clusters of themes across all transcripts. Throughout this procedure, transcripts were revisited and reconsidered to ensure that identified themes were grounded in the text of the interview.

### **5.9.1 Cross Case Analysis**

The next part of this process involved gathering all clusters of themes from the eight interviews. All groups made for each participant were then separated, to be regrouped using emergent themes taken from all participants' transcripts. These were cut into separate pieces of paper along with their constituent quote, participant number, page number and line number in order that they could be physically moved around to begin to form groups where they appeared similar and connected in some way. These groups became known as sub-themes, from which fewer and more general but related themes were identified and referred to as master themes. Smith (2004:71) proposed that during

this process, one should *'imagine a magnet with some of the themes pulling others in and helping to make sense of them'*. It was necessary at this stage for themes to be reasonably general in order for all interviews to be represented. Upon examining them, three master themes were produced where they shared particular aspects of experience relating to participants' accounts of their work with clients. This level of analysis provides a fuller interpretation of how sub-themes relate in the context of research question.

Each participant's account was then re-examined to ensure that all data relevant to these constituent themes was included. This was achieved by cutting and pasting all relevant quotes from a word processor to new files comprising their corresponding themes, the purpose being to establish experiences common to participants' accounts and relative to the master and sub-themes.

From this analysis, the master themes and sub themes are then presented in a table with a corresponding quote to illustrate the outcomes. This also serves to reflect the internal coherence of a process whereby the researcher has revisited transcripts repeatedly to revise and ensure that participants' accounts are retained throughout the whole of this analytic process. Eatough et al (2008:1780) writes:

*'The analytic process reworks and refines researcher understandings and interpretations in an iterative fashion until some degree of closure is reached'*.

This analytic process is then set out in a narrative form, providing further illustration of participants' interpretations of their experiences and the researcher's interpretations of them. Also, refer to section 7.8 (Discussion) for further demonstration of the researchers efforts to establish quality in her research.

## 6. Results

### 6.1 An overview of the results section

The aim of this section is to present the three master-themes, with their constituent sub-themes in turn, which make up therapists' experiences of working with clients diagnosed with 'BPD'. A summary of themes identified from the eight interview transcripts is presented in the table below (See 6.2: Table 2). Within this section, each sub-theme will be accompanied by direct quotes taken from participant interviews that support it. This will be followed by a description of the quote and the meaning that was being made of the data. All quotes will be presented in italics. The line number will follow each quote to allow for cross-checking with transcripts. Each quote will be introduced by the participant's name, changed to protect their identity. Due to constraints of space, not all quotes will be presented in this section. Please refer to appendix 8 for a list of participant quotes each supporting their constituent sub-themes.

From the transcripts, a number of central themes emerged which were grouped into

master-themes. These master-themes represented important aspects of participants' experiences. These themes were selected due to the frequency with which they appeared in transcripts, the emphasis to which experiences were described and where descriptions were seen as referring to particular subjective experiences. These were distinguished from some extracts, for example, which seemed to be describing how participants did therapy rather than how they felt about a particular experience. A table displaying those participants who contributed to each of the nine sub-themes is displayed in appendix 7.

Three thematically interconnecting but categorically distinct master-themes have been identified reflecting particular aspects of therapists' experiences. As will be discussed, these themes run parallel, inter-relate and overlap but remain distinguished by particular aspects of participants' experience.

MASTER-THEMES	SUB-THEMES
1) Recognising the borderline signature	1) Identifying the borderline client through the self: Special rules apply 2) The Borderline Therapist: Losing touch with the self 3) The Unforgettable Client
2) The borderline relationship: The Emotional Impact	1) The Struggling Therapist: Managing the self 2) Feeling Inadequate 3) Using the self to manage negative feelings
3) Struggling within the working context	1) Struggling within a multi-disciplinary team 2) Providing therapy in an impoverished Mental Health Service: Reconciling Impossible Opposites 3) Struggling with diagnosis

Table 2: 6.2: Table of master-themes and sub-themes.

### **6.3 Master Theme 1: Recognising the Borderline Signature**

A number of participants expressed some difficulty in accepting the formal diagnostic

category of 'BPD'. For example, some participants pointed to the limitations of the diagnosis in telling them anything about the subjective world of the client. Although there was difficulty in accepting the diagnosis, participants employed a more experiential way of recognising the presence of 'BPD'. For example, some participants seemed to recognise the 'borderline' client by the way they behaved. Others described these experiences in terms of what the client demanded. Participants also seemed to recognise the presence of the 'borderline' client by the way in which they found themselves responding to and feeling about the client's presentation.

### **6.31 Sub-theme one: Identifying the Borderline Client Through the Self :**

#### **Special Rules Apply**

*'It almost felt like it was a whack, an emotional whack to me...*

*there was this absolute fury and rage'*

Seven out of the eight participants described a range of responses elicited by the perceived emotional demands of their 'borderline' clients'. For example, some participants described disturbing feelings in response to their clients, referred to here by Jeanette as a 'jarring':

*'I had an understanding of how most people...say if they've got depression...how they might have various defences or various anxieties...that kind of thinking and almost...you could connect with them in a kind...in a kind of way that when you're working with them...that sort of umm had a flow to it...quite quickly...so you almost had a communication that worked and that didn't happen with personality disorders...it was like a jarring...a very difficult way to begin to relate.'* (Line 18-25)

Here, Jeanette articulates a more seamless way of connecting with people that seems almost taken for granted as indicated by her use of the word *flow*. She uses this to contrast

her experience of relating with a 'borderline' patient. Jeanette's use of the term *jarring*, seems to indicate something abrasive and uninviting, and may imply a sense that the client is trying to disturb something inside the therapist, that feels difficult. For others, the disturbance extended to a feeling of being invaded:

*'I guess one of the hardest things is that kind of experience ahh, I mean some people call it projective identification, I experienced with aggression, that was quite scary, it feels, I mean it, to me manifests in a physical, a real physical feeling inside my chest which almost feels like palpitations and I feel really sort of quite invaded.'* (Line 52-57)

In the above extract, Jan conveys, in visceral terms, the intensity with which she experiences her client. This is conveyed almost as a psychological assault that appears to penetrate her emotional and physical self. Her use of the word *invaded* seems to indicate a feeling that her client is somehow trying to get inside her. Jan further suggests how her experience goes well beyond an intellectual level of relating with her client. This is indicated by her reference to the psychoanalytic term *projective identification*. This feels more distancing and struggles to convey the subjective and deeply personal experience put forward here by Jan.

It isn't surprising that some participants switched off in the face of these emotional demands as conveyed within the above extracts. Three participants described how they emotionally retreated in particular ways. For example, Jeanette referred to this as;

*'Sometimes it's just being bored or feeling tired... whatever it might be or fuzziness... and I had this fuzziness with her and I was so aware of it.'* (Line 358-361)

Jeanette's use of the word *fuzziness* implies a sense of confusion and difficulty in thinking and, together with feeling *tired* and *bored*; she seems to feel there is a real danger that

she is unable to respond to the emotional needs of her client. She describes emotionally disengaging from her client and attending to her own emotional experience, perhaps seeking refuge in the face of her client's demands.

This is similarly conveyed by Jan who clearly indicates a sense that she has switched off in the face of being wanted and needed:

*'You could be talking about something really horrendous and it could be like talking about buying a loaf of bread in Tesco.'* (Line 58-62)

and also;

*'The other one would be that kind of yearning, yearning for a close person, wanting somehow me to provide that very very strongly and me feeling really quite unable to give that umm feeling extremely tired and bored sometimes when the demand for attention is so great.'* (Line 64-68)

In these extracts, Jan conveys a complex emotional dilemma – she feels the client's wish to be very close, indeed, almost inside her, whilst simultaneously retreating in the face of such intense emotional demands. These feelings seem to overwhelm her so much so that she appears unable to provide a helpful response. Tony similarly described this experience. However he not only recognises the dilemma that he's placed in but understands that he has to keep on trying, despite feelings of futility that are so bad he feels invalidated;

*'Some how, their life is so awful, that they cannot possibly be expected to respond in a reasonable, taking responsibility type way because somehow they're different and then in turn that invalidates I or anyone in the room is able to offer but of a double bind of, you have to keep trying.'* (Line, 65-71)

In this extract, he seems unable to make use of his usual, familiar ways of understanding

and working with clients. Such uncertainty seems to throw Tony into a state of not knowing, thus triggering a feeling of impotence. It almost feels as if he is having to do therapy stripped of his skills. Tony seems to cite the cause of his invalidation as being down to the client. However, it seems that his own preconceptions serve as a barrier in his work and reinforce his sense of impotence. This combined with a compulsion to *keep trying* conveys a sense of almost having nothing left to give. These invalidating feelings not only penetrate Tony but, as he indicates, *anyone in the room*. Here perhaps Tony is indicating something of his client's invalidating experience. Moreover, Tony's use of the word *anyone* may be referring to the many layers of this participant, constituting both his professional and personal self and thus the extent of these invalidating feelings.

### **6.32 Sub-theme Two: The Borderline Therapist: Losing touch with the self**

In the above theme, participants described characteristic feelings experienced in response to the emotional demands evoked in the therapeutic relationship. These feelings seem to be characterised by a sense of powerlessness where participants seem to feel invaded or pushed aside by the patient, emotionally shut down and unable to respond effectively. In response to these overwhelming feelings, it seems conceivable that participants are left susceptible to an influence beyond themselves.

Participants' accounts suggested that many felt they were losing touch with themselves, in part due to being psychologically coerced into thinking, feeling and behaving in uncharacteristic ways. Six participants described these kinds of experiences. Phrases such as *caught up* and *lured* were used to convey experiences whereby participants no longer appeared to feel in charge of themselves and, as illustrated in the following quote, no longer recognised aspects of their experience as their own. In a sense they appear to embody aspects of their client's world. Here, Jon described the intensity of his anger in response to his client's father:

*'The anger I felt in relation to his father... for example, was bordering on wanting to be physically violent with the father... if I'd of got my hands on him... I used to feel like that and that's not a normal feeling I have.'* (Line 208-211)

Jon conveys here a sense that he has lost touch of his former self. By contrast, there is a strong sense of involvement, familiarity and presence in this deeply engaging moment with his client. He described himself as intensely angry towards the person his client refers to as his father. The fact that his client has conveyed this information so potently has perhaps brought about this dramatic emotional response from the therapist. The participant reflects on this moment remarking on this being an experience he has of himself that he does not recognise, of feeling almost murderous towards his client's father. This takes further the *invaded* feeling Jan referred to in the previous sub-theme. It suggests that this is not just a feeling of being invaded but that something rather alien has got inside Jon and changed him in a way that he doesn't recognise.

Other participants described similar experiences but in the following case, intense feelings are evoked in response to the client themselves. Below, Tony describes the dramatic shifts in the way he felt towards his client, which seemed to go from feeling very close to wanting to create a lot of distance between them:

*'I'm very aware of thinking of specific clients or client that I've worked with and I can easily oscillate in the room, you know almost from minute to minute, a feeling of having wonderful moments of feeling really close to someone and the next time, wanting to tell them to fuck off and feeling really angry with them.'* (Line 132-136)

His use of the word *oscillate* conveys how changeable the therapist feels within himself in the presence of his client. The word *oscillate* also seems to suggest that the therapist has

lost touch with himself, that he is unable to retain a constant state. Again, the therapist's intensity of feelings implies a strong sense of engagement and familiarity in the situation being described and there is little space to think beyond the immediacy of the situation. This is conveyed by the intensity of the feelings described and the ease to which these dramatic shifts seem to occur for him. This extract further illustrates the powerful responses evoked within the therapeutic relationship that lead participants to feel pushed in different and opposing directions. The use of the words *fuck off* suggests a level of violence, possibly in response to a feeling of the client becoming too close as indicated in this extract; *feeling really close*. His reaction also indicates how the person of the therapist is very much invested in, and impacted upon, in this relationship.

Robert took this further in the following quote, more explicitly suggesting a merging of his and his client's experience. This conveys that the client has got inside him and left Robert to figure out what belongs to him and what belongs to his client:

*'Are you fearful...you've got to work out which is your fear and which is their fear.'* (Line 310-311)

Implicit in Robert's quote is a sense that he becomes unsure of himself and how he feels. This experience with his client has somehow disabled an aspect of himself so much so that he struggles to recognise something of himself in this experience. Jeanette further indicated this confusing relationship with the self in relation to her client:

*'Well, who or where do these feelings belong...I laugh about that, we certainly made unconscious and was when I went to a shop and picked out a jumper and turned up in the therapy and it was the same colour as hers, so I sort of thought, what's happening here, who's merging with who.'* (Line 264-169)

In this extract, Jeanette suggests that she has been unable to maintain her usual boundaries. Her use of the word *merging* suggests that, like Robert, she has lost touch

with an aspect of herself. She seems to take this further too, by implying that she has perhaps been taken over, that she has started to behave like her client, beyond her own personal boundaries and beyond the boundaries of the therapy room. This is perhaps similar to what Jeanette refers to as being *caught up in some sort of messiness* (Line 430). The *messiness* Jeanette refers to constitutes a blend of client and therapist.

### **6.33 Sub-Theme Three: The Unforgettable Client**

The breach of the therapist's boundaries extend beyond the personal, the therapy room and the therapeutic hour. Participants described in a variety of implicit and explicit ways, how their clients found a permanent residence in the therapist to some extent. For some, this occupation spanned several years. For all, the 'borderline' patient was unforgettable.

Within this theme, participants articulated the presence of something extraordinary or striking that became difficult to forget. These experiences were discussed in a number of ways and were illustrated through powerful feelings, experiences and some dramatic descriptions. Whilst some focussed on their client's physical appearance, others spoke about *specific actions or behaviours that they remembered as particularly powerful or unusual*.

In light of previous sub-themes, perhaps it is unsurprising that a number of participants were able to remember clients from several years earlier. For example, Linda described her client from *a good 10 maybe 15 years ago* (Line 35-36). These clients seemed to become etched in the minds of participants through these profound experiences, so much so that they became so difficult to forget. What seems to set these striking observations apart in particular is a sense of accountability on the part of the therapist. This can be illustrated in Tony's extract, where he discussed an experience of ending with his client and his concern in response to her self harming behaviours:

*'They were bad cuts and it's summer and I was very aware that she walked about in the summer with very short sleeved t-shirts, so there's these, loads of scars and it's horrible.'*

(446-448)

Tony provides a highly visual description of his client's scars, which feels uncomfortable to the listener. Perhaps this is not only in response to hearing about the client's physical scars, but also in response to hearing about the impact of these on Tony. As he talks about his client's cuts being seen by others, he seems to feel utterly exposed as a therapist:

*'I was very much in this...where I felt like I wanted her not to show people...that I wanted her to wear jumpers to cover her arms...I was concerned that people would see it and I would get the blame...they would say that because of me...umm I was very (I: ashamed), I wasn't ashamed but I was very aware of not helping much over the years and here's like evidence'* (463-468)

In these two extracts, the experiences represented by the client's cutting seem to run very deep for Tony emotionally. So much so, that this could be seen as getting inside Tony. He expressed this further in the second quote, *I was so much in this*. This refers to his sense of self-blame, involvement and accountability. The vivid images conveyed seem to indicate how exposed and responsible the therapist feels. It is as if he wants to cover up his sense of exposure, as indicated by his wish for the client to cover herself up. In a sense, the therapist takes ownership of the scars by feeling so accountable for them. This would suggest a far deeper level of remembering the client. The client seems to get into the therapist.

Other powerful descriptions that appear to become etched in the minds of participants include those offered by Jeanette who described her memorable client:

*'Somebody arrives and one particular lady...she arrived, very umm...very full on lady covered in her leathers and studs...you know...she was out to look intimidating and burst through the doors and they smashed against the wall.'* (Jeanette, 90-94)

The very dramatic observation made here illustrates how Jeanette's client stands out in a very physical sense. The words used, in particular *burst* and *smashed*, indicate something very powerful that could be seen as (capable of) overwhelming, something that feels very intrusive and overpowering, pushing the therapist out of the way. Given the dramatic and emotionally penetrating nature of the images that participants describe, it is hardly surprising that these are easily recalled. As Joanne commented:

*'They are clients that are least easy to forget...very often you know...historically... the people that I've worked with 10 years ago...something like that...they can still be in my mind [laughs]...the borderlines...where perhaps the others have faded.'* (Line 74-75)

In this extract, Joanne refers to the client being in her mind but this seems to feel rather different from simply remembering the client. As interviewer, I felt that Joanne was referring to something physical, like an alien object that seemed to occupy her mind long after the relationship had ended, irrespective of her wish to have it there.

What seems to unite these experiences is the way in which the client becomes something that is almost pushed into the mind of the therapist, that finds permanent home or residence there. For many, the profound emotional experiences they report coupled with the sense of accountability they imply seem influential in bring about these unforgettable experiences. The therapists' experience of themselves in their work with clients produced something of a psychic scar.

## **6.4 Master-theme 2: The 'Borderline' Relationship: The Emotional Impact**

When discussing experiences of working with clients diagnosed with 'BPD', participants did so by reflecting on the emotional impact of their work. The impact of these experiences fell into distinctive but interrelated themes. What is described in the first sub-theme is a particular sense of feeling inadequate as therapists. These strong feelings of inadequacy led some to doubt their competence as therapists and in the second sub-theme, participants describe the ways in which they struggle to manage these difficult feelings within themselves. What emerges from this personal struggle in the final sub-theme is a facility to manage or contain the clients' feelings. Perhaps these personal struggles form the building blocks of their work with clients in that they provide a framework from which to understand themselves and their clients' experiences.

### **Sub-theme 1: Feeling inadequate in their responses to their patients**

*'it seemed so pathetic in the face of what I was feeling'*

All participants spoke about a feeling of lacking something essential when working with their 'borderline' clients'. Under this umbrella of feeling inadequate, they reported feeling powerless in their work, deskilled, responsible for their clients' distress and accountable for their predicament.

A common experience expressed by six participants were feelings of powerlessness and uncertainty in their relationships with clients, particularly those at risk of self-harm and suicide. Arthur described his response to a distressed client as follows:

*'I also at times felt feeble, you know that she'd be telling me about the feelings, the unbearable, and I would say something like; 'well you know I realise from what your saying that, this is just you know, feels too much to bear' but it seemed so pathetic in the face of what I was feeling.'* (Line 254-260)

In this extract, Arthur seems to be describing a feeling of failing himself as well as the patient despite his willingness to respond in a helpful way. He struggles to articulate an adequate emotional response to his client and describes it as *pathetic in the face of*, not of what the client is saying, but of what he himself is feeling. Arthur is at a loss to express anything in the face of what he is feeling about his client's material. He is also intensely critical of himself for this so-called failure.

This experience is similarly expressed by Linda who described her feelings towards herself following a therapy session with a client as:

*'a remarkably difficult session where I thought I knew nothing...you know...I was left after it feeling really...I know nothing about this...I don't know how I'm supposed to...how to understand this'* (Line 210-212)

In these two extracts both participants appear to be describing their experience of inadequacy in different ways. For Arthur, this appears to be in the way he responds to his client and for Linda this seems to be about her lacking an understanding of her client. As before, both responses express something that seems self critical and almost unacceptable, as if their professional competence is somehow stripped away. This was explicitly confirmed by Arthur, who commented:

*'...you know, the feelings were so strong for her, despite all the practice and experience I'd had, she'd conveyed her feelings so powerfully, I didn't know how she could stay alive.'*  
(Line 265-268)

And similarly described by Robert:

*'I qualified and you felt that you should know these things and that you're immune to it in some ways but you never really knew what was going on you know in terms of how I felt after seeing this patient'* (Line 32-35)

Both Arthur and Robert potently express a sense of failure in their professional competence that feels crushing. Tony takes this further when he talks about ending with his client. He appears to have an even more devastating personal sense of inadequacy and a feeling that 'the self' is in itself insufficient when talking about ending with his client. Tony seems to be saying not only that he doesn't have enough skill, he is actually not good enough as a person to work with his client:

*'...but that opportunity to use all that experience of one another...you know...I didn't feel able...skilled enough...whatever...a good enough person.'* (Line 529-531)

Thus, the participant draws attention to a lack of the necessary professional and personal qualities he feels are needed to provide a helpful experience for his client.

Robert similarly describes an assault on every aspect of himself in his work. Not only is his professional self lacking, and not only is the self profoundly insufficient, but as illustrated here, the self is being beaten up, punished and assaulted:

*'...you've been beaten up almost...you know...and in every way...your professionalism...your interpretations, everything.'* (Line 73-75)

The above anxieties led some participants to change aspects of their clinical practice. In some cases, they spoke about, *playing it safe* with their clients in order to avoid addressing any difficulties in the therapeutic relationship that could exacerbate their own sense of inadequacy. For example, Tony elected for a safer approach to ending with his client despite his recognition of missing an opportunity for something potentially more worthwhile, as indicated here:

*'I almost just sort of played a much more traditionally counselling type role.'* (Line 534)

Here, Tony seems to imply a departure from an aspect of himself that ordinarily occupies an important role in his practice. He described his convincing reasons for opting for something safer:

*'I was very conscious that I didn't want us to end on bad terms...of all the things, it just felt that that was the most important, that I didn't want our...it sounds like a deathbed...last moments to be of the controversial type.'* (Line 539-542)

Here, Tony illustrates his predicament. That is he feels caught between the opportunity for an authentic ending experience, that could be *controversial* or to end on good *terms*. This predicament appears to lead to the inevitable sense of inadequacy for the therapist.

