

A study to establish what constitutes an effective therapeutic alliance and how this can be achieved and maintained with a difficult to engage client group, those with a diagnosis of Borderline Personality Disorder.

Thesis submitted in partial fulfilment of the Doctorate in Clinical Psychology for the
University of Leicester

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Statement of Originality

I confirm that this is an original piece of work.

The literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.

A study to establish what constitutes an effective therapeutic alliance and how this can be achieved and maintained with a difficult to engage client group, those with a diagnosis of Borderline Personality Disorder.

Aims:

A broad aim of this thesis was to add to the literature concerning the experiences of therapists who had created and maintained therapeutic alliances with clients diagnosed with Borderline Personality Disorder (BPD).

Literature Review:

The review identified that the therapeutic alliance had a strong influence on the outcomes of therapy in general clinical practice. The alliance had a positive effect on therapeutic outcome, independent of the model of therapy involved. Breakdown in the alliance could be predicted, enabling remedial steps to be taken by the therapist. The evidence for the matching of therapist to client by gender and ethnicity is inconclusive. Research with regard to the therapeutic alliance and BPD would suggest that the alliance is harder to achieve with this client group. Once established there is some evidence that it is rated stronger where cognitive therapies are used than those from the psychodynamic perspective. Frameworks are being developed which will enable the therapist to compare their emotional response to clients with normed data.

Methodology:

A qualitative research study which involved semi-structured interviews of twelve therapists from nursing, psychiatry and psychology. The study was designed to capture the therapist's personal experiences of forming therapeutic alliances with Borderline Personality Disorder clients. The interviews were audio recorded, transcribed and then analysed using Grounded Theory methodology.

Main findings:

A model was constructed which described the psychological aspects of forming an alliance with Borderline Personality Disorder clients. The model comprised four main categories. Therapists had to manage 'unavoidable influences' from persons outside of the alliance, 'cultural and gender differences' that existed between the therapist and client and their own 'emotional reactions' evoked by interactions with the client. Key to their successful management was the effective use of 'clinical supervision'. The model was independent of any therapeutic model of treatment.

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And most importantly to the twelve interviewees who gave up their time to participate in very frank and open discussions of their professional working experiences.

Word Count

Section	Number of words
1. Literature review	7,998
References & Appendices	7,034
Subtotal	15,032
2. Research report	12,581
References & Appendices	3,441
Subtotal	16,022
3. Critical appraisal	2,629
References & Appendices	1,551
Subtotal	4,180
Total	35,234

Notes on style

This thesis, consisting of a literature review, a research paper and a critical appraisal has been written with a view to submission to the Journal of Clinical Psychology. It has been written in accordance with the guidelines to contributors for this journal and therefore their recommended system of referencing and heading conventions have been used. See Appendix A of the Literature Review for further details on style.

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Section 1

Literature Review

The influence of the therapeutic alliance between therapist and client, the impact of gender and race on this relationship and the consequences for the treatment of Borderline Personality Disorder.

(Submitted in accordance with the requirements of the British Journal of Clinical Psychology – See Appendix A).

1.1 Contents

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1.2 List of Appendices – Literature Review

- A. Notes for Contributors: The British Journal of Clinical Psychology.
- B. Total Population of the United Kingdom.
- C. Top twenty languages spoken in London.
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A Review of the literature relating to the influence of the therapeutic alliance between therapist and client, the impact of gender and race on this relationship and the consequences for the treatment of Borderline Personality Disorder.

1.3 Abstract.

Purpose:

To review the literature relating to the influence of the therapeutic alliance between therapist and client, the impact of gender and race on this relationship and the consequences for the treatment of Borderline Personality Disorder (BPD).

Method:

A search strategy was used to identify the relevant literature, followed by a critical appraisal of that literature, culminating in a synthesis of the research studies examined.

Results:

The therapeutic alliance has a strong influence on the outcomes of therapy in general clinical practice. Breakdown in the alliance can be predicted, enabling remedial steps to be taken by the therapist. The evidence for the matching of therapist to client by gender and ethnicity is inconclusive. Research with regard to the therapeutic alliance and BPD would suggest that the alliance is much harder to achieve with this client group. Once established there is some evidence that it is rated stronger where cognitive behavioural type therapies are used than those from the psychodynamic perspective. Frameworks are being developed which will enable the therapist to compare their emotional response to clients with normed data.

Conclusions:

This review has highlighted many positives; the strong evidence base for the alliance, the predictive value of measuring the alliance and the encouragement to treat Personality Disorders. Of particular interest is the development of frameworks to assist the therapist to improve their cultural competency and emotional awareness.

1.4 Introduction.

The current review will first examine the evidence relating to the therapeutic alliance in general terms before specifically looking at the impact of gender and race and finally its application to Personality Disorder (PD) and Borderline Personality Disorder (BPD).

The therapeutic alliance has been proven over many studies to be a significant influence in producing positive outcomes in therapy (Bowers & Clum, 1988; Horvath & Symonds, 1991). Various instruments for measuring the success of the therapeutic alliance have been developed. As well as measuring success, these measures offer the potential to predict a breakdown of the alliance, enabling the therapist to consider taking some form of reparation. However, conflicting evidence will be presented as to whether assessments by therapist, client or an independent observer offer the most accurate predictions (e.g. Gunderson *et al.*, 1997, Horvath and Symonds, 1991). Although considered to be independent of therapeutic orientation (Bordin, 1994), the possibility that the quality of the alliance is influenced by the therapeutic model employed will be explored.

A secondary consideration for the current review is the impact that gender and race has on the therapeutic alliance. Although not conclusive, a number of studies have reported improved ratings of the therapeutic alliance when the patient and therapist were matched by gender. Interestingly, although patients demonstrated a preference for therapists of the same ethnic background, there was little evidence to suggest that this resulted in improved clinical outcome (e.g. Maramba & Hall, 2002).

Evidence will be presented to show that individuals such as those diagnosed with PD/BPD were often considered too difficult to engage in a productive therapeutic alliance (Yeomans *et al.* 1994). The previous experiences of this patient group, including a history of the poor management of relationships and the inability to trust others had made the creation and maintenance of therapeutic relationships particularly difficult (Norton & Hinshelwood, 1996). Consequently, there has been reluctance on behalf of clinicians to work with people diagnosed with PD/BPD. Clinicians had stated they were not skilled sufficiently to deal with this group of patients (NIMHE, 2003). However, the current review will show that attitudes towards the treatment of PD have changed. PD is now high on the Government's Health agenda. The various Government publications and those of the British Psychology Society which are currently driving initiatives in relation to the treatment of PD/BPD will be examined.

The difficulties associated with the diagnosis of PD and BPD will be examined as will its prevalence within the UK. The differences ascribed to gender and race will be presented as will the potential for an effective therapeutic alliance for those suffering from PD and in particular BPD.

It should be noted that some authors use the terms 'service users' and 'patient' whilst others, 'client'. For the purposes of the current review these terms have been treated as interchangeable. Individual authors' particular descriptions have been preserved and therefore all three terms can be found in this current review.

1.5 Methodology

Search Strategy

The current review employed a search strategy using a number of academic electronic databases, namely, Psychinfo, Scopus, ISI Web of Science and Medline. The aim of the strategy was to identify informative and well evidenced literature in relation to the therapeutic alliance and its impact on the treatment of difficult to engage clients, in particular those with a diagnosis of Borderline Personality Disorder (BPD). The search included the use of a number of keywords as shown below. The use of inclusion and exclusion criteria ensured the parameters and focus of the literature review was maintained.

Keywords:

Personality disorder, borderline personality disorder, alliance, therapeutic alliance, measuring the alliance, cognitive therapy, cognitive analytical therapy, cognitive behaviour therapy, dialectical behaviour therapy, psychoanalytic psychotherapy, developing the therapeutic alliance, ethnicity, diversity, race and gender.

Inclusion and exclusion criteria.