Furthermore, the participant's reference to a *deathbed* indicates something of the depth of sadness and regret stirred in this therapist in response to his client. Moreover, it's as if the *last moments* of the therapy were in fact a death, and he feels it's crucial to keep the dying patient happy. Tony's struggle felt tangible for the researcher during the course of this interview.

Participants also reported various urges, thoughts and feelings about themselves which emerged from their feelings of inadequacy or insufficiency:

*'I can remember how strong the feeling was...the wish to do something about it... umm and the wish to invent a story where there was something I could do about it...it wasn't in a direct sense in terms of stop it...but I did feel, you know...surely there's something I could say or some action I could take but there wasn't.'* (Arthur, 249-253)

Here, Arthur conveys his lacking in something essential that is not within his capacity to provide. Within his interview, Arthur cited several examples throughout his years of experience, where he felt an adequate response, within him self, was never realised but somehow the pursuit for something else seemed to linger. This further illustrates the

prevailing feelings of personal and professional insufficiency encountered within participants' clinical practice with their clients.

#### **6.42 Sub-theme 2: The Struggling therapist: managing the self**

*'we deal with damaged people a lot of the time and I think  
we get damaged by that sometimes'*

Strong feelings of inadequacy felt by participants led some to doubt their competence as therapists. Six participants described various ways in which they struggled to manage the strong reactions evoked by their clients. They both implicitly and explicitly discussed a number of ways in which they tried to survive these experiences that for some were intense and that for others felt like assaults on 'the self'. These ways of managing for participants often meant surviving the moment to moment experience in the room until an opportunity to reflect could be realised. Tony described the way in which he survived these moments:

*'Its like your hanging onto something a lot of the time, you know, trying to hang onto some construct or idea and not get swept away with what's happening in the room.'* (Tony 618-621)

In the intensity and power of what is going on in the room, Tony needs to hang on for dear life in case he is *swept away*. The *constructs* he refers to seem to represent an anchor to hold him down, to manage these intense feelings by helping him to make sense of his experience. Where Tony finds an anchor in theory, Robert implies a more desperate predicament. Below, he described feelings evoked in himself and illustrated his personal struggle in managing this very difficult experience:

*'A lot of my experience was how...how sort of awful, dirty and disgusting I felt after seeing this patient and never really quite knowing what it was about umm and ahh at one stage*

*sort of thinking...you know...do I really want to do this work.'* (Line 28-31)

Robert's use of the words *awful, dirty and disgusting* suggest that something has got under his skin and infected his very 'self'. He gives a strong sense that he lacks a capacity to manage these feelings leading him to question whether he is cut out for such a demanding job. Perhaps the fantasy of leaving in itself becomes a way in which Robert manages these feelings within himself in the absence of anything else.

Others too described the way in which they were left struggling with their feelings towards their clients. For instance, Tony described conflicting feelings towards his client that led him to struggle to find a way to respond:

*'...cos it's incredibly difficult to say to someone, look, I really do care about you and I'm not just saying that (and I wasn't) but it will be a fucking relief not to ever see you again, you know, do you know what it's like to work with you and I think god, how do you say that.'*  
(Line 506-509)

Here, Tony conveys an almost impossible emotional dilemma. Tony cares for his client, but is worried that his care will be overwhelmed by other, negative feelings that have been left unsaid. In speaking directly with his client within this extract, there is a strong indication that Tony is acutely aware of how his message will be received. For example, he seems to need to reassure both the client and the interviewer that he cares for his client where he says *I'm not just saying that (and I wasn't)*. His need to make this aspect of his message very clear seems to indicate a sense for him that it could become very much lost in the midst of other powerful and opposing feelings. As with Robert's fantasy of leaving, the interviewer gets a real sense that Tony has accumulated these very negative feelings towards his client that until now have remained unspoken. The *fucking relief* Tony refers to seems not just to be about ending with his client but also perhaps in being able to say

something so honest and in a way that provides an avenue to express his own feelings in this relationship. As Tony finds such a message impossible to deliver, these powerful words are left with him to struggle with.

Almost all participants spoke about managing difficult reactions and feelings through the use of supervision. This support offered a way for therapists to think about and make sense of their clients' experiences particularly by reflecting on themselves. For some, this process was described in deeply personal terms. This indicates that the therapist is very much needing to look deep inside themselves in order to make sense of something potentially very deep in their clients. In the following extract, Jon described feelings towards his client that he was struggling to make sense of:

*'I couldn't bear her (laughs), I couldn't stand her and I didn't know why, I liked her, but I couldn't some how, she used to make me angry and I couldn't understand that really and I took it to supervision umm and I realised in the end that I was potentially being quite harmful to her.'* (Line 247-252)

Through supervision, Jon came to realise that there were issues in his early life that have made it difficult for him to work with his 'BPD' client:

*'I had a problem in my early life with my mothers silences and there was just a real transference with her which I couldn't see at all.'* (Line 253-255)

This extract conveys the level of personal scrutiny Robert engages in to manage his feelings when working with his 'borderline' client.

Within these extracts, there is a sense that participants experience a great sense of personal exposure and emotional impact. Furthermore, there is an indication that the therapist must experience and manage themselves in ways in order to be in a position to

manage the very difficult experiences expressed by the client. This is presented in the following sub-theme.

### **6.43 Sub-theme 3: Using the self to manage negative feelings**

*'I needed to stay with her but not go to the hell hole she was in'*

Whilst the previous sub-themes have concerned participants' attempts to manage themselves, albeit feeling totally inadequate at times, the final sub-theme emerged from participants' accounts of how this struggle subsequently enabled them to manage or contain their clients' feelings.

Participants described various ways in which they managed their clients' feelings. Words such as *carrying*, *holding* and *containing* were frequently used to convey this complex relational activity. These words could be as easily used to describe the ways in which a baby is cared for during their delicate and crucial years of dependency. This resembles the ways in which therapists found themselves describing how they managed their clients' experience. The ways in which participants described managing their clients' distress seems to have a different quality than simply providing comfort, as is often traditionally associated with the term 'managing difficult feelings'. There was a feeling of participants getting far closer to their clients' experience, almost getting into their clients' experience to bring about an opportunity to manage.

For six participants, managing their clients' feelings was considered to be a necessary part of the therapeutic task. For Linda, what was of great importance was to manage her client's fear in the absence of her capacity to do so for herself:

*'I wouldn't have been able to stay in that room...bearing in mind she had to stay in the room of abuse, the abuse room...she couldn't switch off...umm...so I think it was really*

*important that I was able to manage my fears about what will I do and...I am going to get her out of this and you know...I did what I did and that worked and we were able to talk.'*

(Line 246-250)

In this extract, Linda is managing her own fear as well as that of her client. Linda's ability to manage this fear on behalf of her client seems to set the client free from an acutely distressing experience (described elsewhere). This extract also conveys how close to the client's experience Linda is prepared to get despite this being a very traumatic experience. Linda seems to imply that her client is reliving an abusive trauma. Although she is unable to reach out to her, resulting in her impulse to get someone who can help, she stays. In a sense, she subjects herself to something akin to her client's experience as conveyed in her solitude, as she tries to reach out to her unreachable client. Indeed, she is feeling very frightened while attempting to manage this highly disturbing experience.

This was similarly conveyed by Robert, who put himself forward as a surrogate for his client's feelings in the following extract, as well as holding onto something of his own anxieties:

*'They need their anxiety to be held you know and that anxiety might be fear that they might kill themselves...they fear that psychic annihilation really...you know... they might disappear or die, cease to exist, all those things they give to you in a fear maybe of death and umm...you know what...to be able...you need to...that's why you hold onto it for so long is because the patient hasn't come to the stage...the insight and the understanding of themselves to understand that they can take that back.'* (Line 260-266)

In this extract, Robert offers a framework to explain his need to manage his client's feelings. He seems to be describing a form of self-sacrifice by the way in which he puts himself forward on behalf of the client. His use of the words *anxiety, fear and death*

powerfully conveys what the therapist is willing to emotionally endure. It is apparent to the interviewer that the participant is describing this task in quite a matter of fact way. What is taken from this is something akin to him being like an experienced parent describing his parenting style. For Robert, *holding* the client's feelings is indicated as a core therapeutic task. Similarly, Jon described the way in which he managed his client's feelings. In this extract Jon doesn't just hold onto his client's feelings but seems to embody aspect of the client's relational world:

*'My own feelings about it in terms of wanting to help and the countertransference that I felt I was receiving...you know...the impact he was making on me and sorting that out...the impact he was making on me was sometimes very difficult...umm you know...I suppose it ranged from; 'who the hell do you think you are looking at me like that' to when he began to look at me at all to yeah, very negative feelings like 'for god sake pull yourself together...you know...stop being such a sniveling little wooss.'* (Line 195-202)

In this extract, Jon embodies someone abusive and aggressive and this becomes more profound as the therapist begins to speak directly to his client here, almost embodying the abuser. The abuser in this extract contrasts with the therapist who is *wanting to help*. However, there is a feeling that these dual roles held by the therapist are sometimes difficult to distinguish. Robert suggests a need to allow *your self to be formed* (Line 110-111) so as to gain an understanding of the client's experience whilst at the same time, as described by others (see below), a need to hold onto the 'self'. In the above quote, Jon becomes a paradox, in that he wants to be close to his client, whilst as the abuser, he wants to push the client away, thus placing great distance between them. This need to hold onto the self in order to manage his client's material is similar to the way in which Linda described her efforts to manage very difficult feelings for her client:

*'I needed to stay with her but not go to the hell hole she was in.'* (Line 245-246)

Implicit in John and Linda's extracts is their reliance on themselves to manage their clients' very difficult experiences. There is a feeling with both that the therapist could become lost or risk becoming consumed by the power of the experiences they confront with their clients. For instance, Linda's reference to *the hell hole* profoundly conveys a sense of being very close to falling, worst still becoming lost from the self into an unbearable, unthinkable situation situated somewhere in her client's psyche.

Other participants described in different ways the emotional demands that became part and parcel of the therapeutic task to manage:

*'You're carrying sort of all that along with the anxiety of them, the possibility of them acting out at the same time, if they're suicidal or self harming or doing all those sorts of things so you're carrying all of that and that's quite difficult, I mean that's one of the most difficult times in the work.'* (Robert, Line 80-83)

Robert uses the word *carrying* twice in this extract to convey the heavy burden he feels, a burden that cannot be put down and which becomes, for him, a preoccupation. There is a feeling here that the therapist has to walk on a tightrope, holding onto the life and death of the client. Robert is left with the uncertainty that his client might harm herself or worse still, kill herself. In this respect, holding this anxiety appears to be implicit in the work and in itself becomes something to be managed by the therapist.

## **6.5 Master-theme Three: Struggling within the working context**

When discussing their experiences of working with 'borderline' clients, it was apparent that all participants did so in relation to the working context. Participants described their experiences in a number of ways, relating their experiences of working along side other professionals involved in the care of their clients, of providing therapy to 'borderline' clients within the NHS, and their experiences of working alongside alternative frameworks.

The previous sub-theme focussed on the struggles, dilemmas and difficulties participants were confronted with and felt they needed to manage. These emotional struggles arise from both clients and therapists with a constant tension between participant's perception of themselves as lacking and the emotional demands of the client. Within the following master-theme, the feeling of lack is revisited in relation to participants' experiences of the working context.

#### **6.51 Sub-theme 1: Struggling within a multidisciplinary team**

*'One way of dealing with it [the client] basically, it was oh rights, over to you, you have them'*

The theme of lacking something essential, identified in the previous master-theme, also extended into participants' experiences of working alongside fellow professionals within multidisciplinary teams. Arthur located his feelings of inadequacy and a sense of feeling constrained within his relationships with professional colleagues:

*'My greatest difficulty in working with borderline personality disorder is not the patients, it's the mental health services and liaison with other workers.'* (76-78)

There was a sense here that the relationship between Arthur and his colleagues was a real struggle when it came to issues around his 'borderline' clients. Whilst the exact nature of the difficulty Arthur refers to was not clear, Jeanette was more explicit about the difficulty

she experienced with her colleagues in the following passage:

*'I think mental health services umm need to understand that this is part of somebody's internal stuff really, is the reason why they are acting in a certain way and then to be able to work with that rather than to be seeing them as attention seeking you know, quite routinely that sort of language can be used.'* (560-565)

In the above extract, Jeanette suggests that her colleagues lack a particular understanding of 'borderline' clients. She indicates that this lacking in understanding manifests in terms of the narrow ways in which her colleagues respond to 'borderline' clients. The implication that they are not able to work with a wider understanding suggests that what they do can become limited or even unhelpful. Jeanette finds her colleagues responding at a more superficial level that focusses on behaviour, but appears lacking in thought or empathy.

Jeanette's experiences of colleagues seemed to mirror the experiences of other participants. Their discussions around this theme tended to focus on the unhelpful attitudes of professionals. For instance, they described colleagues suggesting that clients should *pull themselves together*, or that clients were deliberately behaving in a particular way. I would suggest that these attitudes could be understood as rejecting and dismissive almost as if colleagues are pushing clients away without thinking a great deal beyond their initial presentation. Perhaps this narrow framework is a way in which professionals can protect themselves from a feeling of lacking in something helpful. The focus on the behavioural as a way that perhaps protects the professional but feels very distancing for the client, was implied in the following extract by a client who fed back her experience of professionals in response to her self-harming:

*'She said that when she was talking with her care coordinator, they'd asked her about the cutting but actually they couldn't give a toss about her, all they were interested in was the cutting.'* (Arthur, line 303-305)

Arthur takes from his client's feedback, that what his colleagues are *interested in* is narrow and ignores the person of the client. In Arthur's words they *couldn't give a toss* potentially conveys the client being tossed aside, by the professional. Arthur took this further in the following passage:

*'The majority of the staff do not see people with personality disorders as legitimate patients...so there is a real difficult job in having some kind of multi-disciplinary team work that is containing for the patient umm where a large number of staff think...a...their not a proper patient to start with and they shouldn't be getting mental health services...umm...that's one bit and also kind of linked to that...a very...I think moralistic attitude that they bloody well need to pull themselves together'* (Arthur, 80-86)

For Arthur, colleagues do not even see 'borderline' clients as having a legitimate need that can be responded to by Mental Health Services. In this passage, he indicates something of the challenge this presents when working within a team supporting 'borderline' clients and the conflicting views that are likely to feature.

Not only are clients *beyond help*, they are not even deserving of help according to Arthur's experience of some of his colleagues. This seems to indicate that they are relating to the diagnosis rather than the clients themselves. Within participants' accounts, other professionals lack a framework that is helpful and that facilitates an understanding beyond the initial presentation of the client. Instead, the framework may be used to distance, dismiss and even reject the needs of the client. Within this theme there is a great sense that colleagues push clients away, perhaps in response to feeling deskilled or ill equipped to respond. This is particularly evident in Arthur's account when discussing his experience of a psychiatrist:

*'I know on other occasions, he felt quite helpless with personality disorders and he said quite openly, he just didn't know what to do with them.'* (Line 350-352)

Here, the psychiatrist articulates his feelings towards his 'borderline' clients to Arthur.

These feelings of helplessness, and his difficulty knowing how to respond, mirror those

feelings reported by participants in the previous master theme. They perhaps also resemble the feelings of colleagues who promote the kinds of attitudes and reactions talked about within the present section. Professionals seemed to respond in a variety of ways to their sense of helplessness and lacking. In addition to professionals pushing clients away, some participants felt that clients were pushed back onto the therapist to manage as described in the following quote by Joanne:

*'I've had them not wanting to know, that you know the patient, you're the best one to deal with it, I've had difficulties getting people taken on by the crisis team so it's a very mixed response.'* (Line 237-239)

and:

*'I mean, not always but the sort of response will umm almost; what do you expect us to do'* (Line 247-248)

This leads the therapist into feeling very much isolated and unsupported in her work with colleagues. Joanne is left to manage not only her client's distress but perhaps hold those feelings that are particularly difficult for colleagues to manage themselves – helplessness and a sense of lack. This is an enormous task for the therapist, one that can be seen to underpin Robert's view that *'its important not to be isolated'* (line 150).

It follows that this helplessness, this sense of lacking among colleagues, becomes directed at the therapist. There is a sense that someone must be responsible. This seemed to be the case for Arthur. During his interview, he discussed how he visited a client on the ward to provide consistency and worked in a way to provide a *'calming function'* for his client in crisis. In doing so, he described a situation where he felt blamed for his client's deterioration:

*'So the story grew that I'd stirred her up and then she created trouble on the wards'* (Line 156-157)

Here, Arthur refers to the perceptions of his colleagues towards him in response to his distressed client. This passage conveys how, in his experience, colleagues attribute him with a great sense of psychological power to influence the way in which the client presents. It also suggests that Arthur feels that he is seen as responsible for his client's distress. His use of the words *story*, *stirred* and *created* suggests something of almost mystical power that the therapist holds. That he too, like the 'borderline' client, has perhaps become very much misunderstood.

## **6.52 Sub-theme 2: Providing therapy within an impoverished Mental Health**

### **Service: reconciling impossible opposites**

*'We have a lot of things to think about other than patients'*

Six participants discussed their experiences of working with their clients within a Mental Health Service. These experiences were discussed in various ways with a particular focus on the impact of an impoverished service. Within this theme, participants conveyed a great sense of feeling limited in what they could offer their clients within an NHS setting. Without exception, this experience of feeling that what was offered was not enough was conveyed through the concept of time. Robert described this experience of working within these constraints:

*'It's a lifetime you're trying to resolve, you know, its very slow work umm and I suppose feeling that everyone understands that sometimes it's quite difficult so umm particularly sometimes being rushed to finish a piece of work'* (Line 126-129)

Here, Robert conveys the impossible predicament he faces, in meeting a *lifetime* of his

client's unresolved needs whilst fulfilling the expectations of his service. Initially in this quote, Robert used the words *lifetime, resolve and very slow work*. Independent of any contextual pressures, these words indicate the very difficult task this therapist is faced with. Having to rush to resolve a lifetime suggests that within this context, the therapist is inevitably set up to fail. The *everyone* he refers to is not revealed here but there is a sense that pressure is coming from all directions, the Mental Health Service, his colleagues, his client and himself.

Further on, Robert described the way in which he attempts to reconcile these impossible opposites, finding a way to negotiate the tensions between his duty of care for his client and the guidelines set out by which he has to work:

*'I'm sure I'm going over some of the guidelines with how many sessions you can offer borderline personality disorder patients here. I'm sure I've busted my limit (laughs).'* (Line 139-141)

In this passage, Robert is caught between a number of opposing needs – his professional autonomy, his duty of care for his client and the guidelines set out for him by the service. His use of the term *going over* suggests Robert has gone beyond the limits of what he can do. Yet he finds himself giving more in an attempt to cope with his own sense of feeling limited. Perhaps these external limitations set out by the service tap into the therapist's sense of himself as limited, of feeling that what he gives his client isn't enough. Robert responds to this feeling within him self by *going over*, perhaps giving more. His use of the word *busted* within this context could refer to busting a gut, working flat out.

Joanne, while engaging in the same impossible dilemmas as Robert, responded to these feelings quite differently:

*'I just feel limited all the time...I mean...I'm just about to discharge somebody at the moment who feels that she's gained a lot from therapy but I mean...understandably does not want to leave and in my heart of hearts I feel...no...you're using it...I think you could really work well for maybe another year...maybe longer you know... there's been a lot of damage...but I know I've got to discharge her...I don't have a choice...that we can't hold onto people in the current climate and actually its quite sad both for me and the client.'*

(Line 194-200)

The first part of this passage perhaps crystallises more explicitly Robert's message in the previous extract. This section in isolation doesn't give an indication as to the origins of Joanne's *limited* feeling. Further on in this quote, it becomes clear that Joanne feels this way because of the artificial limits being imposed on her work. It also seems to resonate with her own sense of feeling limited. *All of the time* implies that regardless of time, this feeling is experienced, and runs very deeply indeed for her. Joanne goes on to compassionately describe her impossible predicament. Her use of the words *heart of hearts* suggests a real sense of closeness, even a maternal closeness with her client. It feels as if the client is almost being torn away from her, as if Joanne was holding onto what *we can't hold onto*. This closeness feels even more pronounced as she begins to address her client directly in this passage. These words remain unsaid to the client and in this respect the service comes to represent something restraining and imposing, something that takes over the autonomy of the therapist and leaves her feeling inconsequential. Joanne conveys a strong sense of powerlessness in this extract, and a compromise on her professional and personal autonomy. Above all, this extract echoes the experience of feeling that what is offered is not enough. Jon similarly implies this in the following extract:

*'I mean in the NHS, I think treating borderline personality disorder in the NHS although*

*quite courageous...I'm not sure its very helpful to see them once a week, it's a dilemma I think about between the real needs of the person'* (Line 41-46)

Here, Jon highlights the disparity between the needs of the client and what can be offered in the NHS. His use of the word *courageous* within this context implies that success is perhaps an unlikely outcome. His use of the words *real needs* suggests that this is not what directs treatment in the NHS. Treatment decisions are instead guided by something artificial and are incongruous with the needs of the client. Furthermore, implicit in this passage is an inconsequential therapist, practising on a leap of faith, but restrained in providing something that is very much needed. Jon's experience of the Mental Health Service as lacking is further conveyed through his experiences of working with clients on a private basis:

*'I see much more success with borderline personality disordered people in my private practice where I am able to see people more than once a week.'* (Line 50-52)

and:

*'So I'm not sure it would work if we were in the NHS and you were able to see people for twelve years (laughs) then maybe there would be a possibility but normally it's about a year, I mean this guy wouldn't have stood a chance I don't think.'* (Line 183-186)

In these two extracts, Jon discusses the differences between what he is able to provide his clients in his private practice and what can be provided in the NHS. Jon begins to talk much more in the first person in these extracts. This conveys a sense of ownership, autonomy and empowerment and contrasts with the therapist who feels limited in what he/she can offer (as described in previous quotes). Within his private practice, Jon is not faced with his limitations in quite the same way, having instead what feels like the luxury of time.