The current review was focused on the treatment of adults and therefore any studies relating to children, adolescents and elderly adults were excluded. Safran and Muran (1996) made reference to the concept of the therapeutic alliance as having originated in

early psychoanalytic literature (e.g. Sterba, 1934; Zetzel, 1956) and therefore all the searches were restricted to the period between January 1930 and July 2008.

Scope of the Review.

The final selection of material was made with the following in mind:

- . To provide sufficient evidence of the important and influential link between the therapeutic alliance and outcome.
- . To allow a brief overview of the methods and instruments used to measure the therapeutic alliance and the relationship with therapeutic outcome.
- . To highlight the impact of the alliance with those diagnosed with Personality Disorders and in particular those with the BPD.
- . To summarise the impact of difference between the therapist and the client in terms of gender and race, in particular how difference may impact on the alliance and therapeutic outcomes.

This review examined meta-analyses, literature reviews, studies and commentary from learned theorists.

1.6 The Therapeutic Alliance.

The following definition encapsulates the essence of the therapeutic alliance:

“A mutual collaboration between patient and the therapist in pursuit of common therapeutic goals, the therapeutic alliance is a critical ingredient in the success of psychotherapy”. (Gabbard *et al.* 2000, p 40).

The therapist’s role within the therapeutic alliance could be considered as a form of facilitation which provides the support and a safe environment needed to help the client achieve what on their own they found difficult or indeed had previously failed to accomplish.

Evidence in support of the therapeutic alliance.

When considering the efficacy of any model of therapy, one cannot ignore the significant impact the therapeutic relationship between the client and the therapist has on the eventual outcomes. For example, Bowers and Clum (1988) carried out a meta-analysis of 69 studies and found the best outcomes were achieved when technique focussed therapies were combined with a therapeutic alliance. Research by Patton *et al.* (1997) suggested that if the therapeutic alliance is strong, the client is better able to deepen the significance of the therapeutic material presented by the therapist and to recognise and overcome difficulties and make therapeutic progress.

In their book, 'What Works for Whom', Roth and Fonagy (1996) described a number of studies highlighting the benefits of the therapeutic alliance. In particular, they cited Horvath and Symonds (1991) whose meta-analysis of 24 studies produced similar results to that of Bowers and Clum (1988), linking the quality of the therapeutic alliance to the overall outcome of the therapy. Safran and Muran (1996) also cited the Horvath and Symonds' study as an exemplar of the "considerable amount of evidence demonstrating that the quality of the therapeutic alliance is one of the better predictors of outcome, regardless of the particular type of therapy". Bordin (1994) referred to this phenomenon as its 'trans-theoretical status' given that the positive impact of the therapeutic alliance was evident irrespective of the model of therapy employed.

Martin, Garske and Davis (2000) reviewed 79 studies examining the association between the quality of the alliance involving adult patients and their therapist and the outcome of therapy. A moderate yet consistent relationship was identified, ($r = 0.22$). Once again the trans-theoretical status of the therapeutic alliance was evident with the type of treatment provided having no bearing on the correlation between the quality of the alliance and the quality of the outcome.

Measuring the quality of the therapeutic alliance.

Over the years various measures have been created which examine the quality of the therapeutic alliance at various stages of the therapeutic process. Not only can they be used to evidence the positive effect the therapeutic alliance can have on outcome but they can, with some reliability predict the potential for relationship breakdown. The majority of

these measures are of the self-report type completed by the therapist or the client.

Observer ratings are also available and more sophisticated independent measures are being developed. A selection of the more commonly used measures is now considered.

Cecero *et al.* (2001) conducted a randomised control trial (RCT) involving 60 participants to test the internal consistency, inter-rater reliability and inter-correlations between the six most commonly used self report measures of the therapeutic alliance. They found that all six measures of the alliance had acceptable levels of consistency, reliability, inter-rater reliability and measured a similar construct. The observer ratings: California Psychotherapy Alliance Scales (CALPAS); Penn Helping Alliance Rating Scale (PENN); Vanderbilt Therapeutic Alliance Scale (VTAS); and the Working Alliance Inventory (WAI-O Observer Rating)), were significantly correlated with each other. The Working Alliance Inventory Therapist Rating (WAI-T) had significant but lower correlations to the Penn, VTAS and CALPAS observer ratings. The Working Alliance Inventory Client Rating (WAI-C) was not significantly related to the observer ratings. This study was based on one single early session, the second therapy session. This was a weakness of the study. It could have been improved upon by further analyses of alliance measures taken at various points in each treatment phase for a fuller understanding and an assessment of the accuracy of the measures throughout the period of therapeutic engagement.

Summers and Barber (2003) reviewed the previous research of three measures of the therapeutic alliance: the CALPAS; the PENN; and the WAI. All three measures included ratings from the therapist, the patient and an independent observer. Like Cecero *et al.*

they found further evidence that the WAI-O was strongly correlated with the CALPAS but only moderately correlated with the PENN. The CALPAS was found to have adequate predictive validity irrespective of the model of therapy used by the therapist (e.g. Cognitive Behavioural Therapy, (Fenton *et al.* 2001) and Psychodynamic Psychotherapy (Barber *et al.* 2000)). Most importantly, Horvath and Symonds (1991) concluded as part of a meta-analysis that the patient self-report was by far the most reliable predictor of outcome.

A more recent study involving the PENN rating scale was conducted by Vogel *et al.* (2006). The measure was taken at the start of the sixth session. The therapeutic alliance and treatment outcome were found to be significantly related. There were however a number of limitations to this study. The results of this study only related to moderate cases of Obsessive Compulsive Disorder (OCD) as the more complex OCD cases and conceivably the more challenging to the creation and maintenance of the therapeutic alliance were excluded. In addition, the single measure was taken after five sessions had been completed. By this time some element of symptom reduction had been successfully obtained and this success may have been influential in the assessment of the alliance and its predictive value of post treatment outcomes.

Different therapeutic models and the therapeutic alliance.

As referred to earlier, it had been proposed that the impact of the therapeutic alliance may be independent of the therapeutic model deployed (Bordin, 1994). Though it is agreed that the alliance is a common factor across different therapeutic models, Goldfried (1991)

called for further research to identify the similarities and the differences across therapeutic orientations and the quality of the alliance. Raue and Goldfried (1994) proposed that different therapies may tap into different aspects of the alliance. They suggested that psychodynamic psychotherapy is characterised by more emotionally charged and potentially more uncomfortable sessions, whereas cognitive-behavioural therapy (CBT) is smoother and consequently leads to less strained sessions. This suggestion seems to play down the potentially distressful and ego threatening situations such as exposure, cognitive restructuring, clarifying dysfunctional interpersonal patterns or the process of challenging a client's thinking style that CBT can invoke (Schulte & Eifert, 2002).

Raue *et al.* (1997) examined the quality of the therapeutic alliance involved in sessions of psychodynamic-interpersonal therapy (PIT)¹ compared with sessions of CBT. Fifty-seven clients diagnosed with major depression received 16 sessions of either PIT or CBT. The Working Alliance Inventory was used to rate the therapeutic alliance across both therapies. The results indicated significantly greater alliance scores for the CBT sessions.

Martin, Garske and Davis (2000) pointed out that although the co-relational aspects between the therapeutic alliance and outcome are evident, the mechanisms that underpin this relationship are not clear. If better understanding of this mechanism can be achieved then it may be possible to detect when a therapeutic alliance is beginning to break down and for the therapist to take remedial action. Indeed, accepting that there may be times when the relationship will be at risk, such remedial steps could be considered as part of

¹ Also referred to as Interpersonal Psychodynamic Therapy (IPT).

the therapist's intervention plan. The acknowledgment of the likelihood of breakdown and the need to repair the alliance has been termed by Safran *et al.* (1990) as the 'rupture/repair' cycle. More sophisticated measures are being developed, including the assessment of what has been termed by Gray and McNaughton (as cited in Michalak *et al.* 2005) as the client's Behavioural Inhibition System (BIS).