Participants seemed to respond to these time constraints in a variety of ways. Robert responds by going over his limit. Joanne responds by complying, feeling limited and becoming a limit. For Jon, he doubts he would engage in this work within an NHS setting. Perhaps his private work provides some compensation for the sense of lacking he is faced with in the NHS. This is also the case for Joanne, who described what she was able to do in her private practice and contrasted her experience of this with the NHS:

*'...something about freedom...working privately in terms of how you set up the therapy and of umm how you can change the frequency of the session and really how you hold the frame and how you can make adjustments to the frame...its not entirely within your own remit and you can spend as much as you like actually reflecting on the session and if you don't know you've got a client that is more demanding...more challenging...you don't have to book somebody in straight afterwards...you don't have to see everyone on the hour and umm...it's a bit of a conveyer belt in the NHS.'* (Line 355-342)

In this extract, Joanne appears to indicate how constrained she feels in the NHS. These constraints impact both on her client and her capacity to reflect on her practice. She implies that the quality of her work is compromised in the NHS and suggests less opportunity to look after her self, as indicated in the lack of thinking time. This is contrasted with *as much as you like* referring to the luxury of time but also the necessity of time to take care of herself and her patient in her private practice. This further conveys a great sense of impoverishment in what the Mental Health Service can provide as described by Joanne.

### **6.53 Sub-theme 3: Struggling with Diagnosis**

*'I've got theoretical things going on in my head when I*

*think about it and I don't like that because it means I'm  
trying to fit people into that category' (22-24)*

Perhaps it was no surprise that the sense of lack and inadequacy that participants described in relation to themselves, professional colleagues, and the Mental Health Service should extend to issues of clinical diagnosis. Almost all participants described an uneasy relationship with the diagnostic term: 'Borderline Personality Disorder'. In particular, participants described the way in which the diagnostic term was used and in many cases misused. What was particularly striking was that participants tended to introduce this difficult relationship with diagnosis very early on in their interviews. They then proceeded to provide very rich accounts of their work with clients diagnosed with 'BPD'. Perhaps this acknowledgment too reflected the way in which the diagnosis was handled within therapists' work, that is, that it was set aside before proceeding with the complex and unique work with clients. This was illustrated in the following quote within the first few sentences of John's interview:

*'I would say first of all that the diagnosis borderline personality disorder...I'm not sure its something I work with or not...umm...I know people are diagnosed with borderline personality disorder...I tend to see people really with mental health problems.'* (Line 8-11)

This extract shows a rather uncertain therapist, uneasily thinking about the place of diagnosis in his work with clients. He certainly seems to suggest an uneasy relationship with the diagnosis. Within this extract, the therapist acknowledges the presence of a diagnostic system with which he is vaguely affiliated but the suggestion is that this is not something he subscribes to or relates to directly within his clinical practice. Instead, he introduces his particular framework for understanding mental health problems through his direct experience of working with clients. Implicit in this extract is the sense that, for others, the diagnosis somehow takes over what is seen. The *people* he refers to in this

somehow get pushed aside by the diagnosis. Jon took this further in the following passage, implying that the diagnosis has engulfed the person, as it is the label that professionals begin to relate to:

*'I suppose that the label, borderline personality disorder doesn't does it...I was going to say, it doesn't scare me, it scares quite a lot of people, it doesn't tell me much about the patient in my experience, it doesn't tell me much about the internal world of the patient.'*

(11-15)

Implied in this quote is that the person becomes very much fused with the diagnosis. Jon indicates that this view taken by some focusses only on the external appearance of the person, suggesting a superficial view lacking in depth or concern for the client's *internal world*. Furthermore, it precludes the possibility of thinking about the person beyond the diagnosis. Seeing the individual as a 'borderline personality disorder' therefore seems to give rise to a range of possible feelings, including fear as illustrated in the above extract. In the following passage, the label attracts other responses that appear to feature irrespective of the person behind the diagnosis:

*'You hear lots of clinicians you know, oh, you can never do anything with borderline personality disorder, you'll never sort them out and I just think umm (clients name removed), I think about him, and I think that's wrong actually.'* (Jon, Line 160-163)

Within this extract, Jon thinks about a specific person with whom he has worked to evaluate the perceptions of his colleagues. Jon offers a perspective born from direct experience that feels closer and therefore more meaningful. Again, Jon implies that the way in which 'borderline' clients are conceptualised is distancing and dismissive of the person, and therefore limits thinking beyond the diagnosis.

It was Arthur's experience too, that the label evoked particular views that were detrimental to the person beyond the diagnosis. In the following extract, Arthur described the way in which 'BPD' was conceptualised by a fellow colleague:

*'I remember one team I was in, a very good worker saying...well for me...you know, the main thing I try to distinguish is between the mad and the bad and I'm afraid I think in that demonology, borderline personality disorder is often in the category of bad.'* (Line 381-384)

His use of the word *demonology* implies an association with a devil – that 'BPD' is devilish, evil and, beyond the forces of help. It followed that for participants, the diagnostic label seemed to promote a way of thinking about clients that was narrow, limiting and could clearly be seen as rejecting of the person. Furthermore, as implied in the above extract, could be potentially damaging. It seemed understandable that Arthur's ambivalent relationship with the diagnosis made it difficult to work with:

*'The term borderline personality disorder is an unfortunate one and I don't find it easy to deal with patients directly using the term'* (Arthur, 531-532)

In acknowledging how his own relationship with the diagnosis impacted on the way in which he responded to clients given this label, he and Jan too considered how their professional colleagues' relationship with the diagnosis impacted on their responses to clients:

*'I think that one element to the punitive attitudes towards borderline personality disorder is because people often don't respond in any central way to medication and I think that may be an element in this case, a wish not to have this women on the books of this particular team because they worry that their normal repertoire may miss her needs.'* (Arthur, 354-358)

and:

*'You see, BPD's don't respond to medication very well, you know they just get the sedative effects to start with and oh, that's fine then, and then damn it, a couple of weeks later and I'm still not well, so you know, general psychiatry doesn't help them a great deal in that sense, so I guess that that's quite frustrating to the kind of nurses and the doctors, the idea that somehow they can help these people to make them better.'* (Jan, Line 326-331)

Arthur's passage brings to mind a previous sub-theme, 'the struggling therapist, managing the self'. This sub-theme outlined the various ways in which participants struggle in their work with their clients and also the ways in which they attempted to manage themselves in these very difficult situations. Here, I think Arthur is similarly considering the struggles of the psychiatrists, when they too are stripped of their usual mode of treatment. Here, Arthur

suggests that his colleagues respond in a way that is punishing to the client. In this case the client is rejected from the service as he/she doesn't fit the medical model framework. Jan also discussed this in her interview. She too considers the frustration for colleagues whose framework for helping clients rests on the assumption that they will respond in a particular way and that they will get better.

## 7. Discussion

### 7.1: An overview of the results

Through the process of investigating therapists' experiences of working with people diagnosed with 'BPD' using IPA, three main themes depicting the experiential concerns of participants were identified. These were: a) Recognising the borderline signature; b) The borderline relationship: the emotional impact; c) Struggling within the working context.

This chapter will first review the three main themes and their sub-themes. A discussion of selected sub-themes will follow with an aim to consider these in light of existing findings.

The first main theme referred to the various ways in which participants detected the presence of 'BPD'. The majority of participants found the formal diagnostic category problematic and instead based their conceptualisations on subjective and experiential notions of 'BPD'. Therapists recognised the presence of 'BPD' in terms of how they were feeling and how they found themselves responding. Participants seemed to describe their experiences by paying particular attention to the way they felt, both emotionally and physically, when faced with a client. Terms such as '*jarring*', '*invaded*' and '*palpitations*' were used to describe intense and uncomfortable feelings that conveyed a sense that the client was trying to get inside the therapist. A sense of confusion and disorientation seemed to emerge from these assaults on the self. In the face of these experiences, some therapists found themselves psychologically retreating as indicated in their descriptions of feeling '*switched off*' and '*bored*' in response to the perceived emotional neediness of their clients. These intense emotional experiences left some feeling unable to respond to their client, stripped of their personal and professional competence but

needing to keep trying.

This led to a second distinct but related sub-theme: The borderline therapist; losing touch with the self. Here participants described the ways in which they found themselves psychologically coerced into thinking, feeling and behaving in particular ways. In a sense, they did not seem to recognise themselves. These descriptions took the previous sub-theme further, from the idea that something is trying to invade, to something alien had penetrated the self of the therapist. Therapists found themselves oscillating between feelings of closeness to feelings of wanting to get away from the client, thus conveying an internal battle with the self and the internalised 'borderline' client. These feelings left the therapist questioning their self-experience in terms of which feelings belonged to them and which belonged to that of the client. This '*merging*' described by one participant illustrated a sense that the 'borderline' client has found a home in the therapist.

This psychic breach extended beyond the therapeutic hour with many participants describing the ways in which their clients seemed to live on inside of them. This third sub-theme: The unforgettable client - referred to the ways in which clients were remembered on a deeply personal level. These types of clients seemed to have a distinct striking presence that made them so memorable. The client was seen to evoke feelings of intimidation, accountability and responsibility. The therapists' experience of themselves as limited and powerless in their work with clients produced something of a psychic scar. The client seemed to reflect a profound experience of themselves as lacking and similar traumatic feelings seemed to get lodged into the therapist beyond the life of their work together.

The second main theme: The 'borderline' relationship; the emotional impact - referred to the ways in which therapists described their experiences of working with clients with a particular focus on their emotional reactions. The first sub-theme referred to therapists'

experiences of themselves in response to their work with these particular clients, i.e. feeling inadequate. This was conveyed by a number of participants who described feelings of uncertainty and helplessness in response to their clients who were at risk of self-harm and suicide. The language participants used to describe themselves included '*pathetic*', '*I know nothing*' and '*I don't feel able*'. Despite the years of experience of working with this client group, participants continued to experience these profound feelings of lacking something essential, and appeared so critical of themselves in response to this sense of insufficiency. These feelings appeared to refer to a need for something greater than a professional competence but what they felt was a deeply personal sense of lacking. Participants described various responses to their feelings. For one participant, this involved adjusting his practice in a way that felt safer but also compromised his authentic self in practice. Others described a sense of looking deep within themselves in the hope to find this essential something that never surfaced.

It followed that participants were left struggling to manage these profoundly lacking feelings evoked by their clients. Some participants conveyed how they would struggle with these feelings by describing their internal experiences during their sessions with their clients. This personal struggle was conveyed in various ways. Some participants spoke about their attempts to hang onto something external to the therapeutic relationship in an attempt to survive the intensity of their experience. For example, one participant described hanging onto a theoretical construct so as not to get '*swept away*'. Another described hanging onto the prospect of ending with the client to bring about relief from his negative feelings towards him/her. These inadequate feelings led some to doubt their professional competence. Supervision was highlighted by a number of participants as an essential part of managing their personal struggle. An openness to looking deep within themselves was implicit in participants' descriptions, in an attempt to facilitate insight into these often

confusing experiences. Whilst this sub-theme centred around participants attempts to manage themselves despite at times feeling totally inadequate to do so, the next sub-theme concerned how this very struggle gave rise to what was considered an implicit part of the therapeutic task, i.e. using the self to manage the difficult feelings of the client.

A number of participants used words such as '*containing*', '*holding*' and '*carrying*' which seemed to convey a sense that some capacity within their clients was suspended and needed to be held. Participants conveyed their experiences by describing specific instances in their work with their clients. There was a sense of going beyond managing negative feelings. Instead participants conveyed a sense of getting inside the client's world whilst holding onto themselves. There were indications of sacrificing themselves, becoming what their clients needed them to be in any given moment. One participant likened himself to the client's abuser, perhaps as a way to bring about understanding of the client's experience. Another described the use of herself to manage her client's traumatic experience during a session. Implicit in all participants' descriptions in this theme was a concern with 'being' with the client rather than 'doing' something to the client. The use of the therapist's self was considered central to this therapeutic task.

Also indicative in participants' accounts of their work with clients diagnosed with 'BPD', was the frustration and dissatisfaction with particular aspects of their working context. The first of these themes was concerned with participants' struggle with professional relationships. Many described a lack of understanding by other mental health professionals and the use of sometimes derogatory terms such as '*attention seeking*', '*not a proper patient*' and how they should '*pull themselves together*'. This led some participants to believe that input by other professionals was often short sighted, limited or even unhelpful. This theme highlighted the experience of working alongside other frameworks and the tensions between these. For instance one participant talked about his

nursing colleagues tendency to focus on behaviour at the expense of attending to the client's emotional needs. Others observed how their colleagues also felt limited and deskilled in responding to their clients. Unsurprisingly, it followed that participants experienced clients with a 'BPD' diagnosis being pushed away and often left for the therapist to manage. This resulted in participants feeling marginalised, responsible and misunderstood echoing the very experiences of their clients.

Therapists' struggle with professional colleagues also extended to their struggle with limited NHS resources. These were not considered adequate for the needs of their clients. A disparity between the needs of the clients and the expectations of the service were reported by a number of participants. Therapists reported a lack of professional autonomy and feelings of powerlessness when working with their 'BPD' clients. These contextual pressures appeared to reinforce a sense of feeling limited in what they could offer. Limited time also impacted the therapists' opportunity to look after themselves and reflect on their practice, an activity that was deemed crucial as demonstrated in the previous main theme. Some participants referred to time as a luxury and described more promising conditions in their private practice where professional autonomy and intuitive practice could be more readily harvested.

Participants' uneasy relationship with the working context also extended to their relationship with the diagnosis itself. A number of participants described a difficult relationship with the diagnosis. Working alongside this framework evoked uncomfortable feelings. The diagnosis was seen as narrow in what it could tell the therapist about the person with the label. Other participants felt that the diagnosis was a term that was often misused to describe difficult clients and therefore a means of inciting negative views.

## **7.2 An exploration of Selected Themes in light of existing findings**

A deeper exploration of selected themes will now be presented with a view to consider

how the present study compares and differs from existing findings in the literature.

Although all themes represented the concerns of participants, selected themes will be discussed due to word constraints. The themes selected for deeper exploration were chosen on the basis that they featured heavily across participants' accounts and revealed interesting differences in light of existing research.

### **7.3 Master-theme 1: Recognising the Borderline Signature**

#### **Sub-theme 1: Identifying the Borderline Client through the self: Special Rules Apply**

A number of participants expressed some difficulty in accepting the formal diagnostic category of 'BPD'. This difficulty was articulated for some in terms of the diagnosis not being able to inform the participant about the subjective world of the client. Some participants spoke of electing not to use the term whilst others commented on the negative connotations associated with the label. Rather than relying on standardised diagnostic criteria such as DSM-V, therapists appeared to recognise the presence of 'BPD' experientially, via their emotional and physical reactions and in terms of how they found themselves responding to their clients. This study did not attempt to determine the accuracy of participants' notions of 'BPD'. However, subjective descriptions resembled some aspects of the formal diagnostic criteria. The descriptions set out in DSM-V include 'inappropriate anger', 'affective instability', 'identity disturbance', 'unstable self image/sense of self' and 'recurrent suicidal behaviour'. An example of the way in which participants' subjective experiences were consistent with this criteria can be demonstrated with an extract taken from Jan. This resembled criteria 8 'inappropriate anger' described by Jan as:

*'It almost felt like it was a whack, an emotional whack to me...there was this absolute fury and rage.'*

In this extract, Jan relies on her felt experience to detect the presence of her client's intense anger. This is in line with Brandshaft and Stolorow's (1984) observations. They suggest that *'when the needs [of the borderline patient] are not recognised, responded to or interpreted empathically, violent negative reactions ensure'*. This suggests that Jan could have been experiencing her client's hyper-sensitivity to relational stimuli. This was experienced both physically and emotionally for her and formed the basis for identifying the presence of 'BPD'.

Overall, these findings highlight participants' reliance on their felt experiences to facilitate an understanding of their clients' emotional experiences. Their experiences form part of an informal diagnostic process, in detecting the presence of 'BPD'. These findings demonstrate the importance of subjective measures in identifying the presence of 'BPD' and may call into question the applicability of the DSM-V for psychotherapists in this study. These findings may also imply that the medical model, aligned to a positivist epistemological position, may not be an adequate framework from which to inform participants about the subjective world of the client. Many participants expressed difficulties using the diagnostic label and all participants drew on alternative ways in which to make sense of their clients' experiences. This limitation of the DSM-V diagnosis is further endorsed by evidence showing high rates of comorbidity. For example, Kreisman and Straus (1989) found that 90 per cent of clients diagnosed with 'BPD' also had other diagnoses.

Given that there are 93 different combinations of the diagnosis (Stone, 1991), it follows that alternative strategies may help overcome difficulties inherent in the current system of classification. The findings in this study are also in line with Miller's (1994). He argued that the diagnostic criteria set out in DSM-V only provides a partial view of a person's

difficulties and called for the implementation of subjective measures as these could reveal important information about the internal world of the client. In turn, this could facilitate a deeper understanding of the client's emotional world and facilitate a better therapeutic relationship.

All participants in the current study drew on their subjective experiences to detect the presence of 'BPD'. Meanings of these experiences were conveyed in both emotional and physical terms. For example, some therapists described a sense of feeling 'invaded' as if the client was trying to get inside them. The 'borderline' client was felt through the 'self' of the therapist in a way that, for some, felt violating, overwhelming and impossible to respond to. These experiences are similarly described in the psychoanalytic literature (e.g. Holmes, 1999 and Kernberg, 1975) where the rapid onset of intense emotions in the 'borderline' client can leave the therapist feeling 'paralysed' to respond. Within the current findings, it seemed that participants were referring to experiences akin to those of the client. These internalised feelings enabled participants to recognise the presence of these experiences in their clients. The presence of 'BPD' was also detected in the body via physical sensations. Van Manen (1988) suggested a tendency to become aware of our bodies when we feel physically unwell. With this in mind, the results would suggest that the body becomes a source of information that detects the presence of 'BPD'. On reviewing the literature, no research was found that focussed on physical reactions of therapists working with this client group. This interesting finding would require further research.

In order to draw general conclusions about the utility of an emotional and physical template to identify the presence of 'BPD', it would be useful to investigate the experiences of other clinician populations using an idiographic approach. An interesting finding from a quantitative study (Betan, Heim, Conclin and Westen, 2005) found consistent countertransference reactions among therapists from a variety of theoretical

orientations in response to case vignettes. However, these findings differ from other studies that point to differences in responses across clinician populations (e.g. Commons et al, 2008). Qualitative research, with its ability to provide in depth accounts, is lacking and could help uncover the nature of these variations.

Furthermore, it would be useful to make comparisons with other clinical populations (for example, depression) to determine the specificity of reactions between various clinical groupings. McIntyre and Schwartz (1998) study found that distinct clinician reactions were identified in response to clients diagnosed with 'BPD' and those diagnosed with depression. This may further endorse the current findings pointing to the potential for subjective measures to produce consistent and useful strategies to identify differences across different client populations. However, to date there is a paucity of qualitative research investigating these differences.

In response to the perceived emotional neediness of their clients, therapists described the ways in which they found themselves shutting down both emotionally (e.g. feeling bored) and physically (feeling tired). The importance of therapists monitoring their reactions in this way has been well documented in psychoanalytic writings. Within this framework, these reactions are understood in terms of countertransference. This use of the therapist's self serves as a source of information about the client's internal world (Gabbard, 2001), which contains representations of self and others. Within an object relation's framework, early relationship patterns are reactivated in the context of a therapeutic relationship and arise in the transference. This suggests that participants' feelings of being taken over may indicate something of their clients' own early relational experiences of being taken over or dominated by caregivers. Similarly, feelings of boredom and switching off in the face of the perceived demands of the client could indicate something of an emotionally unavailable and unempathic parental figure. Interestingly, similar themes were identified in

a study investigating clients' personal meanings of suicide through the voices of psychotherapist participants (Richards, 2000). Themes identified were considered within a psychodynamic framework. Within this study, a theme of 'invasion/engulfment and abandonment' was identified. This theme referred to experiences of suicidal patients who experienced one or more parents as over interfering in a way that was more about the needs of the parent than those of the child. This was understood as a form of abandonment. In the current study, feelings of being taken over, and in the face of these intense emotions, feeling shut down, could be seen as mirroring early relational experiences. Furthermore, these findings are consistent with the themes identified in Richard's (2000) study. However, Richards (2000) investigated suicidal clients and it was not clear in the current study whether participants were referring to clients with suicidal tendencies.