Predicting potential breakdown in the therapeutic alliance.

Michalak *et al.* (2005) set out to test the activation of the BIS to see if it could be used as an indicator of the potential for breakdown within the therapeutic alliance. They hypothesised that a client's behaviour would become inhibited as they struggle with the internal conflict between the strong desire to seek help and the need to avoid interpersonal discomfort unless the therapist can create a high quality alliance. Michalak *et al.* used established methods of measuring the BIS (Mason & Blankenship, 1987) for example, the frequency of the use of the word 'not' by the client and the amount they spoke in general during the therapeutic session. Michalak *et al.* found in their study of 40 clients that the two measures of behaviour inhibition were highly correlated: clients who used the word 'not' more frequently spoke less overall in the sessions. The quality of the therapeutic alliance was measured using the Therapist Evaluation Questionnaire (TEQ). The indicators of inhibition were significantly correlated to the results of the TEQ.

Michalak *et al.* (2005) identified the potential of the BIS as a useful predictor in the breakdown of the therapeutic alliance. However, the authors advised caution due to the low reliability of three out of six of the sub scale scores of the TEQ. Replication of the

study using one or more of the common measures of the alliance previously reported should be considered.

Gender has been considered in the Michalak *et al.* study with both the therapist and the client being relatively equally distributed between males and females. However, the ethnicity of the participants was not reported. There needs to be consideration of the cultural affects on the concept of inhibition and whether it would still hold as a reliable indicator of the quality of the therapeutic engagement. For example, in some cultures, lack of eye contact may be seen as inhibited behaviour whereas in others it may be considered a sign of respect.

The majority of the participants in the Michalak *et al.* (2005) study presented with Axis I (DSM-IV-TR) difficulties such as anxiety and depression. Further studies are required to examine the potential of using the BIS with Axis II disorders such as Borderline Personality Disorder (BPD). When faced with the ambivalence of being stuck between a desire to avoid distress and the prospect of reward and relief in therapy, the general expectations of the BPD client of being hurt or abused in interpersonal relationship situations may make withdrawal from treatment more likely.

The BIS is considered to be activated as a consequence of the therapeutic alliance not being strong enough to support the client through painful and difficult times. However, the use of the word 'not' by the client might also be attributed to the client who is seeking

to exert some control of the therapeutic alliance (Safran & Muran, 1996). Alternative methods of identifying client's behavioural inhibition need to be considered.

The current review has considered measures of the therapeutic alliance that had acceptable levels of consistency, reliability and inter-rater reliability (Cecero *et al.* 2001; Summers & Barber, 2003; Vogel *et al.* 2006). Studies have shown that these measures have adequate predictive validity, irrespective of the model of therapy employed (Barber *et al.* 2000; Fenton *et al.* 2001). However, there is conflicting evidence as to whether the ratings obtained by the therapist; the client or an observer offer the most accurate predictive capability (Gunderson *et al.* 1997; Horvath & Symonds, 1991). A number of studies have shown the therapeutic alliance to be stronger where Cognitive Behavioural Therapies (CBT) have been used compared with Psychodynamic based therapies (Cristol *et al.* 1975; Ruae *et al.* 1997). This finding has been contradicted (Brunink & Shroeder, 1979; Marmar *et al.* 1989) and the question is raised as to whether the alliance is actually stronger in CBT type therapies or whether it is an anomaly of the items considered in the measures used which ignore potentially threatening and distressful aspects of CBT (Schulte & Eifert, 2002).

The Behavioural Inhibition System is an example of a more sophisticated measure of the therapeutic alliance, which is limited in its present form by its lack of cultural sensitivity and its inappropriateness for use with Axis II disorders such as BPD.

Working with clients therapeutically is a complex matter. None of the measures considered in the current review take account of the influences outside of the control of the therapist which nonetheless may impact on the therapeutic alliance. Examples of such influences are; the attitude of other health carers, substance misuse, symptoms of psychosis and the experience of dysfunctional relationships. Such patients may appear disinterested or actively testing the therapeutic relationship when in fact they are seeking reassurance and encouragement.

1.7 Recognising and managing the differences between therapist and client and the therapeutic alliance

There are many potential differences that are possible between the client and the therapist. Age, social, economic and employment status, level of education received, sexuality, marital status and general life experience are examples. Most research, however, has concentrated on gender and ethnicity.

Matching Therapist to Client by Ethnicity and Gender.

There are those who would argue that therapists of the same ethnicity to their clients are likely to have had similar experiences and are therefore more likely to fully appreciate, understand and be able to help their clients with their difficulties (e.g. Atkinson & Schein, 1986). The alternative view is that the culturally sensitive therapist should be able to overcome the differences in the same way they have to overcome differences that may exist between therapist and the client with regard to religion, sexuality, gender, education and socioeconomic status (e.g., Vontruss, 1988).

Wintersteen *et al.* (2005) reviewed the literature relating to gender and racial differences between therapist and patient and the impact on treatment outcome and highlighted the following studies. With regard to gender, Luborsky *et al.* (1971) concluded, following a review of the available literature, that if the patient and therapist are matched by gender, better treatment outcomes were more likely. Research by Fowler *et al.* (1992) found that generally, female patients preferred female therapists. Jones and Zoppel (1982) found that female therapists reported their patients more satisfied with the therapy process than did their male counterparts. Female therapists were also found to report stronger therapeutic alliances with their patients (Dolinsky, 1998). However, other research has failed to demonstrate that matching therapist and patient by gender will lead to improved outcomes (Cottone *et al.* 2002) or decreased drop out rates (Sterling *et al.* 1998).

With regard to race, studies have shown that low-income minority ethnic people were less likely to seek and complete mental health treatment (e.g. Agosti *et al.* 1996). Where they did seek mental health assistance they were more likely to seek therapists from the same ethnic background (Thompson *et al.* 2004). Some authors have theorised that racial matching should be encouraged to promote culturally competent treatment practices (e.g. Campbell & Alexander, 2002; Sue *et al.* 1991). Maramba and Hall (2002) found that although racial matching did not improve treatment outcome, it did increase mental health service utilisation and retention.

Ethnicity, language and religious implications.

The current review examined the scale of diversity within England and Wales. The most recent census of the population was carried out in 2001 by the Office for National Statistics and revealed that 9% (5,055,871) of the population declared themselves to be Asian, Black, Chinese or of mixed heritage. More than 300 languages are spoken by children in London, making it the most linguistically diverse city in the world. Though 71% of the population described themselves as Christian, approximately 15% (7,342,905) of the population belonged to numerous other religious denominations. More population information can be found at Appendices B, C, and D.

With language and religious difference comes significant cultural divergence which requires understanding and tolerance on behalf of the therapist. The current review has identified significant differences within the population in terms of ethnic origin, language and religion. The extent of the diversity may pose many practical difficulties in terms of matching like for like with regards to therapists and their clients. Indeed, Nadirshaw (1992) highlighted the level of diversity that exists *within* Black communities. Further, the under representation of male and minority ethnic therapists creates significant practical difficulties in conducting research with a large enough sample size (Sterling *et al.* 2001).

Provision of therapists and in particular clinical psychologists

Whatever the merits of matching clients to therapists who are of the same or similar culture, ethnicity or gender, the reality is that there are too few male and minority ethnic

clinical psychologists to facilitate such practice (Department of Health, 2004; Turpin & Fensom, 2004; Williams *et al.* 2006). The British Association for Counselling and Psychotherapy has a similar pattern of representation within its membership (see Appendix E).

Developing cultural competency

Cultural competence refers to knowledge, skills and behaviours which allow effective working with clients from diverse backgrounds. Nadirshaw (1992) maintained that it was wrong to assume that people who shared the same cultural background will share a common framework for understanding the problem. It is not necessary for the therapist to be a ‘culture expert’ but they should learn to accept positively the other’s value system and to develop a cultural sensitivity in which to work in a non-judgemental way. By using a racial identity model, the therapist can learn to recognise the individual differences among people whether they are the same or different, ‘racially’ or culturally (Patel *et al.* 2000).

Cross (1995), developed a Black racial identity model; similarly, Helm (1990), developed a White racial identity model (as sighted in Patel *et al.* 2000). Both models describe the transformations that occur within people as their attitude changes from negative stereotypes to the adoption of a non-racist position. Day-Vines *et al.* (2007) considered that the willingness and capability of the White therapist to integrate issues of ‘race’ into their therapy was directly related to their position within the White racial identity model. Day-Vines *et al.* (2007) coined the phrase ‘continuum of broaching styles’ to describe

how clinicians deal with diversity with their clients, ranging from avoiding the situation altogether to complete recognition and acknowledgement of the impact of ‘race’ on the client’s presentation. Five broaching styles were described:

1. Avoidant
2. Isolating
3. Continuing/incongruent
4. Integrated/congruent
5. Infusing

Each broaching style is clearly linked to the corresponding stages of the White racial identity model. The racial identity models of Cross (1995) and Helms (1990), together with the broaching styles of Day-Vines *et al.* (2007) are reproduced in Appendix F, p. 76.

Whealin and Ruzek (2008) reported that a lack of cultural competence may prevent diverse clients from seeking mental health care. They devised their own 10 point action plan for achieving cultural competency. In recognition that much influence is exerted on the client outside of the therapeutic alliance, strategies were included within the plan to ensure cultural competence existed in all aspects of the therapeutic experience for the client, including organisational issues and the cultural understanding and attitude of non clinical staff who may come into contact with them.

In recognition of the need to increase cultural competency among its membership, the Division of Clinical Psychology of the British Psychology Society produced “Clinical Psychology, ‘race’ and culture: a training manual” (Patel *et al.* 2002) as a resource for clinicians to help them relate better to clients from cultures different to their own.

The following study, Burkard *et al.* (1999), provided encouragement for the educational approach to increasing cultural awareness in the absence of the ability to match the patient to the therapist along ethnicity lines. The study involving 124 white Euro-American graduate students enrolled in graduate counselling classes. Burkard *et al.* found that a negative attitude toward race had a negative impact on the alliance and that a positive attitude toward race had a positive impact on the alliance irrespective of the race of the client.

1.8 Introducing Personality Disorder (PD) and in particular Borderline Personality Disorder (BPD).

The current review has examined the therapeutic alliance in general terms irrespective of the treatment condition. The review now focuses on the therapeutic alliance and the treatment of PD and in particular BPD. Firstly the diagnostic criteria for PD will be examined with the intention of defining the condition. The cultural difficulties inherent in the diagnostic criteria will be explored. Similarly, the diagnostic criteria for BPD will be examined along with the consequences for therapists in terms of building clinically therapeutic relationships with clients with this particular disorder. The prevalence of BPD will then be explored. To conclude this section, the history of reluctance by clinicians to engage with PD and BPD clients will be discussed followed by the national initiatives designed to address this situation.

PD and BPD defined.

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association 2000) defines a PD as “an enduring pattern of

inner experience and behaviour that deviates markedly from the expectations of the individual's culture" (p.685). The assertion that PD relates to the 'individuals culture' raises a number of questions and doubts as to the reliability of the diagnostic tools in a multi-cultural setting. Clinicians are advised to "take into account the individual's ethnic, cultural and social background" and "to obtain additional information from informants who are familiar with the person's cultural background" (p. 687). Diagnostic tools for the classification of mental health and personality related disorders are rarely normed on minority ethnic groups (Marsella & Kameoka, 1989) and despite this awareness, little has been done to address this failing (Fletcher-Jenson *et al.* 2000).

In multi-cultural societies such as in the United Kingdom and the assertion that clinical psychology is ethnocentric and reliant on Westernised culture (Williams *et al.* 2006), it begs the question as to whose expectations and whose culture is the PD definition referring to? Should it apply to those from non-Western cultures? The colloquial approach to the creation of the diagnostic criteria may be a contributory factor in this difficulty. Frances, (as cited in Sampson *et al.* 2006) noted that the classification of the various PDs was based on the outcome of committee decisions and derived from clinical tradition and experience and intuition rather than research evidence. Blackburn (2006) also criticised such diagnoses as they did not allow for the specifying of degree or severity of the condition.

A focus of the current review was BDP. DSM-IV-TR defines BPD as "a pervasive pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (p.685).

The aspects of instability in interpersonal relationships and impulsivity lie at the heart of the difficulties for the therapist with this particular client group in the creation and maintenance of the therapeutic alliance.

The Prevalence of BPD.

There is very little in the way of recent data relating to the prevalence of BPD in Britain, so are reliant on somewhat dated information. BPD affects two percent of adults, with women being diagnosed with BPD two to four times more often than men (Kroll *et al.* 1982; Swartz *et al.* 1990). There is a high rate of self-injury without suicide intent, as well as a significant rate of suicide attempts and completed suicide in severe cases (Gardner *et al.* 1985; Soloff *et al.* 1994). BPD patients account for 15 to 20 percent of psychiatric inpatient admissions (Kroll *et al.* 1982; Zanarini *et al.* in press).

Approximately 10 percent of mental health outpatients have BPD and it is particularly common among adolescent and young adults between 18 and 35 years. BPD patients will often present with co-morbid difficulties such as eating disorders, addiction problems, suicide attempts, depression or anxiety disorders and additional personality disorders, all of which increases the challenges for the therapist in forming the alliance. NIMHE, in their 2003 document 'Personality Disorder: No Longer a Diagnosis of Exclusion', noted that when compared with white people, people from the black communities within Britain attract a diagnosis of PD relatively infrequently. It is not clear whether this reflects a true difference in prevalence or relates to errors in the diagnosis of BPD for, as Marsella and Kameoka (as cited in Williams *et al.* 2006) have identified, PD diagnostic tools have not been normed on Black populations.

Encouragement for the Treatment of PD/BPD.

The attitude of clinicians toward PD/BPD is crucial in the formation of the Therapeutic Alliance. Vaillant (1992) maintained that the label ‘borderline’ was used by clinicians for patients they did not like. Lewis and Appleby (1988) found that PD patients were regarded as manipulative, attention seeking, annoying and in control of their suicidal urges and debts, and Nehls (1998), that patients were disadvantaged by the PD label. Forsyth *et al.* (2007) found that mental health workers were less likely to behave empathically or to help service users with a diagnosis of BPD compared to those with a major depressive disorder.

The National Service Framework (2003) for adult mental health services outlined the responsibilities to provide ‘evidence based effective services’ to those who experience significant distress or difficulties as a result of personality disorder. NIMHE (2003) published specific guidance on the type of services that needed to be developed to help people with a diagnosis of personality disorder. Particularly relevant extracts from the document with regard to the therapeutic relationship with PD patients are reproduced as Appendix G.

There is a clear message in the document from NIMHE (2003) that for effective therapeutic relationships to be formed with personality disordered patients, healthcare professionals need the appropriate training to fully understand personality disorder, to become confident with interacting with this client group and to reduce the negativity expressed. Clinicians should recognise that personality disordered patients do experience distress and seek acceptance and most importantly, need to be heard.

‘Breaking the Cycle of Rejection, the Personality Disorder Capabilities Framework’ (NIMHE, 2003) and ‘The Capable Practitioner’ (Sainsbury Centre for Mental Health, 2001) provided outlines of the types of capabilities required by staff to successfully engage with personality disordered clients. Disappointingly, they did not provide specific detail on how to build therapeutic relationships with them.

More recently, a number of recommendations have been made to cover what was seen as shortfalls in the quality of services delivered. For example, there was recognition of the lack of PD services for women and for black and minority ethnic communities (NIMHE, 2006, p.6). The aim of improving services for PD suffers generally and the benefits of forming robust therapeutic alliances with clients were supported by the British Psychological Society (Alwin *et al.* 2006).