Other research consistent with the current findings was that of McIntyre and Schwartz (1998). They used a quantitative method to investigate 155 psychotherapists' experiences of working with clients diagnosed with 'BPD' and identified a tendency for clinicians to emotionally distance themselves from this client group. This current study goes further to indicate what therapists may be withdrawing from, that is a sense that the whole self is being taken over. These findings suggest that working with these types of clients can present the therapist with significant challenges. Within participant descriptions, the 'borderline' client appeared to represent a serious threat to the self of the therapist. Shutting down or switching off could be understood as an inbuilt mechanism that protected the therapist from this psychological invasion. Participants were left experiencing a great sense of emotional impotence, an internal void and, as conveyed by a number of participants, a sense of having nothing else to give.

These findings highlight a difficulty of working individually with clients diagnosed with

'BPD'. Furthermore, these results imply a limitation to the therapeutic approach employed by participants. This perhaps endorses the need to consider wider systems of support in conjunction with individual therapy when working with these clients. Kreisman and Straus (1989) among others highlight such difficulties inherent in working individually with this client group and highlight the benefits of a psychodynamic group therapy approach. They suggest that this can serve to moderate the intensity of emotions that, in a one to one therapeutic relationship, can feel overwhelming and difficult to respond to. Bateman and Fonagy (2006) similarly demonstrate the utility of group-based treatment for clients diagnosed with 'BPD'. They provide strong evidence for the efficacy of an eighteen month intensive day program, using a modified psychodynamic approach, namely Mentalisation Based Therapy.

Overall, the results in the current study are in line with other findings, that working with the clients under discussion is emotionally demanding and challenging (e.g. Commons Treloar, 2009). Furthermore, that working therapeutically with this client group evokes specific reactions that can serve to inform the presence of 'BPD'. Results from the current study provide a more detailed account as to the nature of these emotional demands as well as highlighting some difficulties in working on a one to one basis with these individuals.

#### **7.4 Master-theme 2: The 'Borderline' Relationship: The Emotional Impact**

##### **Sub-theme 1: Feeling inadequate in their responses to their patients**

Within participant interviews, frequent references to feelings of inadequacy were made. These experiences have been widely reported in clinical illustrations (e.g. Adler, 1975, and Holmes (1999). In addition, Mohoney (1991) reviewed the literature and identified themes of self-doubt and self perceived incompetence to be a widespread phenomenon among psychotherapists. This study replicated findings that feelings of inadequacy are

independent of clinician experience (Orlinsky et al, 1999) but results were not specific to working with 'borderline' clients. The current findings also resonate with views offered by Kernberg (1975) in his extensive writings about 'BPD'. He suggests that regardless of experience, all therapists are likely to doubt their professional competence when working with 'borderline' clients. Indeed, feelings of inadequacy led some to question themselves both professionally and personally.

Linked to these feelings, participants described experiencing helplessness, and a sense of feeling responsible for their clients' distress. For some, these experiences were particularly pronounced in response to clients' self-harming and suicidal tendencies. These findings contradict previous evidence revealing negative and derogatory attitudes towards clients who self-harm (Alston and Robinson, 1992). In the current study, critical feelings were instead directed towards the therapist him or herself. Further differences were also revealed when comparing the current findings with previous research. For example, Alston and Robinson (1992) found clinicians to be lacking in empathy in response to self-harming behaviour. In the present study, frequent references were made that conveyed an empathic approach among participants. These results support the findings that differences exist between clinician populations in their attitudes and responses to self-harm (Commons Trelour, 2008).

However, results from the present study were in line with some qualitative studies that investigated the experiences of therapists working with clients considered to be self-deceptive (Westland and Shinebourne, 2009) and therapists' experiences of working with suicidal patients (Richards, 2000). In both studies, participants reported feelings of inadequacy, self-doubt and a sense of failure in response to their work with clients. However, these results differed from the current study in that sources of inadequacy were seen as arising from their work with clients in response to particular client behaviours and

tendencies (i.e. self deception and suicidality). What was apparent in the current study was that therapists' feelings of inadequacy arose in response to a personal sense of felt insufficiency.

When describing personal feelings of inadequacy in this study, participants seemed to be trying to articulate a profound sense of personal insufficiency. These feelings seemed to be evoked in response to the level and intensity of their clients' emotional needs. Phrases such as *'I don't know how I'm supposed to...'*, *'I don't feel able...a good enough person'* and *'it seemed so pathetic in the face of what I was feeling'* conveyed a grave sense of human insufficiency on the part of the therapists. These reported experiences resonate with the existential notion of a 'bottomless emptiness' proposed by James Park (1971:77). According to Park *'this devastating existential hollowness and screaming internal void is really an encounter with our existential predicament'* (1971: 77) With this notion in mind, participants' sense of lacking something essential has flavours of this deeply troubling existential dilemma.

Participants' feelings of inadequacy also point to established psychoanalytic concepts such as projective identification (Klein, 1946). This is considered to be a commonly employed defensive strategy among 'borderline' clients in an effort to rid themselves of unbearable feelings. This concept was later extended (e.g. Bion, 1959) to refer to how these intolerable feelings were placed into the therapist who then identified with them. The therapist is subsequently nudged into thinking, feeling and responding in particular ways. Many writers (e.g. Kernberg, 1975) have referred to the tendency for 'borderline' clients to project feelings of hopelessness into therapists. Within this framework, participants' intense feelings of inadequacy, helplessness and accountability may reveal something of their clients attempts to rid themselves of feelings that cannot be tolerated within themselves. Therapists in the current study identified such feelings within themselves.

Moving onto the next sub-theme, therapists attempted to manage these difficult feelings, albeit at times feeling totally unable to do so. It was felt that this struggle became stimulated in response to feelings of inadequacy arising within the context of their work.

Feelings of inadequacy felt by experienced clinicians working with clients diagnosed with 'BPD' in this study may have important implications for understanding other clinicians.

Questioning one's own professional competence has been identified as a major cause of stress in psychotherapists (Mahoney, 1991). Furthermore, these feelings are considered potentially damaging for practitioners and can negatively impact on their work with clients (Orlinsky, Howard and Hill, 1975) as well as affect their personal lives (Guy, 2000).

Despite these important implications, this area remains under researched. Within the current study, a number of therapists highlighted the importance of supervision. However, results highlighting an impoverished NHS may imply that the provision of personal care for practitioners may not in itself be adequate. Indeed one participant described explicitly how the working context did not provide sufficient opportunity to reflect on her practice. This suggests that a number of factors influence participants' feelings of inadequacy. These will be explored further in the following theme.

## **7.5 Master-theme 3: Struggling within the Working Context**

### **Sub-theme 1: Struggling within a multidisciplinary team**

Participants described in a variety of ways the difficulties and issues that arose from working within a multidisciplinary team. Some participants were concerned by the negative attitudes held by colleagues towards clients with the 'BPD' label and implied the use of constructions of 'BPD' that differed from the psychological constructions held by participants themselves. Participants spoke about the way colleagues used terms such as '*attention seeking*', that the 'borderline' client '*was not a proper patient*', that they should '*pull themselves together*'. These phrases were observed and used in interviews to

convey the struggle for participants in working alongside other colleagues. These findings are in line with a number of others studies confirming the presence of negative attitudes among mental health professionals working with clients diagnosed as 'BPD' (e.g. Lewis and Appleby, 1988). Furthermore, these results resonate with findings that this group of clients are seen as challenging and disruptive (e.g. Horsfall, 1999). Worryingly, previous research indicates that these views are likely to influence treatment decisions (Radley, 1994) leading to premature discharge. These views observed by participants in the current study were similarly revealed in an IPA study exploring doctors' responses to self-harm (Hadfield et al, 2010). Within this study, treatment was influenced by the moral attitudes held by practitioners.

Previous research has tended to focus on the impact of these negative attitudes towards clients diagnosed with 'BPD'. This differs from that of the current study, which instead revealed the impact of these views and practices on the therapist. This under researched perspective is particularly important given findings highlighting the importance of team morale and multidisciplinary approaches to working with BPD. In line with this evidence, Bateman and Fonagy (2006:54) suggested that:

*'Maintaining good team morale is essential to prevent 'burn out' and to minimize inappropriate responses towards patients and to other therapists.'*

These recommendations are in line with other quantitative findings (Cleary, Siegfried and Walter, 2002), investigating the attitudes of mental health practitioners working with 'BPD' clients. Negative attitudes towards clients were influenced by a lack of education, a belief that clients diagnosed with 'BPD' were difficult to treat and a perception of services as inadequate. In view of these results, the authors suggested a need for the development of well-defined structures within team approaches. These previous findings suggest that

negative attitudes may arise from a variety of influences.

Therapists in the current study experienced feelings of isolation when working with their clients. Specific examples were given by participants, including coping with mixed reactions from the team in response to their concerns about clients' distress and risk. Others described feeling that their clients were pushed onto them. One way of understanding this dynamic is that the therapist became a vessel for his/her colleagues' sense of helplessness in these situations. This theme further conveyed the enormous task faced by therapists working with clients diagnosed with 'BPD' in a community mental health team.

These results also resonate with findings focussing on countertransference reactions, discussed earlier in this section. Participants reported a range of subjective experiences working alongside professional colleagues. These included feeling isolated and marginalised in their work. Whilst occasionally participants were viewed by colleagues as *'the best one to deal with it [the patient]'* suggesting an idealised view of the therapist, at other times, there was a sense that therapists felt blamed for their clients' distress thus conveying a feeling of denigration. These feelings have been described extensively in the psychoanalytic literature as common countertransference reactions to working with clients diagnosed with 'BPD' (e.g. Kernberg, 1975). Within this framework, it is proposed that the team comes to represent the internal world of the client. Thus, participants observed team members thinking, feeling and responding in particular ways, which conveyed unhelpful and destructive responses. These responses could be understood as colleagues mirroring the internal world of the client. This point was illustrated by Bateman et al (2006:56). They suggested that:

*'...negative, anxious and hopeless attitudes will fuel despair and mirror many of the inner*

*feelings of the patient who begins to feel that what is inside is now outside.'*

This quote highlights the symbolic significance of team cohesiveness and the concerning implications for its absence not just for clients but also for the professionals striving to help them.

## **7.6 Master-theme 3: Struggling within the working context**

### **Sub-theme 2: Providing therapy in an impoverished mental health service: reconciling impossible opposites**

Participants' accounts of their experiences of working with clients diagnosed with 'BPD' were given in relation to the working context. Experiences were described in various ways with a particular focus on the inadequacy of NHS healthcare provision for this client group. These results are in line with findings from a qualitative study (Commons Treloar, 2009), conducted in New Zealand, investigating mental health practitioners' experiences of working with 'borderline' clients. In this study, an identified issue for clinicians concerned 'inadequacies in the health care system'. A further study (Price and Paley, 2008) in the UK, used grounded theory to investigate psychotherapists' experiences of working in an NHS setting, and revealed similar experiences. Within this study, participants reported inadequate therapeutic conditions that negatively impacted their work with clients. Implicit in participants' accounts in the present study was a link between feeling personally limited in what they could offer clients and insufficient NHS resources. Participants felt particularly limited in terms of how many sessions they could offer their clients and cited other pressures (e.g. paperwork) that distracted them from the therapeutic task. Again these results were echoed in Price et al's (2008) study.

The uneasy relationship between psychotherapy and service provision has been well documented particularly in the United States where therapists are under increasing pressure to deliver briefer interventions in response to a managed care system. Writing on

this subject, Sperling and Sack (2002:326) suggested managed care *'evokes images of malignant intrusions into patient treatments, disappearing referrals, and unbearable documentation requirements...and this is for good reason.'* It was evident that, although under a different system, similar concerns were described by participants in the current study. This experience resonates with observations made by Allen (2004:138) *that 'mental health services tend to be overstretched, inconsistent and fragmented, and have been in a state of repeated structural change over many years.'* Indeed at the time of interviewing participants, it was apparent that many organisational changes were being made within the service and direct links between these changes and what therapists could offer clients were made.

Whilst the importance of a containing 'emotional atmosphere' (Winnicott, 1954) has been highlighted in psychoanalytic theory, there is a paucity of research focussing on the importance of a containing physical environment. More specifically, there is a lack of research literature focussing on the impact of the NHS setting and context on psychotherapists' work. Liberman (1970-72, Vol 1) suggests that when a therapeutic setting is not constant, this is likely to impinge the therapeutic process. In the current study, participants reported experiences that suggested that an NHS setting impacted negatively on therapeutic work with 'BPD' clients. Some participants spoke of much more success with clients in their private practice as they felt more in control of their setting and their autonomy. These 'luxuries' were used to contrast experiences of work in an NHS Mental Health Service setting.

It followed that participants found themselves caught between their clients' intense needs and the limited NHS resources available. In order to illustrate this impossible predicament, I refer here to one participant's experience of working with his clients in an NHS Mental Health Service:

*'It's a lifetime you're trying to resolve, you know its very slow work and I suppose feeling that everyone understands that, sometimes its quite difficult so umm particularly sometimes being rushed to finish a piece or work'* (Robert, 126-129)

This sentiment was echoed by a number of participants in the current study, conveying the opposing needs and expectations of client and context. On the one hand, participants recognised that their clients needed more in terms of support from others and longer therapeutic contracts, and on the other hand they recognised that these resources were not available. Attempting to reconcile these impossible opposites further reinforced therapists' personal sense of insufficiency. This has far reaching implications for mental health services, if therapists are increasingly pressured to adopt an efficiency focussed attitude when working with 'BPD' clients. Given that these clients are considered highly sensitive to rejection and abandonment, such system-based pressures risk reinforcing early relational experiences that led them to need help in the first place. These concerns were further endorsed by Allen (2004:138). Writing from a systemic perspective she considered:

*'Mental health services [to] have the potential to replicate fragmentation, inconsistency, untrustworthiness and intrusion that may have characterized these service users early experiences.'* (p.138)

These issues were particularly pronounced across participant transcripts. A number of participants provided examples of inconsistent responses to their clients and the detrimental impact this had. Examples of inconsistent responses included a client being moved to different care coordinators without informing the therapist.

Further implications of these findings concerns the wellbeing of practitioners working within

a constrained mental health service. Independent of the inherent difficulties involved in working with clients diagnosed with 'BPD' and the potential for clients to evoke feelings of inadequacy in practitioners, it appears that the health care system itself represents a potential factor that may contribute to feelings of inadequacy and insufficiency within clinicians. Findings in the present study revealed that working with 'borderline' clients in the NHS threatened the professional autonomy of some participants. Instead, decisions about treatment were seen as governed by something artificial (e.g. NICE guidelines, 2008). These recommendations were often seen as in conflict with the views of participants. For example, participants reported that the needs of their clients were often beyond the scope of recommendations. These findings resonate with the views of Mollon's (2009:131). He suggested: *'those that work in the NHS will know, from tangible daily experience, that a huge agenda of control is currently distorting therapeutic work with clients'*. The extent to which these organisational changes are impacting therapeutic practice and conflicting with government policy, (e.g. Personality Disorder: No Longer Diagnosis of Exclusion 2003) remains an under researched area. However, this would be an important area for further investigation in view of these current findings coupled with current reorganisation activities underway within the NHS.

These findings, pointing to the insufficiency of Mental Health Services specifically for 'BPD' clients, could also be usefully understood from a psychodynamic perspective. Within this framework, insufficiency of resources may represent something of a defence against the therapist's confrontation with his/her own sense of limitation as well as his/her clients. These limitations are then projected onto a system that, with all its shortcomings, make for a suitable object from which to deflect such difficult feelings. Obholzer and Roberts (1994) similarly describe this process within organisations, whereby staff members locate their vulnerabilities in a suitably 'troubled' object. Within psychoanalytic writings, Kernberg (1975) described a particular countertransference problem with 'borderline' clients that

also resonates with this idea. Referring to a difficulty in managing unbearable feelings in the relationship, he suggested:

*'The therapist pairs him/herself with the patient, helps the patient to deflect his/her aggression from the therapist to external objects, and absorbs some of the patients aggression and masochistic submission while rationalizing these activities as total dedication.'* (Kernberg, 1975:170)

Within this framework, the Mental Health Service becomes the object in which difficult feelings are placed. Unfortunately, these unconscious processes are difficult to investigate

empirically. This phenomenon in itself requires further research. However, with this additional framework in mind, the limited Mental Health Service becomes both 'reality and metaphor' (Shapiro, 1986) or what Bondi and Fewell (2003) describe as 'non process' issues becoming intricately embedded in therapeutic 'process'.

In line with previous points covered in this discussion, one can only speculate as to what an adequate, consistent and sufficient health care service response would look like, or if an adequate response can exist. This point was similarly made by Guimon et al (2010) who suggested *'severe patients can be difficult to manage even in the best hospital conditions'*. It is considered that the service in itself may parallel the personal sense of insufficiency described by participants. However, to pick up on what Bondi et al (2003) referred to as a 'non process' issue, the current findings suggest that the origins of inadequacy and insufficiency cannot be easily explained. These experiences appear to be influenced by a complex interaction between client, therapist and context.

Overall, the current research findings for the final master theme reveal strong views among participants characterised by concern and dissatisfaction towards the lack of NHS

resources for the provision of community services for clients diagnosed or diagnosable with 'BPD'. This lack of resources included the number of sessions participants were able to offer clients, the lack of multidisciplinary team working, support offered to clients and therapists alike and the presence of a dominant medical model framework that for some undermined therapeutic practice. This qualitative study has offered a useful way in which to capture the impact of government policy, designed to target these specific issues across community services. For example, *Breaking the Cycle of Rejection: The Personality Disorders Framework* (2003) was designed to promote training for staff about personality disorders with a view to challenge negative attitudes. The current results would suggest that changes made as a result of various policy implementations have not gone far enough to sufficiently impact front line staff. Of course these experiences are specific to the participants interviewed within the current study and it is difficult to establish the applicability of these findings across other services or professional populations. However, these findings may provide a basis for investigating this further. The limitations of the current study are considered further below (see section 7.10).

## **7.7 Negative Case Analysis**

This section is intended to consider some differences that emerged in the data and that either contradicted or did not support the identified themes. This is otherwise referred to as a negative case analysis. On reviewing the transcripts on a number of occasions, one main difference was identified that contradicted the theme: struggling within the working context. As previously discussed, the majority of participants referred to their struggle with three main aspects of the working context. These struggles included working alongside professional colleagues and working within an impoverished mental health service. However, these experiences that conveyed an uneasy relationship were not supported in Robert's account (participant 7). For Robert:

*'The NHS can contain borderline patients in a way because it has access to sort of inpatients and for this patient, you know there's possibilities in terms of therapeutic communities for example, so that's quite good'* (line 145-147)

Robert's experience of the NHS as a containing service brings to mind what Obholzer and Roberts (1994) referred to as the *'keep death at bay service'*. This refers to the idea that the NHS serves to alleviate cultural anxieties about death and illness. In other words, the health service becomes a *'collective unconscious system to shield us from the anxieties arising from an awareness of illness and mortality'* (Obholzer and Roberts, 1994:71).

Robert's experience may imply a sense that something more than himself (i.e. the NHS) is needed, available, and capable of holding the 'borderline' and unconsciously, Robert's anxiety. Thus, Robert's experience perhaps reflects this cultural psyche as proposed by Obholzer et al (1994). His view interestingly contrasts with the experiences of other participants in the study who, as already discussed, make numerous references characterised by feeling uncontained and unsupported within the context of the NHS.

Soon after Robert's extract, he talked about his previous work experience and the absence of these additional services. Robert also disclosed that he has worked within his current role for eighteen months although he had worked with people diagnosed with 'BPD' for several years. On reflection, it seems apparent that Robert may be making sense of his current experience in light of his previous experience of working within a different service. By implication, what he experiences in his current role as 'good' was perhaps lacking in the previous service in which he was employed. It is possible that Robert's limited time in post may have influenced his experience. This may account for this difference between his account and those of other participants. Although all participants were required to have at least five years experience of working with clients diagnosed with 'BPD', the study did not stipulate a minimum length of time working in a Secondary Mental Health Service. This

may need further consideration when designing future research given that the contextual factors was considered central to participants' experiences. Furthermore, this difference may further highlight the significance of context on participants meaning making. On the other hand, there were many aspects of Robert's interview that were in line with other participants and as demonstrated in the verbatim quotes in the results section, were included in the analysis.