The potential of the therapeutic alliance with PD/BPD patients.

Views as to the potential of the therapeutic alliance with PD/BPD patients are very much divided, ranging from those who think such alliances are very unlikely, to those who think the alliance is an essential element to helping patients improve.

Norton and Hinshelwood (1996) argued that severe PD patients have interpersonal problems that can prevent an effective therapeutic alliance being formed. They cited issues such as compulsory treatment in inpatient settings that can reinforce mistrust and hamper the formation of an alliance. Yeomans *et al.* (1994) reported that BPD patients frequently dropped out or were non compliant with treatment and Clarkin *et al.* (1987) found that the presence of BPD together with an Axis 1 disorder (as defined in DSM-IV-TR) adversely affected the development of the therapeutic alliance. Whereas, Friedman

(1969) and Adler (1979) maintained that an effective working alliance between BPD clients and the therapist develops so late in psychoanalytical therapy that the client may no longer have a borderline personality.

Many authors have championed the importance of the therapeutic alliance for the PD patient group. For example, Greenson (1965), Sterba (1934) and Zetzel (1956) all argued that an alliance was a prerequisite to engaging in psychotherapy. Bloom and Rosenbluth (1989) argued for the use of contracts between the PD patient and therapist in order to facilitate the creation of an effective therapeutic alliance and Gabbard *et al.* (1994) argued that whatever technique is used, a strong therapeutic alliance is the foundation upon which to base treatment for BPD. However, studies have found that the quality and collaborative nature of the alliance can fluctuate even after the therapeutic process is well advanced (e.g. Allen *et al.* 1990; Gabbard *et al.* 1988; Horwitz *et al.* 1996).

Gunderson *et al.* (1997) claimed their study to be the first longitudinal study of the therapeutic alliance with a sample of BPD patients. The quality of alliance was rated by the therapists and the 34 patients using the Penn Helping Alliance Questionnaire (HAQ) at six weeks, six months and then annually for up to five years. Eleven patients dropped out due to dissatisfaction with the therapy. The therapists' and the patients' alliance ratings provided at the 6 week stage for this group of 11 and the 23 who remained long term were compared. The patients who remained scored significantly higher on the therapist rating scales than those who left. The authors maintained that this finding indicated that as early as 6 weeks into therapy, the assessment of the therapist may be a good predictor of who will drop out and who will stay long term in therapy. This finding

is in stark contrast to the findings of Horvath and Symonds (1991) referred to previously whose meta analysis identified the patients' rating as the most reliable predictor of outcome. This raises questions as to whether the BPD patient's distrusting nature and poor relationship experience influences their ratings.

Rather than accepting that drop out is inevitable, Gunderson *et al.* (1997) suggested that where this is indicated, consultation on how to best address this possibility should be considered. This would enable some forward planning and preparation to facilitate what was termed by Safran *et al.* (1990) as the 'rupture/repair' cycle. However, there is a need for the Gunderson study to be replicated with a larger sample size. There is a possibility that the patients who rated the alliance low at week 6 were influenced by not wanting to appear to no longer need treatment. Future studies will need to control for this possibility.

Bennett *et al.* (2006) in a small study of four positive outcome cases and two poor outcome cases involving BPD clients found that the ability of the therapist to identify threats to the alliance and to focus on addressing these threats as they arose were key to overall successful outcomes in therapy. In a study involving a BPD cohort of 36 women (aged 18-45 years), Yeomans *et al.* (1994) found that an adequate treatment contract and a positive therapeutic alliance were key to engaging the BPD client to remain in treatment.

1.9 The treatment of PD/BPD and the role of the therapeutic alliance.

Commonly used therapeutic models in the treatment of PD/BPD.

There are many therapeutic models used to address the difficulties experienced by the BPD client. Of particular note are: Cognitive Analytical Therapy (e.g. Ryle, 1997); Cognitive Behavioural Therapy and Dialectical Behaviour Therapy (e.g. Linehan, 1993); and Psychodynamic Therapy (e.g. Bateman & Fonagy, 2001) in the treatment of BPD. There is a wealth of research studies examining the efficacy of these therapies, however, they are not be reviewed here as the focus of the current review is with the therapeutic alliance and not the various models of therapy. What is of interest is whether the therapeutic alliance varies dependent on the model of therapy being used.

Interaction between the therapeutic alliance and the model of therapy in cases of PD/BPD.

Previously in the current review, mention was made of the trans-theoretical nature of the therapeutic alliance. However, it was also noted that research studies had shown the quality of the alliance seemed to vary across different treatment models. Brunick & Schroeder (1979), and numerous others (cited in Spinhoven *et al.* 2007), highlighted that the research in this area was predominantly with heterogeneous groups of patients with Axis I disorders and the findings were ambiguous. Despite these mixed results, there was evidence that cognitive behavioural therapy (CBT) was typified by supportive communication, expressed sympathy and interpersonal contact when compared to psychodynamic psychotherapy. Spinhoven *et al.* (2007) hypothesised that these differences may be more pronounced in the treatment of BPD.

To test their hypothesis, Spinhoven *et al.* (2007) conducted a 3 year longitudinal study involving 78 BPD patients. Half were treated with schema focused therapy (SFT), a cognitive based treatment, the other transference-focus therapy (TFT), a psychodynamic approach. WAI scores indicated that both patients and therapists rated the therapeutic alliance higher in the SFT treatment group than those within TFT treatment group. Citing Beck *et al.* (1990; 2004) and Young *et al.* (2003), Spinhoven *et al.* suggested that this difference may be due to the additional effort within SFT in adopting an unthreatening and supportive attitude and the development of mutual trust and positive regard. In contrast to the SFT, citing Gunderson (2000), Spinhoven *et al.* considered that the TFT with its use of contract negotiations may introduce an unnecessary defensive and adverse tone inducing negative transferences which applies pressure to the alliance. Spinhoven *et al.* proposed that rather than being independent entities, the therapeutic alliance and the treatment condition may interact and influence one another.

Verheul *et al.* (2003) produced further evidence of the interaction between different therapeutic models and the therapeutic alliance following a 12 month randomised control trial of DBT for 58 women with BPD. They found that both the DBT group and the Treatment as Usual (TAU) control group rated the alliance highly using the WAI-P. The authors cited Linehan (1993) and her assertion that the creation of a positive therapeutic alliance is a key feature of DBT. As the DBT group produced much better outcomes than the TAU group, the authors hypothesised that the efficacy of DBT may have resulted from its persistent and enduring focus on certain target behaviours rather than an optimal

alliance. They suggested there were different interactions and influences operating between the alliance and the two treatments, resulting in different outcomes.

Studies have shown the difficulties associated with forming therapeutic alliances with BPD clients. However, successful alliances can be formed. There appears to be some variance in the quality reported, dependent on the model of therapy being used. Reliable measures exist and others are being developed which can be used to monitor and evaluate the progress of the alliance and predict potential ruptures thus enabling remedial action by the therapist. More studies are required to test these measures specifically with the BPD client group. Furthermore, greater understanding is required of the therapists' emotional and behavioural responses.

1.10 Emotional and behavioural responses of the therapist.

Betan *et al.* (2005) recognised that clinicians respond to the patient in a number of ways: conscious and unconscious; emotional and cognitive; intrapsychic; and behavioural.

Betan *et al.* described how the clinician's responses to the patient provided insight into patterns the patient wittingly or unwittingly evokes from significant others. They aimed to create a measure that therapists could use, irrespective of the model of therapy being followed, to compare their own cognitive, affective and behavioural responses with a set of normed data.

Using a random sample of 181 psychiatrists and psychologists drawn from the membership registers of the American Psychiatric and Psychological Associations, Betan *et al.* (2005) completed a study designed to test the ability of a counter-transference

questionnaire to assess the clinicians' cognitive, affective and behavioural responses during their interactions with 'personality disordered' patients. The participants employed the following therapeutic models:

73 (40.3%) Psychodynamic

55 (30.4%) Eclectic

37 (20.4%) CBT

16 (8.8%) Not known

Factor analysis of the counter-transference questionnaire yielded eight factors, of which five were found to be present for the participant clinicians when engaging with BPD patients:

1. Overwhelmed/disorganized
2. Helpless/inadequate
3. Special/over involved
4. Sexualized
5. Disengaged

(See Appendix H for a full description).

As countertransference is a psychodynamic concept, the responses from those participants working from a psychodynamic model were excluded from a second factor analysis to ensure the results did not simply reflect the beliefs of the participating clinicians. Similar results were obtained which allowed Betan *et al.* (2005) to conclude that the factor structure was not 'an artefact of clinicians' theoretical preconceptions'.

Betan *et al.* (2005) concluded that the factor structure represented the diverse reactions that clinicians may experience toward their patients which result from a combination of the therapists' own dynamics, responses evoked by the patient and the interaction between the patient and the therapist. As a result of their study, Betan *et al.* (2005) claimed that although each therapeutic relationship is unique, countertransference responses to PD/BPD patients occur in predictable and coherent patterns. These responses are likely to resemble the responses they experience from other significant people in their lives and as such would provide an insight into the patients' relationships. Thus Betan *et al.* (2005) had produced a useful tool for understanding the patient's relationship dynamics, in particular those involving repetitive interpersonal patterns. The data was obtained from clinicians operating with different therapeutic models but showed similar patterns of emotional behaviour within the therapeutic relationship which supported the 'transtheoretical status' of the alliance. Betan *et al.* (2005) have highlighted that there were emotional as well as practical considerations involved in the formation and maintenance of a therapeutic alliance.

There are a number of limitations to the Betan *et al.* (2005) study. One hundred and eighty one participants represented a response rate of only 10%. By the very nature of a self reporting questionnaire, there are inherent difficulties such as defensive bias and failure to recognise certain processes. Observer ratings would have been preferable. Although the participants were reasonably representative of both genders (58% male) and the patients almost equally so, it is not clear whether there were any differences in terms

of emotional response based on gender. For example, other studies have reported gender differences with regard sexual attraction, with males more likely to report being attracted to their patients than females (Sehl 1998). The cultural and ethnic make up of the participants was also not known. Betan *et al.* did, however, report that the patients involved in the study were predominantly white (92.8%). The impact of gender and cultural difference on the alliance and in particular the aspect of countertransference was not considered in this study.

The literature specifically examining the impact of the therapeutic alliance with clients suffering from PD and in particular BPD is limited. The influence the therapeutic alliance has on the treatment effects for those diagnosed with BPD is not well understood which is perhaps not surprising as it is difficult to distinguish what is characteristic of the disorder and what are relational difficulties experienced during a therapeutic relationship (Marziali *et al.* 1999). Beutler *et al.* (as cited in Spinhoven *et al.* 2007) highlighted the lack of attention that has been paid to the therapeutic impact of discrete therapist variables such as age, experience, training, ethnicity and gender and only a few studies (e.g. Betan *et al.* 2005), have examined therapist variables in a relational or interpersonal context.

1.11 Discussion and suggestions for future research.

Sophisticated predictors of therapeutic outcome, of which the Behaviour Inhibition System (BIS) is an example, are being developed which, rather than relying on self reports, examine the behaviour of the patient during therapy (Michalek *et al.* 2005). As BPD patients' previous experiences with relationships are likely to have been negative,

the BIS may not be a most appropriate instrument for this patient group. This needs to be assessed along with research to identify alternative predictive indicators where the therapeutic alliance involves BPD patients.

Many studies have examined the efficacy of therapies and their effectiveness against each other or treatment as usual. There is, however, only limited research relating to the interaction between different models of therapy and the quality of the therapeutic alliance. What research there is tends to favour cognitive based therapies over those from the psychodynamic tradition. Increased understanding of the mechanisms which underpin the interaction between the therapeutic alliance and the various models of therapy is required.

The knowledge, skill, personality and temperament of individual therapists are rarely evaluated. One exception is the work of Betan *et al.* (2005) who have provided a useful way of examining the emotional responses patients elicit from their therapists. As the skills, knowledge and personality of the therapist all go to shape the relationship the therapist has with their patients, an assessment of the impact these elements have on the alliance should be considered. Research may identify additional generic training requirements and pave the way for individual therapists' areas for development to be addressed.

The role of race and gender on the therapeutic alliance has been considered. The impact of racial matching was found to increase the utilisation and retention of mental health services but not necessarily the impact on treatment outcomes (Maramba & Hall, 2002).

There is conflicting evidence in relation to the benefits to therapeutic outcome with the matching of therapist to client by gender (Cottone *et al.*, 2002; Luborsky *et al.*, 1971). As therapists and in particular, clinical psychologists, are predominantly white and female, there is a need for further developing cultural competencies in clinical practice. An assessment of how culturally aware and culturally sensitive psychologists and other therapists currently are would be useful and if necessary, further promotion of cultural competency training to improve the therapeutic approach should be considered.

PD/BPD is no longer considered untreatable. There is a growing body of evidence of the positive impact the therapeutic alliance has on outcome of treatment with PD/BPD clients (e.g. Bennett, 2006). A qualitative analysis of how therapists create and maintain the alliance with BPD clients, how they manage the emotional impact and whether they modify their approach based on the gender or cultural background of the client would be useful.

1.12 Clinical implications

Providing therapists with a method of identifying and understanding their emotional responses to each client would be very useful clinically, as it would give them valuable insight into the patterns of responses evoked by the client, wittingly or unwittingly, from other significant people in their lives.

Understanding the strengths and limitations of the therapist's interactions with clients will enable directed training and education with a view to improving the quality of future

alliances and consequently therapeutic outcome. By improving the cultural competency of the therapist, increased utilisation and retention of minority ethnic clients through to positive therapeutic outcomes is more likely.

As predictors of therapeutic alliance breakdown improve, the probability for the therapist to make proactive rather than reactive interventions will increase. This will be particularly relevant for the treatment of PD/BPD clients who are characterised by feelings of distrust and relationship difficulties.

1.13 Conclusion.

The current literature review has highlighted many positives: the strong evidence in support of the therapeutic alliance and the recognition and encouragement for the treatment of PD/BPD by psychological therapies for example. More work is needed to encourage and treat mental health and PD sufferers from the minority ethnic population and the initiatives around cultural competency are encouraging.

The recognition that emotional as well as practical aspects of the therapist's interventions are important and influential has been highlighted in the psychodynamic literature for a long time. The development of instruments to enable practitioners from other therapeutic orientations to also consider the causes and meaning underpinning their emotional reactions to clients is an exciting development which warrants further consideration.

1.14 References.

- Adler, G. (1979). The Myth of the alliance with borderline patients. *American Journal of Psychiatry*, 136 (5), 642-645.
- Agosti, V., Nunes, E. & Ocepeck-Welikson, K. (1996). Patient factors related to early attrition from an outpatient cocaine research clinic. *American Journal of Drug and Alcohol Abuse*, 22 (1), 29-39.
- Allen, J. G., Gabbard, G. O., Newsom, G. E., & Coyne, L. (1990). Detecting patterns of change in patients' collaboration within individual psychotherapy sessions. *Psychotherapy: Theory, Research, Practice, Training*, 27(4), 522-530.
- Alwin, N., Blackburn, R., Davidson, K., Hilton, M., Logan, C., Shine, J., (2006). *Understanding Personality Disorder: A Report by the British Psychological Society*. London: The British Psychological Society.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Text Revised. Washington, DC: American Psychiatric Association.
- Atkinson, D., R., & Schein, S. (1986). Similarity in counseling. *Counseling Psychologist*, 14 (2), 319-354.

Barber, J., P., Connolly, M., B., Crits-Christoph, P., Gladis, Sique-land, L. (2000).