## **7.8 Concluding comments of discussion of results**

In concluding the discussion of the present findings, this study reveals the inherent difficulties of working with clients diagnosed with 'BPD' in an NHS Mental Health setting. The complex nature of participants' experiences arises not just from the therapeutic work itself but also from external mechanisms relating to conflicting frameworks, professional relationships and the working context.

This discussion has attempted to link results from the current study with a number of other research findings as well as with other theoretical and clinical ideas. However, it is clear that there is a lack of qualitative research focussing on the impact of working with clients with this diagnosis in an NHS Secondary Care Mental Health setting. Given that the majority of clients diagnosed with 'BPD' are now 'treated' in the community, it is hoped that the current findings will stimulate further research focussing on the areas of concern identified.

In particular, these findings are in agreement with the view that working with clients diagnosed with 'BPD' is emotionally demanding and challenging work. Embedded in participants' accounts was a sense that the work with their clients penetrated the very self of the therapist. It was felt that these ambiguous and testing experiences indicated a sense that the therapist embodied aspects of the borderline client as indicated by them having difficulty recognising aspects of themselves and their reactions, in a sense, losing

touch with themselves.

The current findings also highlight limitations in the utility of the formal diagnostic system. Participants expressed a number of concerns about this system of classification and relied on alternative ways to detect the presence of 'BPD'. Understanding the person behind the label occupied an important framework for participants. These results suggest that the medical model aligned to a positivist epistemology is not adequate in describing, understanding or responding to clients with the diagnosis. These results indicate an acknowledgement that a positivist framework is not in itself sufficient or relevant to therapeutic practice, despite its historical influence on psychoanalysis and psychotherapy. Instead, participants relied on others sources of information to understand their clients' difficulties. For example, without exception, all participants relied on their felt experiences to bring about understanding of their client. The way in which participants drew on their experiences of themselves, their clients and their working context is more aligned to a constructivist epistemology. In contrast with a positivist epistemology, this position holds that meanings emerge from ourselves in relation to others and the world (Neimeyer et al, 1995). Related to this premise, this framework highlights the significance of a person's context in making sense of experience.

Within the current study, participants went beyond their immediate experiences of working with clients diagnosed with 'BPD' to discuss wider issues (e.g. the working context) and how this shaped their experience. This study therefore highlights the importance of employing a methodology capable of retaining these personal meanings. These results suggest that medicalised methods of research and practice are limited in their application to psychotherapeutic practice. More specifically, the current study highlights some constraints for psychotherapists working alongside a medical model framework within an NHS Mental Health Service.

The current findings were also in line with other qualitative and quantitative evidence (e.g. Benham, 1995; Crowe, 1996; Hadfield et al, 2010; Smith et al, 2007), revealing themes of inadequacy among practitioners working with challenging clients. These current results explored these feelings in more detail. It was felt that working with 'borderline' clients led six participants to become confronted with their own limitations and vulnerabilities.

Although this has been described clinically, there is a paucity of research investigating this complex experience. However, there are important implications to these findings in that they highlight the important role of reflective practice and self-care particularly in light of the evidence that these feelings can lead to stress and feelings of incompetence that can then impact on work with clients. The current findings may also provide a useful template to inform other clinicians about the particular challenges of working with this client group.

Feelings of inadequacy and insufficiency were also felt in relation to the working context. Therapists felt caught between the intense needs of their clients and the expectations of the service. Within this context, therapists experienced a threat to their professional autonomy with treatment decisions determined by guidelines and service limitations. In a sense, the working context reinforced participants' own sense of limitation and personal lack. Of particular concern, therapists pointed to a lack of time and space to work with clients and reflect on their practices. In other words emotionally demanding experiences were not only from the therapeutic work with clients but arose from external pressures, resources and professional relationships. These findings suggest the absence of an integrated multidisciplinary team approach to working with clients diagnosed with 'BPD'.

Indeed participants in the current study conveyed an uneasy relationship within the NHS system and found themselves needing to compromise in order to fit in. It is hoped that these results will provoke policy makers and managers to consider these issues with an

aim to promote safer and more containing services for psychological practitioners working in the NHS. This is vital if we are to provide effective responses to clients diagnosed with 'BPD' or presenting with difficulties understood within a medical model framework as 'BPD'. These findings also suggest that acknowledging these challenges and limitations is an important part of the work with clients.

## **7.9 Critical and reflexive considerations**

This section aims to consider some limitations of this study. Furthermore, to demonstrate the researchers efforts to establish quality in the research. In doing so, it is argued that the current study is contingent with the underpinnings of IPA.

### **7.91 Reflecting on my personal positioning**

Firstly, I aim to consider my personal positioning in relation to IPA's commitment to phenomenology and hermeneutics. IPA can be described as operating on a 'double hermeneutic' (Smith and Osborn, 2003). This is when 'the researcher is making sense of the participant, who is making sense of x' (Smith et al, 2009, p.35). Making sense of the participants' experiences both inevitably and purposefully involves interpretation. The researcher will inevitably bring her own assumptions and understanding, which will shape the way in which the research is undertaken. This interpretive activity requires the researcher to recognise and 'bracket off ' her own theoretical assumptions and preconceptions in an attempt to get as close as possible to participants' phenomenological experiences. Smith et al (2009) points out that the researcher may not always be conscious of ones biases and calls for ongoing reflection throughout the research process sometimes referred to as the hermeneutic circle (Moran, 2000; Smith, 2007; Smith, Flowers and Larkin, 2009).

When reflecting on my own preconceptions and biases, I have noticed how my own theoretical assumptions based on the psychodynamic perspective may have been

influential in the way in which I handled data and the interpretation of results. In some cases, my sense making moved beyond what was being said by participants. The following quote and my subsequent sense making of it (see results section: page 77, paragraph 3, lines 1-4) serves as an example where I import a particular understanding that moves beyond the client's own sense making:

*'Some how, their life is so awful, that they cannot possibly be expected to respond in a reasonable, taking responsibility type way because somehow they're different and then in turn that invalidates what I or anyone in the room is able to offer but the double bind is, you have to keep trying' (Tony: Line 65-71).*

In this passage, Tony makes reference to himself or 'anyone in the room'. I attempt to make sense of this extract by suggesting that Tony may be referring to different layers of himself, that is his personal and professional self. On reflection, I recognise this to be moving beyond what is being said by the participant. I instead speculate that Tony's reference to 'anyone in the room' may refer to aspects of his internal world. I am therefore importing assumptions based on a psychodynamic perspective.

A further example of this stance can be seen in the way in which I offer an understanding of the theme: Identifying the borderline client through the self: special rules apply (See page 78, paragraph 2, lines 5-6). Here, I speculate that participants may become susceptible to influences beyond their control due to feeling so overwhelmed by their clients. This interpretation brings to mind Klein's (1946) notion of 'projective identification' which refers to a process whereby the client may unconsciously push unwanted thoughts and feelings into the therapist who may then be nudged into thinking, feeling or behaving in a particular way. On reflection, this interpretation moves beyond what is being said and instead offers an understanding grounded in a psychodynamic perspective. These

examples highlight the importance of reflecting on and acknowledging one's preconceptions during the research process in order to fully engage in what is being said by the participant.

It also demonstrates a particular interpretive position referred to by Ricoeur (1970) as a hermeneutics of suspicion. This stance refers to a position whereby participants' experiences are made sense of in the context of existing theoretical constructs. Here, the researcher is likely to assume a questioning stance and consider what is being said from different perspectives. This position is set apart from a hermeneutics of empathy, which seeks to capture the participant's unique meaning of a given experience. Smith (2009) suggests that:

*'the IPA researcher is in part wanting to...see what is it like from the participant's view, and stand in their shoes. On the other hand the IPA researcher is also wanting to stand alongside the participant, to take a look at them from a different angle, ask questions and puzzle over things they are saying'* (Smith, 2009: 36)

It is argued that these different levels of interpretation during the process of analysis are indicators of good IPA research and would therefore agree with my approach to the analysis.

This study has been able to contribute to our understanding of how the therapist experiences a client diagnosed with BPD. It is hoped that this type of knowledge can be useful to other practitioners in helping them to identify and understand their inner experiences. Previous research suggests that reflecting on one's experience in this way can help facilitate the development of empathy (Richards, 1999). However, in order to deepen our understanding of the therapeutic process, future research would need to focus on both the therapist and clients' experiences.

Finally, it is also important to acknowledge and reflect on the challenge of straddling two epistemologically opposed paradigms in this research project. As researcher, I adopted a position which questioned the established framework for describing and responding to clients' difficulties and yet subsequently used the 'BPD' construct as a benchmark from which to explore participants' experiences within the research. As a Counselling Psychologist working within the NHS, I am accustomed to working alongside diverse frameworks and noticed that the challenges this presents in my professional practice were also encountered and mirrored within this research. On reflection, it may have been useful to explore these epistemological challenges in more detail as well as to consider other ways of conceptualising emotional difficulties.

Within the literature review, it would also have been useful to include studies that had focussed on therapists working within different theoretical orientations. In the current study, participants tended to use theoretical constructs from the psychodynamic approach to help them make sense of their experience (e.g. countertransference). This approach also focuses on the inner feelings of therapists, which can then be used to facilitate understanding of the therapeutic process. This focus may therefore differ from the way in which therapists working within other theoretical orientations may conceptualise and make sense of their experience. (e.g. systemic or cognitive behavioral therapists). This section will now discuss further efforts to establish quality in the research by employing Yardley's (2008) criteria.

## **7.92 Quality and Validity**

Increasing attention has been given to the ways in which qualitative research is assessed for quality and validity. Many argue that the principles used to evaluate reliability and validity in quantitative research are not appropriate to qualitative methodology and argue

instead for criteria relevant to this. Among other researchers, Lucy Yardley (2008) has proposed particular ways in which to establish quality in IPA research. These include *sensitivity to context, commitment and rigour, transparency and coherence and impact and importance*. This section intends to take each of her criteria in turn and aims to demonstrate the ways in which the current study has endeavoured to conduct research with Yardley's principles for quality in mind.

### **7.92 Sensitivity to context**

The first of these principles to assess quality in IPA research is *sensitivity to context*. Yardley (2008) suggests several ways in which this can be established. In the current study, it is argued that sensitivity to context was achieved by giving voice to group of practitioners (psychoanalytic psychotherapists) about an area of experience that remains under researched in the context of a Secondary Care Mental Health Service. More specifically, no qualitative research was found investigating these experiences. Another way in which to demonstrate sensitivity to context according to Yardley (2008) is through the process of data gathering itself. The way in which interviews are conducted will inevitably impact on the quality of them. This quality will rely on the conditions set by the researcher. In the present study, as researcher, I endeavoured to stay as close to participants' accounts as I could, by being aware of my own preconceptions as well as facilitating a dialogue that was discursive and aimed to promote conditions in which participants could speak as freely as possibly about their lived experience.

### **7.94 Commitment and Rigour**

The second of Yardley's (2008) criteria to establish quality was *commitment and rigour*. This too can be established in a variety of ways. An example is by developing competence in the method. In the current study it is hoped that these qualities were demonstrated by setting out the thorough and sensitive ways in which data was gathered

and handled throughout the research process. This was outlined in depth in the method section of this report.

In addition, I have aimed to demonstrate commitment and rigour by developing my skills in conducting IPA research. As a researcher who is fairly new to the use of IPA, I have focussed on improving my skills by attending seminars and lectures. I also attended an IPA workshop. This focussed on conducting interviews, compiling interview schedules and analysing data. This also involved a great deal of role-play and group work to develop skills in various areas of the research process. In addition, I have attempted to develop my skills by reading books and articles about IPA. Finally, I have made good use of supervision throughout the research process. I believe these activities demonstrate the commitment given to this research.

### **7.95 Transparency and Coherence**

The third of Yardley's (2008) criteria; *transparency and coherence* can be demonstrated by setting out step by step the procedure followed in the study. This will include details about recruitment procedures, details about how interviews were carried out and information about the procedure followed to analyse data. According to Yardley (2008), these aspects should indicate that the researcher has thought through these areas of the research and been able to represent these in the body of the report in a way that is clear and unambiguous. In the current study, it is argued that the researcher carefully thought through these important steps and represented these in sufficient detail in the body of the write up. An example of the researcher's attempts to be transparent can be seen in the method section. For example, the researcher included a detailed procedure about her handling of the raw data and how these came to form emergent themes.

### **7.96 Impact and importance**

According to Yardley (2008) an important measure of quality is determined by what is

made of the research by the readership and whether the paper has revealed something of significance. Given the paucity of qualitative research in this area, it is hoped that readers appreciate the importance of these current findings. These results reveal a number of interesting findings already covered in this discussion section. Among them is the finding that participants experience themselves, their framework, the medical model and their working context as insufficient in working with clients diagnosed with 'BPD'. These results have far reaching implications for those responsible for commissioning secondary care services for this vulnerable client group.

Although it is argued that efforts have been made to establish quality and validity in the current research, there are invariably limitations to this study. This will be discussed in the following section.

#### **7.10 Limitations of the study**

By employing a robust qualitative methodology capable of capturing complex experiences, it has been possible to explore, in sufficient depth, participants' accounts of their work with clients diagnosed with 'BPD'. Limitations may arise in generalising findings across other services given the variability of organisational structures across the country. As Heidegger (1927/1962) pointed out, the context will inevitably feature in the way in which a person makes sense of their experience. The current findings were based on practitioners working within, and informed by, a psychodynamic ethos. Therefore this will inevitably shape the way in which participants make sense of their experiences. Interviewing other practitioners working within different frameworks may reveal different views. Indeed this would provide a useful comparison if this were to be investigated.

Given the subjective nature of IPA, differences will also feature in the way in which data is handled and interpreted during the process of analysis. Indeed, Smith and Osborne

(2003) conceded that it '*is generally the case with qualitative research, there is no single definitive way to do IPA*'. This is further endorsed by Yardley (2000) who suggested that the very nature of IPA is to invite a range of interpretations thus reflecting the subjective interactions of the researcher and participant. In an attempt to achieve inter-rater reliability, all participants were invited to read through their transcripts and check through an initial analysis of their interviews. Unfortunately, all participants declined. On reflection, it was felt that these responses may have been influenced by time pressures, as reflected in the results. However, other reliability checks were achieved through consultation with other peers and the investigator's research supervisor. This is otherwise referred to as a type of 'member check' (Mcleod, 2001) and is particularly useful given the potential for researcher bias as previously acknowledged in section 4 entitled; '*a consideration of the researchers experience and preconceptions*'. Furthermore, the process of analysis set out in this thesis aims to demonstrate the rigours involved as discussed in the previous section.

Another variable that may have influenced the way in which accounts were made concerns my role within the service. As a counselling psychologist, I have worked within a Secondary Care Community Mental Health Service for the past four years and regularly work with clients diagnosed with 'BPD'. It is likely that this experience and knowledge would have influenced the way in which participants spoke about their experiences. For example, they may have assumed that I was aware of particular issues given my background. Similarly, given my relationship with the service, that is as a fellow employee, in addition to my role as researcher, participants may have elected not to share particular difficulties on the grounds of confidentiality.

A further consideration concerns my own personal positioning in this area of research and how this may inevitably feature during the process of investigation to interpretation. At the time of conducting my interviews, a client diagnosed with 'BPD', and with whom I had been

working for about a year, took her own life. At the time, on discovering this unexpected and tragic news, I remember feeling a great sense of responsibility and shame. Was it my fault? Was I going to get into trouble? Could I have done something to prevent my client from taking her life? Did I do something wrong? I became quite preoccupied with these impossible questions at the time, to the point that any sadness and grief on losing such a lovely person, and one with whom I had previously felt a deep sense of connection, had somehow fallen by the wayside. This in itself evoked a great sense of shame. I felt selfish for this. I was aware that when interviewing participants, my client's suicide was uppermost in my mind. I did not mention this to any of the participants in an effort to preserve my professional role of researcher. However, on reflection, I wondered if this very difficult experience with which I was struggling during the course of my research paralleled something of my participants' experiences. That is that participants carry a great sense of responsibility for their clients' stability. The guilt and sense of shame participants feel when their clients cannot be held, is something that cannot really be talked about. These feelings touch the therapist on a very personal level that surpasses the professional therapist or in my case, the 'professional' researcher. On reflection, I also consider that the difficulties I struggled to convey here represent a general experience of myself when working with challenging clients in the NHS. It would seem conceivable that part of my reasons for pursuing this area of research was to see if other people experienced similar struggles to my own in their practice. In other words, perhaps I was seeking out a reassuring community in my participants.

I needed to keep in mind my intentionality to seek reassurance and to further my own understanding of working with people diagnosed with 'BPD' throughout this study. During interviews, there were several instances when participants would be describing experiences that resonated with my own. During these moments, I noticed feeling more conscious about how my agenda had the potential to encroach upon participants' stories.

Although I have reflected on my personal positioning in an attempt to facilitate an aim to stay as close to participants' raw descriptions as possible, their accounts are inevitably the result of interpretation. For example, the words used to represent descriptions were chosen by the researcher with an aim to articulate the experiential concerns of participants.

Within the present study, IPA has aimed to privilege the subjective experiences of a small group of participants. Future research employing this methodology may use insights from a single case study. It is argued that this approach may safeguard the nuances inherent in a person's lived experience. It is hoped that the current study demonstrates the capabilities of IPA in accessing an in depth understanding into the experiential concerns of psychoanalytic psychotherapists working with clients diagnosed with 'BPD' clients in an NHS setting. IPA is an approach that is increasingly used within counselling psychology and given the drive towards evidence based practice as guiding service provision, future research endorsing these concerns is in great demand. The risk here of course is that commissioners may legitimise the implementation of other types of therapies (e.g. briefer models) over relationally orientated approaches by citing one particular type of evidence over another.

### **7.11 Conclusion**

This qualitative study aimed to explore the experiences of eight psychoanalytic psychotherapists work with clients diagnosed with 'BPD'. IPA was employed and enabled the research question to be explored in sufficient depth. The results revealed three master themes. The first was 'Recognising the Borderline Signature'. This theme referred to the ways in which participants detected the presence of 'BPD' and highlighted the important role of the therapists 'self' to facilitate an understanding of the client. The second master-

theme; 'The 'Borderline' Relationship: The Emotional Impact' related to the way in which the 'borderline' client evoked intense feelings of inadequacy within the therapist. This theme was also concerned with how the therapist managed and coped with these difficult feelings. The final master theme; 'Struggling within the Working Context' referred to participants' difficulty working within an impoverished and insufficient Mental Health Service. Themes of insufficiency extended to participants' experiences of working with professional colleagues and alongside alternative frameworks.

These results were in line with previous clinical writings and research findings, particularly the finding that clients diagnosed with 'BPD' are challenging and evoke difficult feelings in the therapist. However, the current qualitative study was able to explore in depth the nature of these challenges for participants. More research is needed to explore the relevance of these experiences across other NHS service providers. The findings in the present study indicating the negative impact external factors can have on therapists' clinical work with 'borderline' clients is also an under researched area. According to these results, what happens outside the therapy room has important implications for the quality of what happens within the therapeutic relationship.

In conclusion, this investigation aimed to explore, in detail, the experiences of therapists' work with clients diagnosed with 'BPD' with an aim to highlight those aspects of the work considered particularly important to participants. It is hoped that this research will inspire other mental health professionals to reflect upon the impact of their work on their personal and professional selves. Furthermore, It is hoped that these findings may stimulate others to recognise the value of employing a qualitative methodology to explore these important areas of experience.

## 8. References

Adler, G. (1975). The usefulness of the "borderline" concept in psychotherapy. In: J.E. Mack (Ed.) *Borderline States in Psychiatry*. New York: Grune & Stratton.

Adler, G. and Buie, D.H. (1979). The psychotherapeutic approach to aloneness in borderline patients. In: J. LeBoit and A. Capponi (Eds.), *Advances in Psychotherapy of the Borderline Patient*. New York: Jason Aronson, 1979.

Allen, C. (2004). Borderline Personality Disorder: Towards a systemic formulation. *Journal of Family Therapy*, 26,126-141.

Alnaes, R., and Torgersen, S. (1988). The relationship between DSM-III symptom disorders (Axis 1) and personality disorders (Axis II) in an outpatient population. *Acta Psychiatrica Scandinavia*, 78, 485-492.

Alston, M.H. and Robinson, B.H. (1992). Nurses' attitudes towards suicide. *Omega*, 25, 205-215.

American Psychiatric Association (1980). *Diagnostic and Statistical Manual of Mental Disorders*, (3rd ed). Washington, DC: American Psychiatric Association.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*, (4th ed). Washington DC: American Psychiatric Association.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, (4th ed). Washington, DC: American Psychiatric Association.

American Psychiatric Association (2011). DSM-5 Development. Retrieved from <http://www.dsm5.org>.

Aronson, T.A. (1985). Historical perspectives on the borderline concept: A review and critique. *Psychiatry*, 48, 209-222.

Bailey, S. (2011). Taking up the Challenge: An interpretive Phenomenological Analysis of teachers' perceptions regarding the presence of asylum seeker and refuge pupils (ASR) within mainstream primary schools in the Midlands, and the implications this may hold for Educational Psychologists practice, p.1-218, E-thesis: *unpublished manuscript*.