Alliance predicts patients' outcome beyond in-treatment change in symptoms.

Journal of Consulting and Clinical Psychology, 68 (6), 1027-1032.

Bateman, A. and Fonagy, P. (2001). Treatment of Borderline Personality Disorder with

Psychoanalytically Oriented Partial Hospitalization: An 18-Month Follow-Up.

American Journal of Psychiatry 158, 36-42.

Bennett, D., Parry, G., & Ryle, A. (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: A task analysis.

Psychology and Psychotherapy: Theory, Research and Practice, 79 (3), 395-418.

Betan, E., Heim, A., K., Conklin, C., Z., & Westen, D. (2005). Counter-transference

Phenomena and Personality Pathology in Clinical Practice: An Empirical

Investigation. *American Journal of Psychiatry*, 162, 890-898.

Blackburn, R. (2006). What is Personality Disorder? In M., J., Sampson, R., A.

McCubbin, & P. Tyer, (Eds.) (2006). *Personality Disorder and Community*

Mental Health Teams: A Practitioner's Guide (pp.21-39). Chichester: Wiley.

Bloom, H. & Rosenbluth, M. (1989). The use of contracts in the inpatient treatment of the

borderline personality disorder. *Psychiatry Quarterly*, 60, (4), 317-27.

- Bordin, E., S. (1994). Theory and research on the therapeutic working alliance. In J., D., Safran & C., Muran. (1996). The Resolution of Ruptures in the Therapeutic Alliance. *Journal of Consulting and Clinical Psychology*, 64, (3): 447-458.
- Bowers, T. & Clum, G. (1988). Relative Contribution of Specific and Non-specific Treatment Effects: Meta- Analysis of Placebo-Controlled Behaviour Therapy Research. *Psychological Bulletin* 1988, Vol 103, (3): 315-323.
- Burkard. A., W., Ponterotto, J., G., Reynolds, A., L., Alfonso, V., C. (1999). White counsellor trainees' racial identity and working alliance perceptions. *Journal of Counselling & Development*, Vol 77, (3), 324-329.
- Campbell, C. I. & Alexander, J. A. (2002). Culturally competent treatment practices and ancillary service use in the outpatient substance abuse treatment. *Journal of Substance Abuse Treatment*, 22 (3), 109-119.
- Cecero, J., J., Fenton, T., L., Nich, N., Frankforter, T., L., & Carrol, K., M. (2001). Focus on the therapeutic alliance: The psychometric properties of six measures across three instruments. *Psychotherapy* 38, 1.
- Clarkin, J. F., Hurt, S. W., & Crilly, J. L. (1987). Therapeutic alliance and hospital treatment outcome. In, J., G., Gunderson, L., M., Najavits, C., Leonhard, C., N.,

Sullivan &, A., N. Sabo, (1997). Ontogeny of the therapeutic alliance in borderline patients. *Psychoherpy Research*, 7 (3), 301-309.

Cottone, J. G., Drucker, P. & Javier, R. A. (2002). Gender differences in psychotherapy dyads: Changes in psychological symptoms and responsiveness to treatment during 3 months of therapy. *Psychotherapy, Theory, Research, Practice, Training*, 39 (4), 297-306.

Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., et al. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, 85(4), 401-409.

Department of Health (2004). *NHS hospital and community health services non-medical workforce census England: 30th September 2003*. Leeds Statistics (Workforce), London: Department of Health. Retrieved 6th May from:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4083714.

Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV-TR), (2000).

Washington DC: American Psychiatric Association.

Dolinsky, A., Vaughan, S. C., Luber, B., Mellman, L. & Roose, S. (1998). A match made in heaven? A pilot study of patient-therapist match. *Journal of Psychotherapy*,

Practice and Research, 7 (2), 119-125.

Farismadan, F. Draghi-Lorenz, R., & Ellis, J., (2006). Process and Outcome of Therapy in Ethnically Similar and Dissimilar Therapeutic Diads. *Journal of Psychotherapy Research*. 17 (5): 567-575.

Fenton, L., R., Cecero, J., J., Nich, C., Fankforter, T., L., Carroll, K., M. (2001). Perspective is everything: the predictive validity working alliance instruments. *Journal of Psychotherapy, Practice and Research*, 10, (4), 262-268.

Fletcher-Jansen, E., Strickland, T., L., & Reynolds, C., R., (Eds.) (2000). Handbook of cross-cultural neuropsychology. In Williams, P., E., Turpin, G., & Hardy, G., (2006). Clinical Psychology Service Provision and Ethnic Diversity within the UK: A Review of the Literature. *Clinical Psychology & Psychotherapy*. 13, 324-338.

Forsyth, A. (2007). The effects of diagnosis and non-compliance attributions on therapeutic alliance processes in adult acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing*, 14(1), 33-40.

Fowler, W. E., Wagner, W. G., Iachini, A. & Johnson, J. (1992). The impact of sex of psychological examiner on sexually abused girls' preference for and anticipated comfort with male versus female counselors. In Wintersteen, M., B., Mensinger,

J., L., & Diamond, G., S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? *Professional Psychology: Research and Practice*, Vol 36. (4), 400-408.

Friedman, L., (1969). The Therapeutic Alliance. In Gunderson, J., G., (2001). *Borderline Personality Disorder, A Clinical Guide*. Washington DC: American Psychiatric Publishing, Inc. (p. 80).

Gabbard, G. O., Horwitz, L., Frieswyk, S. H., Allen, J. G., Colson, D. B., Newsom, G. E., & Coyne, L. (1988). The effect of therapist interventions on the therapeutic alliance with borderline patients. In Gunderson, J., G., Najavits, L., M., Leonhard, C., Sullivan, C., N., & Sabo, A., N. (1997). Ontogeny of the therapeutic alliance in borderline patients. *Psychoherpy Research* 7(3), 301-309.

Gabbard, G., O., L. Horwitz, *et al.*. (1994). Transference Interpretation in the Psychotherapy of Borderline Patients - a High-Risk, High-Gain Phenomenon. *Harvard Review of Psychiatry* 2 (2): 59-69.

Gabbard, G., O., Wilkinson, S., M., (2000). *Management of Counter-transference with Borderline Patients*. Jason Aronson inc. New York.

Gardner. D., L., & Cowdry, R., W. Suicidal and parasuicidal behavior in borderline personality disorder. *Psychiatric Clinics of North America*, 1985; 8(2): 389-403.

Retrieved 30 March 2008 from

www.wrongdiagnosis.com/artic/borderline_personality_disorder_NIMHE.htm#2#

2

Goldfried, M. R. (1991). Research issues in psychotherapy integration.

Journal of Psychotherapy Integration, 1, 5-25.

Greenson, R., R., ((1965). The working alliance and the transference neurosis. In

Gunderson, J., G., (2001). *Borderline Personality Disorder, A Clinical Guide*.

Washington DC: American Psychiatric Publishing, Inc.

Gunderson, J., G., Najavits, L., M., Leonhard, C., Sullivan, C., N., & Sabo, A., N. (1997).

Ontogeny of the therapeutic alliance in borderline patients. *Psychoherpy Research*

7 (3) 301-309.

Gunderson, J., G., (2001). *Borderline Personality Disorder, A Clinical Guide*.

Washington DC: American Psychiatric Publishing, Inc.

Horvath, A., O., & Symonds, B., D., (1991). Relation between working alliance and

outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*,

38 (2), 139-149.

Horwitz, M., Gabbard, G., Allan, J. G., Frieswyk, S., Colson, D., Newsom, G., &

Coyne, L. (1996). *Borderline Personality Disorder: Tailoring the psychotherapy to the patient*. Washington, DC: American Psychiatric Press, Inc. In, J., G., Gunderson, L., M., Najavits, C., Leonhard, C., N., Sullivan &, A., N., Sabo. (1997). Ontogeny of the therapeutic alliance in borderline patients. *Psychoherpy Research* 7 (3) 301-309.