- Bandelow, B., Krause, J., Wedekind, D., Broocks, A., Hajak, G., and Ruther, E. (2005). Early traumatic life events, parental attitudes, family history, and birth risk factors in patients with borderline personality disorder and healthy controls. *Psychiatry Research*, 134, 169-179.
- Bateman, A.W. and Fonagy, P. (1999). The effectiveness of partial hospitalisation in the treatment of borderline personality disorder- A randomised controlled trial. *The American Journal of Psychiatry*, 156, 1563-69.
- Bateman, A.W. and Fonagy, P. (2006). *Mentalisation based treatment for borderline personality disorder: A practical guide*. Oxford: Oxford University Press.
- Becker, D. (1997). *Through the looking glass: Women and borderline personality disorder*. Boulder: Westview Press.
- Benner, P. (Ed.) (1994). *Interpretative Phenomenology: Embodiment, caring and ethics in health and illness*. Thousand Oaks, CA: Sage Publications.
- Benham, E. (1995). Coping strategies. A psychoeducational approach to post-traumatic symptomatology. *Journal of Psychosocial Nursing*, 33, 30-35.
- Betan, E., Heim, A.K., Conklin, C.Z., and Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry*, 162, 890-898.
- Bion, W.R. (1959). *Attacks on Linking*. In E. Bott Spillius (ed.) *Melanie Klein Today: Developments in theory and practice*. Volume 1: Mainly Theory. 1988. London: Routledge.

Bland, A., Tudor, G., and McNeil, W.D. (2007). Nursing Care of inpatients with borderline personality disorder. *Perspectives in Psychiatric Care*, 43(4), 204-212.

Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.

Bohart, A.C. (2005). Evidenced-based psychotherapy means evidence informed not evidence-driven. *Journal of Contemporary Psychotherapy*, 35(1), 39-53.

Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.

Bondi, L., and Fewell, J. (2003). *Unlocking the cage door: The spatiality of counselling*. *Social and Cultural Geography*, 4(4). London: Routledge.

Bowers, L. (2002). *Dangerous and Severe Personality Disorder: Response and Role of the Psychiatric Team*, London: Routledge.

Brandshaft, B. and Stolorow, R. (1984). A current perspectives on difficult patients. In: Stepanski, E. and Goldberg, A. (eds.) *Kohut's legacy*, 93-115. The Atlantic press.

Breuer, J., & Freud, S. (1893-1895/1955). The standard edition of the complete psychological works of Sigmund Freud: Vol. II. *Studies on hysteria*. London: Hogarth Press.

British Psychological Society (2000). *Regulations and Syllabus for the Diploma of Counselling Psychology*. Leicester: British Psychological Society.

British Psychological Society (2004). *Competency Statement, Division of Counselling Psychology: Author*.

*British Psychological Society (2006). Division of Counselling Psychology: Professional Practice Guidelines. Leicester: Author.*

Brown, J.F. (2002). Epistemological differences within psychological science: A philosophical perspective on the validity of psychiatric diagnosis. *Psychology and Psychotherapy: Theory, Research and Practice*, 75(3), 239-250.

Bury, D. and Strauss, S.M. (2006). The scientist practitioner in a counselling psychology setting. In: D.A. Lane & S. Corrie (Eds.), *The modern scientist practitioner: A guide to practice in psychology* (pp. 119-129). Hove, East Sussex: Routledge.

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

Clerkley, H. (1941). *The mask of sanity* (1st ed.). St Louis, MO: C.V. Mosby.

Cleckley, Hervey (1982). *The Mask of Sanity*. Revised Edition. Mosby Medical Library.

Coles, S. (2011). Borderline Personality Disorder: The House Believes. *Clinical Psychology Forum*, 225, 15-18.

Commons Treloar, A.J., and Lewis, A.J. (2008). Professional attitudes towards deliberate self-harm in patients with borderline personality. *Australian and New Zealand Journal of Psychiatry*, 42, 578-584.

Commons Treloar, A.J. (2009). A Qualitative Investigation of the Clinician Experience of Working with Borderline Personality Disorder. *New Zealand Journal of Psychology*, 39(2), 30-34.

Conrad, P. (1987). The experience of illness: recent and new directions. *Research in*

Sociology and Health Care, 6: 1-31. In M. Murray, and K. Chamberlain (1999). *Qualitative Health Psychology: Theories and Methods*. Sage Publications.

Corrie, S. (2010). What is evidence? In R. Woolfe, S. Strawbridge, B. Douglas, and W. Dryden (Eds.), *Handbook of counselling psychology* (3<sup>rd</sup> ed.). London: Sage.

Crowe, M. (1996). Cutting up: Signifying the unspeakable. *Australian and New Zealand Journal of Mental Health Nursing*, 5, 103-111.

Department of Health (2003). *Personality disorder: no longer a diagnosis of exclusion - Policy implementation guidance for the development of services for people with personality disorder*. Leeds: NIMHE.

Department of Health (2003). *Reaching out: An action plan on social exclusion*. Leeds: NIMHE.

Department of Health (2008). *The personality disorders knowledge and understanding framework*. Open University Press.

Department of Health (2009). *Recognising complexity: commissioning guidance for personality disorder services*. Crown.

Eatough, V. and Smith, J.A. (2006). 'I feel like a scrambled egg in my head': An idiographic case study of meaning making and anger using interpretative phenomenological analysis. *Psychology and Psychotherapy*, 79, 115-135.

Eatough, V., Smith, J.A. and Shaw, R.L. (2008). Women, anger and aggression: an interpretative phenomenological analysis. *Journal of Interpersonal Violence*, 23(12), 1767-1799.

Elkins, D.N. (2009). The Medical Model in Psychotherapy: Its Limitations and Failures. *Journal of Humanistic Psychology*, Vol 49(1), 66-84.

Elkins, D.N. (2007). Empirically supported treatment: The deconstruction of a myth. *Journal of Humanistic Psychology*, 47(4), 474-500.

Foucault, M. (1967). *Madness and Civilisation*. Tavistock.

Foucault, M. (1971). 'Nietzsche, genealogy, history'. In J. Faubion (Ed.) Michel Foucault: aesthetics, method and epistemology. *Essential works of Foucault 1954-1984*, Volume 2. London: Penguin, 369-391.

Feather, N. and Johnstone, C. (2001). Social norms, entitlement and deservedness: differential reactions to aggressive behaviour of schizophrenic and personality disorder patients. *Personality and Social Psychology Bulletin*, 27(6), 755-767.

Fraser, K. and Gallop, R. (1993). Nurses confirming/disconfirming responses to patients diagnosed with borderline personality disorder. *Archives of Psychiatric Nursing*, 7, 336-341.

Gabbard, G.O. (1995). Countertransference: The emerging common ground. *International Journal of Psychoanalysis*, 76, 475-485.

Gabbard, G.O. (2005). *Psychodynamic Psychiatry in Clinical Practice* (4th ed.) Washington DC: American Psychiatric Association.

Gabbard, G.O. (2001). Psychodynamic Psychotherapy for borderline personality disorder: a contemporary approach. *Bulletin of Menninger Clinic*, 65, 41-57.

Gallop, R., Lancee, W.J., and Garfinkel, P. (1989). How nursing staff respond to the label 'borderline personality disorder'. *Hospital and Community Psychiatry*, 40, 815-819.

Gelso, C.J., and Hayes, J.A. (2002). Countertransference management. *Psychotherapy*, 38, 418-422.

Gehrs, M., and Goering, P. (1994). The relationship between the working alliance and rehabilitation outcomes of schizophrenia. *Psychosocial Rehabilitation Journal*, 18, 43-54.

Ginot, E. (1997). The Analyst's Use of Self, Self Disclosure, and Enhanced Integration. *Psychoanalytic Psychology*, 14(3), 365-381.

Glaser, B.G. and Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine de Gruyter.

Goldsworthy, R. (2004). Counselling psychology and psychiatric classification: clash or co-existence? *Counselling Psychology Review*, 19(3), 23-28.

Greben, S.E. (1977). 'On being therapeutic'. *Canadian Psychiatric Association Journal*, 22, 371-80.

Guimon, J. and Chouza, J. (2010). Combined Medication and Psychotherapy. *Advances in Relational Mental Health*, 8(3).

Guy, J. (2000). Holding the holding environment together: Self-psychology and psychotherapist care. *Professional Psychology: Research and Practice*, 31(3), 351-352.

Hadfield, J., Brown, D., Pembroke, L., and Hayward, M. (2010). Analysis of Accident and Emergency Doctors' Responses to Treating People who self-harm. *Qualitative Health Research*, 19 (6), 755-765.

Hage, S.M. (2002). Reaffirming the unique identity of counselling psychology: Opting for the 'Road Less Travelled'. *The Counselling Psychologist*, 31(5), 555-563.

Heidegger, M. (1927/1962). *Being and time*. (J. McQuarrie & J. Robinson, Trans.). New York: Blackwell.

Herman, J.L. (1992). The new diagnosis. I: J. L. Herman (Ed.), *Trauma and Recover* (pp.115-124). New York: Harper Collins.

Holmes, J. (1994). The clinical implications of attachment theory. *British Journal of Psychotherapy*, 11(1), 62-76.

Horsfall, J. (1999). Towards understanding some complex borderline behaviours. *Journal of Psychiatric Mental Health Nursing*, 6(6), 425–432.

Heidegger, M. (1962/1927). *Being and Time*. Oxford: Blackwell cited in: Smith, J.A., P, Flowers, and M, Larkin. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Husserl, E. (1927). Phenomenology. In: J.A. Smith, P. Flowers, and M. Larkin (2009). *Interpretative phenomenological analysis: Theory, Method and Research*. Sage Publications.

Hustvedt, A. (2011). *Medical Muses: Hysteria in Nineteenth Century Paris*. Norton and Co.

James, P.D. and Cowan, S. (2007). Psychiatric nurses knowledge, experience and attitudes towards clients with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, 14, 670-678.

Johnstone, L. (1997). Self-injury and the psychiatric response. *Feminism and Psychology*, 7, 421-426.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York: Aronson.

Kernberg, O. (1977). The structural diagnosis of borderline personality organisation. In P. Hartocollis (Ed.), *Borderline Personality Disorders*. (pp. 87-121). New York: International University Press.

Kernberg, O., Seltzer, M., Koenigssberg, H., Carr, A., and Applebaum, A. (1989). *Psychodynamic psychotherapy of borderline patients*. New York: Basic Books.

Klein, M. (1946). Notes on some schizoid mechanisms. J. Mitchell (ed.) *The Selected Melanie Klein*. London: Penguin. 1991.

Knight, R. (1953). Borderline states. *Bulletin of the Menninger Clinic*, 17, 1-12.

Kreisman, M.D. & Straus, H. (1989). *Sometimes I act crazy: Living with borderline personality disorder*. Wiley Publications.

Lancee, W.J., Gallop, R., McCay, E., and Toner, B. (1995). The Relationship between nurses' limit-setting styles and anger in psychiatric inpatients. *Psychiatric Services*, 46, 609-613.

Lane, D.A. and Corrie, S. (2006). Counselling Psychology: Its influences and future. *Counselling Psychology Review*, 21(1), 12-23.

Lewis, G., and Appleby, L. (1988). Personality disorder: the patients psychiatrists dislike. *British Journal of Psychiatry*. 153: 44-49.

Leib, K., Zanarini, M.C., Schmahl, C., Lineham, M., and Bohus, M. (2004). *Borderline Personality Disorder*. *Lancet*, 364, 453-460.

Liberman, D. (1970-72). *Linguística, interacción, comunicativa y proceso psicoanalítico*, Vols. 1-3. Buenos Aires: Galerna.

Linehan, M.M. (1993). *Cognitive-behavioural treatment of borderline personality disorder*. New York: Guildford Press.

Lineham, M.M., Armstrong, H.E., Suarez, A.Z., Allon, D., and Heard, H. (1991). Cognitive-behavioural treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48,1060-4.

Loudis, J. (2011). 'Medical' Musing On Politics, Poetry And Hysteria. In: A. Hustvedt, *Medical Muses: Hysteria in Nineteenth-Century Paris*. Norton and Co.

Luhmann, T.M. (2001). *Of two minds: An anthropologist looks at American Psychiatry (2nd ed.)*. New York: Vintage Books.

Luhmann, T.M. (1991). *Persuasions of the Witch's Craft: Ritual Magic in Contemporary England*. Harvard University Press.

Mahler, M.S. (1972). On the first three sub phases of the separation-individuation process. *International Journal of Psychoanalysis*, 47, 476-485.

Mahoney, M.J. (1991). *Human change processes: The scientific foundations of psychotherapy*, New York: Basic Books.

Manning, N. (2000). Psychiatric diagnosis under conditions of uncertainty: personality disorder, science and professional legitimacy. *Sociology of Health and Illness*, 22(5), 621-639.

Markham, D.M.H. and Trower, P. (2003). The effects of the psychiatric label 'borderline

personality disorder' on nursing staff's perceptions and casual attributions for challenging behaviours. *British Journal of Clinical Psychology*, 42, 20-30.

Masterson, J.F. (1990). *The search for the real self: Unmasking the personality disorders of our age*. New York: The Free Press.

McDonald, M., Pietsch, T., and Wilson, J. (2010). Ontological Insecurity: A Guiding Framework for Borderline Personality Disorder. *Journal of Phenomenological Psychology*, 41, 85-105.

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

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London: Sage.

Merleau-Ponty, M. (1962). *Phenomenology of perception*. London: Routledge.

Miller, S.G. (1994). Borderline Personality Disorder from the Patients Perspective. *Hospital and Community Psychiatry*, 45, 1215-1219.

Mollon, P. (2009). Our rich heritage - are we building upon it or destroying it? (or 'Why are counselling psychologists not angrier with clinical psychologists?'). *Counselling Psychology Review*, Vol 24 (2&3), 130-141.

Moran, D. (200). *Introduction to Phenomenology*. London: Routledge.

Morrall, P. (2008). *The trouble with therapy –sociology and psychotherapy*. Maidenhead: Open University Press.

Monk, P. (2002). You will go to the ball: The philosophical and methodological challenges facing counselling psychologists working in the national health service. *Unpublished doctoral research*. University of Surry: Guildford.

National Institute of Health and Clinical Excellence (2009). *Borderline personality disorder: treatment and management*. NICE Clinical guideline 78. London: NICE.

National Collaborating Centre for Mental Health (2004). *Self harm. The short term physical and psychological management and secondary prevention of self harm in primary and secondary care*. National Clinical Practice Guideline Number 16. Leister: The British Psychological Society.

Neimeyer, R.A. and Mahoney, M.J. (1995). *Constructionism in Psychotherapy*. Washington DC: American Psychological Association.

Neimeyer, R.A. and Rood, L. (1997). 'Contemporary expressions of constructivist psychotherapy'. In: G.J. and R.A. Neimeyer (eds). *Advances in Personal Construct Psychology IV*. Greenwich CT: JAI Press.

Neimeyer, R.A. and Raskin, J.D. (2000). *Constructions of Disorder: Meaning Making Frameworks for Psychotherapy*. Washington DC: American Psychological Association.

Norcross, J.C. (2011). *Psychotherapy Relationships That Work*. Oxford University Press.

Obholzer, A. and Roberts, V.Z. (1994). *The Unconscious at Work*. London: Routledge.

Orlinsky, D., Hansruedi, A., Botermans, J.C., Davis, J., Ronnestad, M., Willutzki, U., et al (1999). Psychotherapists' assessments of their development at different career levels. *Psychotherapy*, 36, 203-215.

Orlinsky, D., Howard, R., and Hill, J. (1975). Conjoint psychotherapeutic experiences: Some dimensions and determinants. *Multivariate Behaviour Research*, 10, 463-477.

Orlans, V. and Van Scoyoc, S. (2009). *A short introduction to Counselling Psychology*. London: Sage.

Palmer, R. (1969). Hermeneutics. Evanston: North-western University Press. In: Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, Method and Research*. Sage Publications.

Paris, J. (2005). Borderline personality disorder. *Canadian Medical Association Journal*, 172, 12, 1579-1583.

Park, J. (1971). *Our Existential Predicament: Loneliness, depression, anxiety and death*.

Potter, J. and Weatherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage.

Price, J.N. and Paley, G. (2008). A grounded theory study on the effect of the therapeutic setting on NHS psychodynamic psychotherapy from the perspective of the therapist. *Psychodynamic Practice*, 14(1), 5-25.

Radley, A. (1994). *The healing relationship: Doctors, patients and nurses. Making sense of illness: The social psychology of health and disease*. London: Sage.

Rapley, M., Moncreiff, J. & Dillon, J. (Eds.) (2011). *Demedicalising misery*. Basingstoke: Palgrave Macmillan.

Ricoeur, P. (1970). *Freud and Philosophy: An essay on interpretation*. New Haven: Yale University Press.

- Rizq, R. (2012). 'Theres always this sense of failure': An interpretative phenomenological Analysis of primary care counsellors' experiences of working with the borderline client. *Journal of Social Work Practice*, 1-24.
- Roberts, D.D. (1997). Differential interventions in psychotherapy of borderline, narcissistic and schizoid personality disorders: The Masterson approach. *Clinical Psychology and Psychotherapy*, 4(4), 233-254.
- Rogers, C. R. (1951). *Client-centred therapy*. Boston: Houghton Mifflin.
- Richards, B.M. (1999). Suicide and internalised relationships: a study from the perspective of psychotherapists working with suicidal patients. *British Journal of Guidance and Counselling*, 27(1), 85-98.
- Richards, B.M. (2000). Impact upon therapy and therapist when working with suicidal patients: Some transference and countertransference aspects. *British Journal of Guidance and Counselling*, 8, 3, 325-337.
- Ryle, A (1990). *Cognitive Analytic Therapy and Borderline Personality Disorder: The Model and the Method*. Chichester, UK: John Wiley and Sons.
- Sable, P. (1997). Attachment, detachment and borderline personality disorder. *Psychotherapy*, 34(2), 171-181.
- Sachse, R. and Eliot, R. (2002). Process-outcome research on humanistic therapy variables. In Cain, D.J. & Seeman, J. (Eds.), *Humanistic Psychotherapies: Handbook of Research and Practice*. Washington, DC: American Psychological Association.
- Sackett, D. and Rosenberg, W. (1995). Evidence based medicine and guidelines. In M. Deigham and S. Hitch (Eds.), *Clinical effectiveness from guidelines to cost effective*

*practice*. Brentwood: Earlybrave Publications.

Sadock, B.J. & Sadock, M.D. (2001). *Kaplan and Sadock's pocket handbook of clinical psychiatry* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.

Schon, D.A. (1987). *Educating the Reflective Practitioner*. London: Jossey Bass. In.

Woolfe, R., Dryden, W., Strawbridge, S. (2003). *Handbook of Counselling Psychology*. 2nd (Ed.), p.6.

Shaw, C. and Proctor (2004) Women at the margins: A feminist critique of borderline personality disorder. *Asylum the magazine for democratic psychiatry*, 14,3, 8-10.

Shapiro, M.J. (1986). 'Metaphor in the philosophy of the Social Sciences'. *Cultural Critique*, 2, 191-214.

Soloff, P.H., Lis, J.A., Kelly, T.M., Cornelius, J., & Ulrich, R. (1994). Risk factors for suicidal behaviour in Borderline Personality Disorder. *American Journal of Psychiatry*, 151, 1316-1323.

Showalter, E. (1985). *The female malady*. New York: Pantheon.

Smith, A.J., Kleijn, W.C., and Hutschemaekers, J.M. (2007). Therapist reactions in self experienced difficult situations: An exploration. *Counselling and Psychotherapy Research*, 7(1), 34-41.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39-54.

Smith, J.A. (1995). Semi-structured interviewing and qualitative analysis. In: Murray, M. &

- Chamberlain, K. (1999). *Qualitative Health Psychology: Theories and Methods*. Sage Publications.
- Smith, J.A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Wellbeing*, 2, 3-11.
- Smith, J.A. & Eatough, V. (2007). Interpretative phenomenological analysis. In: G.M. Beawell, S. Hammond, C. Fife-Schaw & J.A. Smith (Eds). *Research Methods in Psychology (3<sup>rd</sup> Edition)*. London: Sage.
- Smith, J.A. and Osborne, M. (2003). Interpretative Phenomenological Analysis. In: J.A. Smith (Ed.). *Qualitative Psychology: A Practical Guide to Methods*. London: Sage.
- Smith, J.A., Flowers, P. and Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, Method and Research*. Sage Publications.
- Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39-54.
- Smith, J.A. & Osborne, M. (2008). Interpretative Phenomenological Analysis. In: J.A. Smith (Ed.), *Qualitative Psychology: A practical guide to methods* (2nd ed.). London: Sage.
- Sperling, M.B. and Sack, A. (2002). Psychodynamics and Managed Care. *American Journal of Psychotherapy*, 56(3), 362-377.
- Steering Committee (2002). Empirically supported therapy relationships: conclusions and recommendations on the Division 29 task force. In: Norcross, J.C. (Ed.), *Psychotherapy Relationships that Work: Therapists Contributions and Responsiveness to Patients* (pp.441-443). Oxford: Oxford University Press.

- Stern, A. (1938). Psychoanalytic investigation and therapy in borderline group of neurosis. *Psychoanalytic Quarterly*, 467-89.
- Stolorow, R.D. (1995). An intersubjective view of self psychology. *Psychoanalytic Dialogues*, 5, 393-399.
- Stone, M. (1989). The course of borderline personality disorder. In: Tasman, A. Hales., Hales, R.E., Frances, A.J. eds. *Review of Psychiatry*. Vol 8. Washington DC: American Psychiatric Press. 103-122.
- Strawbridge, S. and Woolfe, R. (2003). Counselling Psychology in Context. In: R. Woolfe, Dryden, W. & Strawbridge, S. *Handbook of Counselling Psychology* (2<sup>nd</sup> Ed.) (pp. 3-21). Sage Publications.
- Strauss, A., and Corbin, J. (1990a). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Newbury Park, CA: Sage.
- Strupp, H.H. (1980). Success and failure in time limited psychotherapy: A systems comparison of two cases. *Archives of General Psychiatry*, 37, 595-603.
- Swartz, M., Blazer, C., George, L., and Winfield, I. (1990). Estimating the prevalence of personality disorder in the community. *Journal of Personality Disorders*, 4, 257-272.
- Szasz, T.S. (1961). *The myth of mental illness*. New York: Hoeber-Harper.
- Szasz, T. (1978). *The myth of psychotherapy*. Garden City, NJ: Doubleday/Anchor Press.
- Therriault, A. and Gazzola, N. (2008). Feelings of incompetence among experienced therapists: A substantive theory. *European Journal of Qualitative Research in Psychotherapy*, 3, 19-29.

Ussher, J. (1992). *Womens madness: Misogyny or mental illness?* Amherst: University of Massachusetts Press.

Van-Manen, M. (1998). Modalities of body experience in illness and health. *Qualitative Health Research: An international interdisciplinary Journal*, 8, 7-24.

Westland, S. and Shinebourne, P. (2009). Self deception and the therapist: an interpretative phenomenological analysis of the experiences and understandings of therapists working with clients they describe as self deceptive. *Psychology and Psychotherapy: Theory, Research and Practice*, 82, 385-401.

Widiger, T.A., and Weissman, M.M. (1991). Epidemiology of borderline personality disorder. *Hospital Community Psychiatry*, 42, 1015–1021.

Wilson, J.P., and Lindy, J.D. (Eds.). (1994). *Countertransference in the treatment of PTSD*. New York: Guilford.

Winnicott, D.W. (1954). Metapsychological and clinical aspects of regression within the psychoanalytic set-up. *International Journal of Psychoanalysis*, 37, 16-26.

Widiger, T.A., and Frances, A.J. (1989). Epistemology, diagnosis and comorbidity of borderline personality disorder. In A. Tasman, R.E. Hales, & A.J. Frances (Eds.), *Review of psychiatry*, vol., Washington, DC: American Psychiatric Press.

Wood, A.D. (1973). 'The fashionable diseases': Women's complaints and their treatments in nineteenth-century America. *Journal of interdisciplinary History*, 4 (1).

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.

Yardley, L. (2008). Demonstrating validity in qualitative research. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods*, (2nd ed). London: Sage.

Yen, S., Zlotnick, C. and Costello, E. (2002). Affect regulation in women with borderline personality disorder traits. *Journal of Nervous and Mental Disease*, 190, 693-696.

Zanarini, M.C., Williams, A.A, Lewis, R.E., Reich, D.B., Vera, S.C., Marino, M.F. et al. (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. *American Journal of Psychiatry*, 154, 1101-1106.



**Section D: Systematic Review of Literature/Critical Review**

**Abbie Kirkham**

**Student Number: 100011293**

**Word Count (Excluding references): 5792 words**

**Research Supervisor: Rosemary Rizq**

**School of Social Sciences**

**City University**

**Submitted in partial fulfilment of the requirement for a DPsych (Post Chartered) in Counselling Psychology, City University, 2013.**

## **A critical reflection of the impact and utility of evidence-based practice on the front line: A Counselling Psychologists perspective.**

*'Roses are red, violets are blue, research is a thorn in my side, but it will help my dreams come true.'* (Piercy et al., 2005:369)

This quote was taken from a qualitative study (Piercy et al, 2005) investigating family therapy trainees' feelings towards research. Participants were asked to describe their experiences through the use of poetry and metaphors. I have included this quote here as it usefully captures my own ambivalent feelings towards research. In this review I hope to reflect on my feelings towards different aspects of research and consider how this struggle has impacted on my practice.

### **Aims, Objectives and Rationale for the Review**

During my time as a both a trainee and qualified Counselling Psychologist, I have embarked on a number of different courses and experiences all of which have, to a greater or lesser extent, contributed to my endeavour to develop myself as an ethical and effective practitioner. These experiences have been numerous and diverse, ranging from moments of realising something of significance in personal therapy and supervision, to learning about something of relevance at a professional training workshop. Among these diverse activities, there are particular types of knowledge I have taken on that are said to carry more weight to practice than others. This type of knowledge is referred to as Evidence-Based Practice (EBP).

This critical review aims to consider the utility of different types of evidence under which my diverse experiences broadly fall. That is, those that conform to the standards espoused to within a framework of EBP and those experiences that arguably fall short of empirical scrutiny. EBP has been defined in a number of different ways (e.g. Olsson, 2007). Each use of the term has stimulated particular debates that will be considered in this review where they have presented different implications to my Counselling Psychology practice.

Firstly this review will consider the various ways in which EBP has been conceptualised. It will then consider the relevance of this enquiry within a Counselling Psychology framework and introduce some of the debates arising from these methods of research as they impact on therapeutic practice. These debates will highlight some epistemological tensions within Counselling Psychology research and practice. However, wider discussion regarding the complex debates stimulated by these opposing frameworks are beyond the scope of this paper.

The resistance some psychological practitioners have towards EBP will aim to further illuminate such debates and issues. Throughout this paper, I aim to consider how particular types of evidence have facilitated my professional development and impacted on my practice. I hope to achieve this aim by reflecting on my role as a Counselling Psychologist working within an NHS Secondary Care Community Mental Health Service. In view of my particular interest in working with clients diagnosed with Borderline Personality Disorder (BPD), I aim to provide illustrations of my practice that are particularly relevant to this client group. Given this background, I inevitably find myself straddling a

number of different and opposing epistemological frameworks, which bring to life the impact of these debates in my day-to-day work and therapeutic practice. Before introducing these wider issues, this paper will first consider the historical origins of the term EBP and some of the ways in which the term has been defined.

### **What is Evidence-based Practice?**

The diversity of what we practice in psychological therapy implies a need and ethical responsibility to define our practices. Arguable, EBP serves to provide a framework in which practitioners can define and justify the way they work with clients. However, the appropriateness of this framework for conceptualising complex human difficulties has been widely debated among academic, research and psychotherapeutic professions. Prior to introducing these important debates and their implications for Counselling Psychology, it is necessary to consider the origins of the concept, that is EBP and the various ways in which the term has subsequently been used.

There is a lack of clarity surrounding the definition and function of the concept. The term has been met with some intense resistance as well as being revered for its association with 'best practice'. The term itself is taken from a more specific term, Evidence-Based Medicine coined by Archie Conchrane (Professor of Tuberculosis and Chest Diseases) in response to his experiences of administering medical treatment to his patients in prisoner of war camps during the 1940s. He considered his limited effectiveness in treating his patients to have arisen from his limited knowledge base, which at the time largely rested on his own intuition

and experience and which, Conchrane reflected, led to the unnecessary death of some of his patients. From these experiences, he proposed a coherent framework in which knowledge could be brought together, organised and developed. This would form an evidence base that could be utilised by all doctors. Conchrane's early concept of Evidence Based Medicine has since been adapted to apply to a variety of specialist areas including applied psychology.

Various uses of the term have since been noted in the literature (e.g. Sackett et al, 1996; Olsson, 2007; Midgley, 2009). Sackett et al, (1996:71) defined EBP as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients'. Olsson (2007) distinguished two types of uses of the term. Firstly, EBP was regarded as a series of psychological interventions that proved beyond chance, via the reduction of symptoms, their effectiveness through empirically supported research. The second use of the term noted by Olsson focussed on the way in which research findings were used to inform practice. This latter use of the term is similar to Sackett's et al (1996) and implies that improved outcomes are by and large determined by the use of up to date and 'available' research findings.

These uses of the terms and the context in which EBP emerged suggest that practices that do not empirically demonstrate their effectiveness fall short of 'best practice'. This view is grounded in the values of positivism. Within this framework, it is only 'objective observable or empirically verifiable phenomenon can be considered valid as evidence' (Blair, 2010:20). This approach emphasises a position of enquiry characterised by objectivity and detachment.

Of all the methods that fall within this framework, Randomised Controlled Trials (RCTs) are considered to be the most scientifically robust method for investigating psychological research (Wessley, 2001). It is argued that RCT's operate under the belief that psychological interventions are the active ingredients that lead to change in the same way that pharmaceutical medication targets and brings about relief of physical problems. Elkins (2009), Marzillier (2004) and Mollen, (2009) point out that this is not the case. For example, claims that change results from these particular interventions are heavily contradicted by a vast body of evidence linking the therapeutic relationship with improved outcome (e.g. Norcross, 2011).

Furthermore, it is argued that findings arising from research using RCTs are not always clinically meaningful to practice (Henton and Midgley, 2012). For example, research using RCT procedures tend to base client presentations on those set out in the Diagnostic and Statistical Manual of Mental Disorders, when it is often the case that clients do not fit readily into these categories (Westen, Thompson-Brenner and Novotny, 2004).

In addition, RCTs often aim to administer standardised interventions that conform to a particular therapeutic approach (e.g. Cognitive Behavioural Therapy). Frank and Frank (1991) suggest that this level of adherence to a specific model does not reflect clinical practice. This apparent gap between research findings and practice has been cited by a number of academics and practitioners across a diverse group of disciplines. These include Counselling Psychology (Strawbridge and Woolfe, 2003), Social Work (e.g. Rosen, Proctor,

and Straut, 1999) and Education (e.g. Hiebert, Gallimore and Stigler, 2002). Despite these limitations, the evidence generated from RCT studies had come to dominate clinical guidelines and influence psychological practice. Within Mental Health, the National Institute for Clinical Excellence (NICE) is the body responsible for compiling and disseminating clinical guidance. Evidence arising from RCTs is given an 'A' rating reflecting its so called 'gold standard' position as a method of research. Consequently, therapeutic approaches that do not feature so widely within research using RCTs are becoming overshadowed (e.g. Wachtel, 2010) by approaches more amenable to standardised conditions of research. This inevitably shapes clinical guidelines and can form a basis for commissioning bodies to justify the provision of particular interventions over others. The concern here is that such decisions are driven by political and economic factors over and above the actual needs of individual clients. This is particularly apparent in the Improving Access To Psychological Services Initiative (Department of Health, 2008), which is heavily dominated by brief cognitive behavioural therapy interventions for the 'treatment' of a range of psychological difficulties as conceptualised by the DSM criteria.

### **Counselling Psychology and Evidence-Based Practice**

These issues present a particular difficulty for the Counselling Psychology profession. It is argued that certain phenomenon considered central to understanding complex emotional difficulties are not testable using this method of research (Carter, 2002). Counselling Psychology instead emphasises the importance of 'mutually constructed realities' (Blair, 2010), and the subjective value of experience.

Central to the identity of Counselling Psychology is the important role of the therapeutic relationship (Woolfe, 1990). The profession is thus grounded in a humanistic value base that places emphasis on the subjective meaning of experiences and helping clients to realise their potential (Cooper, 2009). In view of these values, the profession advocates the need for methods of research capable of capturing therapeutic practice. Qualitative methods such as Interpretive Phenomenological Analysis (IPA) (Smith et al, 2003) are considered particularly compatible with the philosophical values underpinning this framework. It acknowledges the importance of more positivistic forms of research (e.g. RCTs) but highlights the limitations of these methods for investigating qualitative experience. In line with its humanistic value base, Counselling Psychology advocates a:

*'...respect for the personal subjective experience of the client over and above notions of diagnosis, assessment and treatment, as well as the pursuit of innovative, phenomenological methods for understanding human experience'. (Lane & Corrie, 2006:17)*

This emphasis is distinguished from other frameworks of research and practice aligned to a positivist framework. Within this perspective, particular importance is placed instead on technical expertise and the delivery of specific types of treatment responses that aim to work on particular symptom presentations.

This is not to say that Counselling Psychologists do not work within a positivist framework as Blair (2010:20) points out:

*'Counselling Psychology is situated at a busy junction of diverse and sometimes competing ideologies, frameworks and paradigms'.*

Among these paradigms influencing Counselling Psychology is the scientist-practitioner model. The model emphasises the important role of research. According to this framework, Counselling Psychologists should aim to be competent scientists and researchers and be able to apply knowledge arising from research to their practice (Jones and Mehr, 2007). The appropriateness of the scientist-practitioner model as a guiding framework for Counselling Psychology research and practice has been heavily debated within the profession. For example, it is argued (Larsson et al, 2012) that this paradigm:

*'...cannot capture the essence of the therapeutic relationship that is integral to the work of counselling psychologists, and the model is in danger of driving counselling psychology towards the 'scientism' it aimed to challenge in the first place' (p.56)*

Despite these inherent difficulties, Corrie and Callahan (2000) deem this model to be necessary particularly for those employed in the NHS, given the association between the scientist-practitioner model and the medical model that occupies a dominant position in the NHS. They suggest Counselling Psychologists 'must embrace the ideology of 'evidence base' practice and conform to the role of the scientist-practitioner model' (Corrie and Callahan, 2000:56). However, others (Bor and du Plessis, 1997) raise the concern that Counselling Psychologists employed in the NHS will be pressured to take on a language synonymous with the medical model framework. Adopting a discourse that centres around 'illness' will inevitably distract practitioners from adopting, a position more aligned to the core humanistic values of Counselling Psychology that emphasises the

importance of a growth perspective (Hage, 2003).

### **Reflecting on my resistance to embrace an EBP framework**

These debates bring to mind my own experience as a Counselling Psychologist working within the NHS Secondary Care Mental Health Service and more specifically, my resistance to employing a framework predicated on an EBP paradigm as underpinned by the medical model. Prior to elaborating on my experiences, I include some relevant details about my position.

My role within this service is to provide individual and group based interventions for clients with a range of psychological and emotional difficulties. My therapeutic approach draws on a psychodynamic perspective. However, I also deliver a structured cognitive behavioural therapy group with colleagues from the wider mental health team for people with a diagnosis of 'BPD', known as Systems Training in Emotional Predictability and Problem Solving (STEPPS), (Blum et al, 2012). Furthermore, my role involves supervising team members and attending team meetings. Because of these diverse duties and responsibilities, I inevitably find myself working closely with colleagues from different professional backgrounds who operate within different epistemological frameworks. Above all, the dominant discourse within the service is embedded in the medical model. Finally, all clients must be deemed sufficiently complex and/or at risk of harm to themselves or others to meet the criteria for this service.

On a number of occasions, I have sat across from a new client who has said something along the lines of: *'My psychiatrist has told me I have got Borderline*

*Personality Disorder and I need to do STEPPS'*. During these moments, a number of issues occupy my mind, all of which seem unhelpful to my new client and leave me feeling somewhat hindered with issues largely unrelated to my client's difficulties. These experiences immediately present me with a dilemma: *My client has been given a diagnosis and seems to have experienced this in a way that helps her to make sense of her difficulties* versus *my client has been given a diagnosis that, in my view, runs the risk of taking her further away from an opportunity to make sense of her difficulties*. This dilemma triggers an intellectual conflict inside me, where I find myself thrown into two opposing epistemological positions adopted by the Counselling Psychology profession: one which embraces a diagnostic system, and the other, which endeavours to recognise the person on their unique terms. Meanwhile, my capacity to be emotionally available to my client in her first session is increasingly limited.

A further challenge that often arises from this predicament concerns the nature of the relationship some clients adopt with the diagnosis. On many occasions, I have experienced clients say something along the lines of: *'Its not me, its my borderline personality disorder'* or *'I cant help it, I've got borderline personality disorder'*. My concern here is that the medical model seems to reinforce the idea that clients have an illness or have something inherently wrong with them and further ossifies their roles of helplessness. This framework lends itself to the subsequent expectation that clients need treatment to 'cure' their 'pathology'. In these instances, it can often feel that I have been assigned the powerful role of the 'professional' who will cure the person of their Borderline Personality Disorder. However, if I do not rely on the same evidence base as the referrer (in

this case, the NICE guidelines for Borderline Personality Disorder, 2009) thus believing that a group based psychological intervention may not be the most suitable option for this person at this time, I am subsequently nudged into a position of rejecting my hopeful client. Conversely if I let the power assigned to me get the better of me, and accept the client into the group, I may instead be setting my client up to fail.

### **Barriers in the application of EBR**

My experience, albeit put rather simplistically, illustrates the specific challenges I encounter within my role working within a Secondary Mental Health Service. A particular problem is the often simplistic translation, and in some cases misuse of the NICE guidelines, that I experience at times as my colleagues using as a basis to justify their decision making, manage their case loads and understandably attempt to manage their stress. Rather than this guidance facilitating decision making, it feels like the guidelines restrict clinicians into thinking within a particular paradigm (i.e. the medical model). As such this limits the opportunity to reflect on a client's presenting difficulties within additional frameworks (e.g. a reflective practitioner framework). Above all, clients who are responded to within this framework run the risk of experiencing further rejection and abandonment, the very experiences that led them to seek help in the first place (Allen, 2004).

Deciding on a particular treatment based on the NICE guidelines does not necessarily reflect the way in which NICE intended its guidelines to be used to facilitate clinical decision making. For example, NICE suggest that client

preferences should also be taken into consideration when deciding a particular course of treatment. However, the way in which NICE guidelines are applied in the above example certainly reflects my own experience of the utility of EBR in clinical practice. This use of the NICE guidelines represents a particular challenge for NICE and represents one of the many barriers they encounter when disseminating research findings.

They have identified a number of barriers to translating research to clinical practice. NICE have taken a number of steps with an aim to increase the use of clinical findings. These steps have included setting up NICE implementation teams across NHS trusts as well as presenting guidelines in more manageable formats (e.g. the quick reference guides). Other initiatives used to help overcome 'barriers to change' are set out in the publication: *'How to change practice: understand, identify and overcome barriers to change' (2008)*. The guide sets out various obstacles to implementation, and offers advice on ways in which these obstacles can be overcome in healthcare settings. What is noticeable from this paper and other initiatives set out by NICE, is the distinct absence of an opportunity to think beyond the scope of such guidelines. As I found in my own practice, rather than guidelines facilitating complex decision making, it seemed to me that the NICE somehow encouraged practitioners to adopt a more narrow way of making decisions, for example deciding that someone fulfilled a set of diagnostic criteria that meant they should be referred to the STEPPS programme. In line with this, Midgley (2009: 33) suggest that the:

'NICE guidelines allows no space for doubt or debate about the value of implementing clinical guidelines and relies on a linear model of translating

information from one domain (research) into another domain (practice)'

Many have argued that the EBP paradigm delivered in this way threatens to undermine clinician autonomy in practice (e.g. Small, 2005). EBP has similarly been referred to as a 'new type of authoritarianism' (Grayson, 1997; Shafer, 1997). As discussed, the concern is that EBP guidelines can be used as basis for justifying the use of particular interventions and a rationale for disregarding other methods of decision making. Others have argued that in their favour, the NICE guidelines and their inclusion of psychological interventions, particularly for the treatment of clients with 'BPD' not only raises the profile of psychological approaches but also promotes those involved in managing a persons treatment to consider psychological intervention when they may have not. This profile is particularly important given the findings on clinician attitudes towards clients diagnosed with 'BPD'. For example, there is a good deal of evidence indicating a perception that clients with a diagnosis of 'BPD' are difficult to treat (Cowan, 2007) and not deserving of treatment (Radley, 1994). The latter author found that these attitudes were influential in treatment decisions. Of concern here, is that although guidance such as NICE may go some way in providing an alternative framework to inform practice (thus one which is based on research findings rather than attitudes), many clinicians suggest that there is often insufficient time to keep abreast of new findings arising from research.

Another issue that has contributed to negative perceptions of EBP concerns the various methods of research employed and the narrow aims which the research targets. In an effort to improve internal reliability, research methods used advocate highly controlled settings with strict inclusion and exclusion criteria. It

is argued that these designs do not represent the complex conditions practitioners encounter in their day-to-day work with clients. In addition, evidence based research tends to focus on treatment efficacy. It is argued that this focus does not take into consideration context specific or individual specific variations that may impact responses to particular psychological interventions. These limitations have led many to ask 'whether the evidence from efficacy trials - and the evidence based paradigm itself - is sufficient in and of itself to underpin policy and practice in routine clinical settings' (Barkham and Mellor Clark, 2003:320). Bowers (2003) suggests that although the EBP paradigm is crucial to informing practice, it is not in itself sufficient. Bowers point (2003) represents an established view, which implies a need to broaden the relevance of an EBP framework.

### **Wider Conceptions of Evidence - Alternative Frameworks**

In line with this point, Midgley (2009) argues that challenges associated with the EBP paradigm are not just concerned with the difficulties involved in translating research into practice settings. He highlights a greater challenge, which is concerned with existing notions of the EBP paradigm. It is argued that current definitions influence clinicians' beliefs that most research findings are not relevant or applicable to practice (e.g. Williams, 1999) as well as being difficult to understand. Many suggest that these concerns go some way to creating a gap between clinical research and practice. For example, Reynolds (2000) argues that the absence of a good working relationship, between those conducting research and those pursuing therapeutic practice, runs the risk of research

becoming further alienated from the concerns arising in the real world.

In an effort to address this gap, a need for wider conceptions of evidence are therefore argued. This extended paradigm (referred to as Methodological Pluralism) would thus make way for the use of qualitative methods and the use of mixed methodologies, something Counselling Psychology has increasingly argued for over recent years (Barbour, 2000; Haverkamp, Morrow and Pontoretto, 2005; McLeod, 2001; Midgley, 2004; Rennie, 1994). In line with this, Strawbridge et al (2003) suggest that:

*'If 'scientific' and 'evidence based' are key terms in the claim of counselling psychologist to professional competence, it is imperative that we examine, reexamine and refine our own conception/s of 'science', 'research' and 'evidence' in order to avoid being drawn into established medicalized forms of practice and research which are limited in their application within our profession' (p.7).*

In agreement with this, Safran (2001) highlights the importance of 'mutuality and dialogue between practice and research' given that both are crucial to one another. Thus, it is believed that embracing wider conceptions of EBP may increase dialogue between research and practice (Morse, 2006). Others (Staller, 2006) take this position further, arguing for the use of alternative frameworks, considered more meaningful to practice. Referred to as 'Practice-Based Evidence' (PBE) (Barkham and Mellor Clark, 2000), this framework emphasises the utility of clinician experience, theoretical knowledge, reflective practice and therapy evaluation (e.g. through audit). Barkham et al (2001) suggest that one of the advantages of the PBE is that the methods used have greater external validity

given that they capture clinical activities in naturalistic conditions. Furthermore, this model highlights the potential for clinicians to use their own practice as a source of evidence to inform themselves and others about their work.

Counselling Psychologists are particularly acquainted with this framework for practice as indicated in their professional practice guidelines (2006). Here Counselling Psychology aims to be:

'Practice led, with a research base grounded in professional practice values as well as professional artistry' (p.2)

Despite these aims, Henton (2012) highlights the relative absence of research activities associated with PBE as indicated by the relative lack of articles on the subject featuring in the *Counselling Psychology Review*. The lack of PBE activities among UK Counselling Psychologists was further indicated in a current UK publication dedicated to this area, which did not include any UK researchers (Barkham, Hardy and Mellor-Clarke, 2010).

However, importantly, it is suggested (Staller, 2006) that PBE has the potential of generating research relevant to the local context. This point brings to mind my own qualitative research project, which aimed to explore the experiences of psychological practitioners working with clients diagnosed with 'BPD'. The results highlighted the relevance of the local working context on clinicians' experiences. For example, some participants reported how they felt unsupported by colleagues in the wider mental health team. This identified problem of practice was thus potentially rooted in local systems. These findings highlight the value of PBE research that gives rise to knowledge arising in the

local working context.

Regrettably, in my role as a Counselling Psychologist working in the NHS, I find myself with little opportunity to participate in research activities. In the eight years I have been employed by the service, the research I have been involved in comprises two substantial qualitative studies conducted in partial fulfillment for my Counselling Psychology qualifications. This research has, on the whole, been conducted outside of my working hours. This could be seen to indicate the value (or lack of it) my organisation places on individual clinicians conducting psychological research and as such, their reluctance to embrace a climate which promotes such activities. This lack of opportunity to participate in research activities is by no means unusual as indicated by Fitzgerald and Osipow (1984) and Watkins et al (1986) who showed that Counselling Psychologists commit the majority of their time to therapeutic practice. This reality further suggests that the scientist-practitioner model and the equal importance it places on research and practice activities may not be realistic and/or accurate in representing Counselling Psychology's professional identity in the NHS.

On reflection, I wonder if the lack of valuing I refer to above implicitly communicated by my organisation has contributed to my own experience as a Counselling Psychologist conducting research. At times, I have found my research activities to be particularly onerous, isolating and frustrating. However, this experience is not unique. Evidence generally indicates negative feelings among Counselling Psychology trainees towards research activities (e.g. Moran, 2011). Regarding my own research, I have spent the last three years conducting and writing up my thesis, dedicating much of my own time to complete it or in

my actual words 'to get it done'. Whilst at times my experience has been heavily overshadowed with feelings of resentment, there have equally been moments where I have found the experience remarkably rewarding. For example, when listening to my participants' interviews and having the opportunity to engage so deeply in their accounts. Furthermore, I believe I have gained a lot from engaging in existing theoretical and clinical literature associated with my area of research.

**Reconciling the uneasy relationship between research and practice -  
reflecting on how different methods of research has informed my  
professional practice**

As indicated in the above section, my relationship with research (both my own and others) has been one of ambivalence. Prior to conducting my own research, I reflect that my struggle to embrace different sources of evidence was because, on the whole, it had not personally resonated with me in way that made it sufficiently meaningful or applicable to my therapeutic practice. My experience is in line with the views of many authors mentioned in this paper, pointing to the existence of a research practice gap (e.g. Small, 2005).

However, I believe my relationship with my own research has provided an opportunity for me to engage in different types of research in a way that has felt meaningful and indeed applicable to my therapeutic practice. As such, to borrow Safran's words (2001), I have found a way to adopt a position characterised by 'mutuality and dialogue' between these different aspects of my work. In this section, I hope to provide some examples of the way in which the different types

of research I have engaged with during the course of conducting my own research have impacted on my therapeutic practice. This includes studies arising from positivistic forms of research (which tends to feature in guidelines such as NICE) and phenomenological forms of research (which tend to fall within the framework of PBE). In reflecting on these personal gains, I would agree with Kasket's view (2012:66) that:

'...being a counselling psychologist researcher may also mean recognising that although you may hold a particular theoretical or epistemological stance, this does not prevent your getting something useful from a piece of research that does not demonstrate that stance'.

Indeed, carrying out my own research required me to become more familiar with many areas of research that adopted different methodological approaches, as well as theoretical writing associated with 'BPD'. Despite my years of experience working with this client group, I did not feel sufficiently familiar with the literature. On reflection, I believe that in the absence of this knowledge, I would question myself that perhaps I did not know something that I should know in a particular situation with a client. Thus I would locate my feelings of not knowing on the belief that I was not keeping abreast of research/theoretical knowledge. This preoccupation would distract me from thinking about other possibilities, i.e. something arising in the relationship with my client. Having become more familiar with the literature, I am aware that this lack of knowledge at the time was not responsible for these experiences. I now find myself feeling more confident and willing to stay with these feelings rather than view them as a

source of my professional incompetence and thus find myself grasping for a position of 'all knowing' in an attempt to rescue myself from these vulnerable moments. This position I refer to as 'not knowing' here is widely recognised as a mentalising stance considered important when working with clients diagnosed with 'BPD' (Bateman and Fonagy, 2006). On reflection, I recognise some factors that have hindered my willingness to adopt a stance characterised by curiosity and openness, and that my precoccupation with not having the relevant sort of knowledge was one of them.

Furthermore, having acquired theoretical and research based knowledge as a result of conducting a research project, I am now in a position where I can elect to use various aspects of my knowledge, whether it be drawing on an Object Relations framework (Klein, 1946) or a Cognitive Analytic framework (Ryle, 1990) from an informed position.

The second way in which I have used my research to inform my practice is by learning from my participants' accounts of their work with clients diagnosed with 'BPD'. This would be considered as a type of PBE. One of the themes to arise from my research was entitled: *Feeling inadequate in their responses to their patients*. I have used these insights to reflect on my own feelings of lacking that can arise when working with clients. These insights have perhaps normalised my experiences and led me to not feel so personally injured by them. In doing so, I have found an increased capacity within myself to think about what may be going on between my client and I. I have previously struggled with these moments in clinical practice to the extent that I have encountered a momentary experience of not being able to think. On reflection, this experience could mirror

something of my client's difficulty in thinking about the mental states of others. Bateman and Fonagy (2006) suggest that this can be apparent in clients who have been traumatised 'because thinking about the mental states of abusers who are also attachment figures is unbearably painful' (p.18-19).

These examples indicate the ways in which I have used research (both my own and others) to inform my day-to-day practice. In addition, it is hoped that my engagement with various methods of research demonstrates the view proposed by Barkham and Baker (2003) among others that PBR and EBP can coexist and work together to provide 'both rigorous and relevant' (p.323) paradigms for research and practice. On reflection, I feel that the level of engagement this piece of work demanded was what made my relationship with research meaningful and facilitative to my therapeutic practice. My personal sense of ownership was also important here, in that there was something particularly empowering in generating my own relationship with research rather than feeling like a passive recipient to research, for example delivered via a workshop. This implies that something more may be necessary when attempting to reconcile the uneasy relationship practitioners have with research. In line with my own experience, Lerner et al (2003) proposes that any level of practitioner participation in research is likely to engender a more relevant and meaningful relationship between consumers and research.

## **Conclusions**

This paper has aimed to reflect on the impact of different types of evidence on therapeutic practice. Furthermore, it has considered the ways in which the

epistemological paradigms underpinning these different types of research methods has influenced my day-to-day work. It is argued that existing conceptions of EBP have a powerful presence in the NHS and as such threaten to overshadow the humanistic values attached to the profession of Counselling Psychology. As such, wider conceptions of EBP are argued for and the need to incorporate additional paradigms of research. It is also argued that broadening the EBP concept will increase its relevance to therapeutic practice.

It is believed that these implications present a particular challenge to the NHS given the current political and economic climate (which is obviously a huge issue of on-going debate elsewhere). As Allen (2004) points out mental health services are in 'a state of repeated structural change'. It is felt that these conditions are not particularly conducive to those necessary to embrace such changes as are implied in this paper. However, as indicated in the Division of Counselling Psychology professional practice guidelines, it is the responsibility of practitioners themselves to keep:

'...abreast of literature, broadening professional and personal experience, consulting with colleagues , participating in workshops, courses and conferences as well as regularly reviewing their own needs and performance' (p.3).

Whilst the practice based atmosphere may feel constrained currently, it is anticipated that developing a more engaging and lively dialogue with different types of research will serve to keep the values held so closely within the profession alive.

## **References**

- Allen, C. (2004). Borderline Personality Disorder: Towards a systemic formulation. *Journal of Family Therapy*, 26,126-141.
- Barbour, R.A. (2000). The role of qualitative research in broadening the 'evidence base' for clinical practice. *Journal of Evaluation in Clinical Practice*, 6, 155-163.
- Barkham, M. and Mellor-Clark, J. (2000). Rigour and relevance: practice based evidence in the psychological therapies. In: N Rowland and S. Goss (Eds), *Evidence-based counselling and psychological therapies*.
- Barkham, M. and Baker, J. (2000). Establishing practice based evidence for counselling psychology. In R. Woolfe, W. Dryden, and S Strawbridge (Eds), *Handbook of counselling psychology* (2nd Ed, pp. 93-117). London: Sage.
- Barkham, M. and Clark, J.M. (2003). Bridging Evidence-Base Practice and Practice-Base Evidence: Developing a Rigorous and Relevant Knowledge for the Psychological Therapies. *Clinical Psychology and Psychotherapy*, 10, 319-327.
- Barkham, M., Hardy, G.E. and Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies*. Oxford: Wiley-Blackwell.
- Bateman, A.W. and Fonagy, P. (2006). *Mentalisation based treatment for borderline personality disorder: A practical guide*. Oxford: Oxford University Press.
- Bor, R. and du Plessis, P. (1997). Counselling Psychology research in health care

settings. *Counselling Psychology Review*, 12, 19-22.

Bower, P. (2003). Efficacy in evidence-based practice. *Journal of Clinical Psychology and Psychotherapy*, 10, 328-336.

British Psychological Society (2006). *Division of Counselling Psychology: Professional Practice Guidelines*. Leicester: Author.

Blair, L. (2010). A critical review of the scientist-practitioner model for counselling psychology. *Counselling Psychology Review*, Vol 25(4), 19-30.

Blum, N.S., Bartels, N.E., St John, D., Pfohl, B. (2012). *Systems Training for Emotional Predictability and Problem Solving (STEPPS 2nd Ed)*. Available on CD-ROM from Level One Publishing ([www.stepsforbpd.com](http://www.stepsforbpd.com)).

Carter, J.A. (2002). Integrating science and practice: Reclaiming the science in practice. *Journal of clinical psychology*, 58(10), 1285-1290.

Cooper, M. (2009). Foreword. In T. Bond (Ed.), *Standards and Ethics in Counselling in Action*. London: Sage.

Conchrane, A. (1972). *Effectiveness and Efficiency: Random reflections on health services*. London: Nuffield Provincial Hospitals Trust.

Corrie, S. and Callahan, M.M. (2000). A review of the scientist-practitioner model: Reflections of its potential contribution to counselling psychology within the context of current health trends. *British Journal of Medical Psychology*, 73 (3), 413-427.

Department of Health (2008) IAPT Implementation Plan: National Guidelines for

Regional Delivery, Department of Health, Editor.

Elkins, D.N. (2009). The medical model in psychotherapy: Its limitations and failures. *Journal of Humanistic Psychology*, 49(1), 66-84.

Fitzgerald, L.F. and Osipow, S.H. (1984). An occupational analysis of counselling psychology: how special is the specialty? *American Psychologist*, 41, 535-544.

Frank, J.D. and Frank, J.B. (1991). *Persuasion and healing: A comparative study of psychotherapy*. (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Grayson, L. (1997). *Evidence Based Medicine*. The British Library: London.

Hage, S.M. (2003). Reaffirming the unique identity of counselling psychology: Opting for the road less travelled by'. *The Counselling Psychologist*, 31(5), 555-563.

Haverkamp, B.E., Morrow, S.L. and Ponterotto, J.G. (2005). A time and place for qualitative and mixed methods in counselling psychology research. *Journal of Counselling Psychology*, 52(2), 123-125.

Heibert, J., Gallimore, R. and Stigler, W. (2002). A knowledge base for the teaching profession: What would it look like and how can we get one? *Educational Researcher*, 31, 3-15.

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review*, Vol 27 (3), 11-28.

Henton, I. and Midgley, N. (2012). 'A path in the woods': Child psychotherapists

participation in a large randomised controlled trial. *Counselling and Psychotherapy Research*, 12(3), 1-10.

Jones, J.L. and Mehr, S.L. (2007). Foundations and assumptions of the scientist-practitioner model. *American Behavioural Scientist*, 50(6), 766-771.

Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, Vol 27 (2), 64-73.

Klein, M. (1946). Notes on some schizoid mechanisms. J. Mitchell (ed.) *The Selected The Selected Melanie Klein*. London: Penguin. 1991.

Lane, D.A. and Corrie, A. (2006). Counselling Psychology: Its influences and future. *Counselling Psychology Review*, 21(1), 12-24.

Larsson, P., Brooks, O. and Loewenthal, D. (2012). Counselling psychology and diagnostic categories: A critical literature review. *Counselling Psychology Review*, Vol 27(3), 55-64.

Lerner, R.M., Wertlieb, D., and Jacobs, R.A. (2000). Toward a science for and of the people: Promoting civil society through the application of developmental science. In R. Lerner, F. Jacobs, and D. Wertlieb (Eds.), *Handbook of Applied Developmental Science: Promoting positive child, adolescent, and family development through research, policies and programs*, Vol 1, 1-28. Thousand Oaks, CA: Sage.

Marzillier, J. (2004). The myth of evidence based psychotherapy. *The Psychologist*, 17(7), 392-395.

McLeod, J. (2001). Developing a research tradition consistent with the practices and values of counselling and psychotherapy: Why 'Counselling and Psychotherapy Research' is necessary. *Counselling and Psychotherapy Research*, 1(1), 3-11.

Midgley, N. (2004). Sailing between scylla and Charybdis: Incorporating qualitative approaches into child psychotherapy research. *Journal of Child Psychotherapy*, 30(1), 89-111.

Midgley, N. (2009). Disseminator's vs revisionists: attitudes to the 'implementation gap' in evidence-based practice. *Journal of Children's Services*, Vol 4(4), 28-36.

Mollon, P. (2009). The Nice guidelines are misleading, unscientific and potentially impede good psychological care and help. *Psychodynamic practice: Individuals, groups and organisations*, 15(1),9-24.

Moran, P. (2011). Bridging the gap between research and practice in counselling and psychotherapy training. Learning from trainees. counselling and psychotherapy training: Learning from trainees. *Counselling and Psychotherapy Research*, 11(3), 171-178.

Morse, J.M. (2006). Reconceptualizing qualitative evidence. *Qualitative Health Research*, 16(3), 415-422.

NICE (National Institute of Clinical Excellence)(2007). *How to change practice: Understanding, identifying and overcoming barriers to change*. London: National

Institute for Health and Clinical Excellence.

National Institute of Health and Clinical Excellence (2009). *Borderline personality disorder: treatment and management*. NICE Clinical guideline 78. London: NICE.

Norcross, J.C. (2011). *Psychotherapy Relationships That Work*: Oxford University Press.

Olsson, T.M. (2007). Reconstructing evidence based practice: an investigation of three conceptualisations of EBP, *Evidence and Policy*, 3(2), 271-285.

Piercy, F.P., McWey, L.M., Tice, S., James, E.J., Morris, M. and Arthur, K. (2005). It was the best of times: Doctoral experiences of family therapy research training through alternative forms of data representation. *Family Process*, 44(3), 363-378.

Radley, A. (1994). *The healing relationship: Doctors, patients and nurses. Making sense of illness: The social psychology of health and disease*. London: Sage.

Rennie, D. (1994). Human science and counselling psychology: closing the gap between research and practice. *Counselling Psychology Quarterly*, 7(3), 235-250.

Reynolds, S. (2000). Evidence-based practice and psychotherapy research. *Journal of Mental Health*, 9(3), 257-266.

Rosen, A., Proctor, E., and Straudt. (1999). Social Work research and the quest for effective practice. *Social Work Research*, 23, 4-14.

Ryle, A (1990). *Cognitive Analytic Therapy and Borderline Personality Disorder: The Model and the Method*. Chichester, UK: John Wiley and Sons.

Sackett, D.L., Rosenberg, M.C., Gray, J.A., Haynes, R.B., and Richardson, W.S. (1996). Evidence based medicine: what it is and what it isn't. *British Medical Journal*, 312, 71-72.

Safran, J.D. (2001). When worlds collide: Psychoanalysis and the empirically supported treatment movement. *Psychoanalytic dialogues*, 11(4), 659-681.

Shahar, E. (1997). A Popperian perspective of the term 'evidence based medicine'. *Journal of Evaluation in Clinical Practice*, 3, 109-116.

Small, S.A. (2005). Bridging Research and Practice in Family and Human Sciences. *Family Relations*, 54, 320-334.

Smith, J.A. and Osborne, M. (2003). Interpretive Phenomenological Analysis. In: J.A. Smith (Ed.). *Qualitative Psychology: A Practical Guide to Methods*. London: Sage.

Staller, K. (2006). Railroads, runways and researchers: returning evidence rhetoric to its practice base. *Qualitative Inquiry*, 12(3), 503-522.

Strawbridge, S. and Woolfe, R. (2003). Counselling Psychology in Context. In: R. Woolfe, Dryden, W. & Strawbridge, S. *Handbook of Counselling Psychology* (2<sup>nd</sup> Ed.) (pp. 3-21). Sage Publications.

Wachtel, P.L. (2010). Beyond 'EST's': Problematic assumptions in the pursuit of

evidence-base practice. *Psychoanalytic Psychology*, 27(3), 251-272.

Watkins, Jr., C.E., Lopez, F.G., Campbell, V.L. and Himmell, C.D. (1986).

Contemporary counselling psychology: Results of a national survey. *Journal of Counselling Psychology*, 33, 301-309.

Westen, D., Novonty, C.M. and Thomson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 13(4), 631-663.

Wessley, S. (2001). Randomised controlled trials : The gold standard? In C.Mace, S. Mooray and B. Roberts (Eds.), *Evidence in the psychological therapies: A critical guide for practitioners*, (pp.46-59) Hove: Brunner-Routledge.

Williams, D.I. and Irving, J.A. (1999). Why are therapists indifferent to research? *British Journal of Guidance and Counselling*, 27(3), 367-376.

Woolfe, R. (1990). Counselling Psychology in Britain: an idea whose time had come. *Psychologist*, 3(12), 531-535. In: In: R. Woolfe, Dryden, W. & Strawbridge, S. *Handbook of Counselling Psychology* (2<sup>nd</sup> Ed.) (pp. 3-21). Sage Publications.