Jones, E. E. & Zoppel, C. L. (1982). Impact of client and therapist gender on psychotherapy process and outcome. *Journal of Consulting and Clinical Psychology*, 50 (2), 259-272.

Kroll, J., Carey, L., Sines, L., Roth, M. (1982) Are there borderlines in Britain? A cross-validation of U.S. findings. *Archives of General Psychiatry*, 39: 60-63 2.
Retrieved 30 March 2008 web4health.info/en/answers/source/border-prevalence.htm

Lewis, G., and Appleby, L., (1988). Personality Disorder: The Patients Psychiatrists Dislike. *British Journal of Psychiatry*. 153, 44-49.

Linehan, M., M. (1993). *Skills training manual for treating borderline personality disorder*. New York: Guildford Press.

Luborsky, L., Auerbach, A., Chandler, M., Cohen, J. & Bachrach, H. (1971). Factors influencing the outcome of psychotherapy: A review of quantitative research.

Psychological Bulletin, 75 (3), 145-185.

Maramba, G. G. & Hall, G. C. N. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology*, 8, (3), 290-297.

Marsella, A. J., & Kameoka, V., A. (1989). Ethnocultural issues in the assessment of psychopathology. In Williams, P., E., Turpin, G., & Hardy, G., (2006). Clinical Psychology Service Provision and Ethnic Diversity within the UK: A Review of the Literature. *Clinical Psychology & Psychotherapy*. 13, 324-338.

Marmar, C., R., Gaston, L., Gallagher, D., Thompson, L., W., (1989). Towards the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment: Journal of Consulting and Clinical Technology*, 1 (1), 46-52.

Martin, D., J., Garske, J., P., Davis, M., K., (2000). Relation of the Therapeutic Alliance with Outcome and Other Variables: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*, 68, (3), 438-450.

Marziali, E., Munroe-Blum, H. & McCleary, L. (1999). The Effects of the Therapeutic Alliance on the Outcomes of Individual and Group Psychotherapy with Borderline Personality Disorder. *Psychotherapy Research*, 9 (4), 424-436.

- Mason, A., & Blankenship, V. (1987). Power and affiliation motivation, stress, and abuse in intimate relationships. *Journal of Personality and Social Psychology*, 52, 203-210.
- Michalak, J., Wiethoff, M., & Schulte, D., (2005). Therapeutic Alliance and behaviour inhibition. *Psychotherapy Research*, 15:3, 334-338.
- Nadirshaw, Z. (1992). Therapeutic practice in multi-racial Britain. *Counselling Psychology Quarterly*. 5, 3, pp 257-261.
- National Institute for Mental Health in England, (2003), *Breaking the Cycle of Rejection, the Personality Disorder Capabilities Framework*. Department of Health.
- National Institute for Mental Health in England, (2003), *Personality Disorder: No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder*. Department of Health.
- National Institute for Mental Health in England, (2006), *Personality Disorder Capacity Plans 2005*. Department of Health, p.6.
- National Literacy Trust (2008). *English as an additional language and other languages spoken in the UK*. Retrieved May 2008 from www.literacytrust.org.uk/Database/STATS/EALstats.html

National Service Framework for Mental Health, (2003). Department of Health.

National Statistics Online (2001). *Ethnicity and Religion*. Retrieved May 2008 from www.statistics.gov.uk

National Statistics Online (2005). *Mid-2005 Population Estimates: estimated resident population by single year of age, sex and legal marital status*. Retrieved May 2008 from www.statistics.gov.uk

Nehls, N., (1998). Borderline Personality Disorder: Gender Stereotypes, stigma and limited system of care. *Issues in Mental Health Nursing*. 19:2, 97-112.

Norton, K., & R., D., Hinshelwood (1996). Severe personality disorders. Treatment issues and selection for in-patient psychotherapy. *British Journal of Psychiatry* 168: 723-731.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., & Nadirshaw, Z. (2002). *Clinical psychology, 'race' and culture: A training manual*. Leicester, British Psychological Society.

Patton, M., J., Kivlighan, D., M., & Multon, K., D. (1997). The Missori psychoanalytic counselling research project: Relation of changes in counselling process to client

outcomes. *Journal of Counselling Psychology*, 44, 189-208.

Raue, P. J., & Goldfried, M. R. (1994). The therapeutic alliance in cognitive -behavior therapy. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp.131-152). New York: Wiley.

Raue, P. J., Goldfried, M. R. & Barkham, M. (1997). The therapeutic alliance in Psychodynamic- Interpersonal and Cognitive-Behavioural therapy. *Journal of Consulting and Clinical Psychology*, 65. (4), 582-587.

Roth, A., & Fonagy, P., (1996). *What Works for Whom: A Critical Review of Psychotherapy Research*. The Guildford Press, New York and London.

Ryle, A. (1997). *Cognitive analytic therapy and borderline personality disorder: The model and the method*. Chichester: Wiley.

Safran, J., D., Crocker, P., McMain, S., & Murray, P., (1990). The Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy: Theory, Research, Practice, Training*, 27 (2), 154-165.

Safran, J., D., & Muran, C., (1996). The Resolution of Ruptures in the Therapeutic Alliance. *Journal of Consulting and Clinical Psychology*, 64, (3), 447-458.

Sainsbury Centre for Mental Health (2001). *The Capable Practitioner. A framework and list of practitioner capabilities required to implement the National Service Framework for Mental Health.*

Sampson, M., J., McCubbin, R., A. & Tyler, P. (Eds.) (2006). *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide.* Chichester: Wiley.

Sehl, M., R. (1998). Erotic countertransference and clinical social work practice: A national survey of psychotherapists' sexual feelings, attitudes and responses. *Journal of Analytic Social Work.* 5 (4), 39-55.

Singleton, N., Meltzer, H., & Gatward, R., (1998). Psychiatric morbidity among prisoners in England and Wales. In P., Moran (2002). *The Epidemiology of Personality Disorders*, National Electronic Library for Mental Health.

Soloff PH, Lis JA, Kelly T, Cornelius J, Ulrich R. Self-mutilation and suicidal behavior in borderline personality disorder. *Journal of Personality Disorders*, 1994; 8(4): 257-67. Retrieved 30 March 2008 from www.wrongdiagnosis.com/artic/borderline_personality_disorder_NIMHE.htm#2#2

Spinhoven, P., Giesen-Bloo, J., van Dyck, R., Kooiman, K. and Arnaud, A. (2007). The Therapeutic Alliance in Schema-Focused Therapy and Transference-Focused

Psychotherapy for Borderline Personality Disorder. *Journal of Consulting and Clinical Psychology Copyright. American Psychological Association*, 75, 104–115.

Sterba, R., (1934). The fate of the ego in analytical theory. In Farismadan, F. Draghi-Lorenz, R., & Ellis, J. Process and Outcome of Therapy in Ethnically Similar and Dissimilar Therapeutic Diads. *Journal of Psychotherapy Research*. 17 (5), 567-575.

Sterba, R., (1934). The fate of the ego in analytical theory. In J., G., Gunderson. (2001). *Borderline Personality Disorder, A Clinical Guide*. Washington DC: American Psychiatric Publishing, Inc.

Sterling, R. C., Gottheil, E., Weinstein, S. P. & Serota, R. (1998). Therapist/patient race and sex matching: Treatment retention and 9-month follow-up outcome. *Addiction*, 93 (7),1043-1050.

Sterling, R. C., Gottheil, E., Weinstein, S. P. & Serota, R. (2001). The effect of therapist/patient race and sex-matching in individual treatment. *Addiction*, 96 (7), 1015-1022.

Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T. & Zane, N. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness

hypothesis. *Journal of Consulting and Clinical Psychology*, 59 (4), 533-540.

Summers, R., F. & Barber, J., P. (2003). Therapeutic Alliance as a Measurable Skill. *Journal of Academic Psychiatry* 27:160-165.

Swartz, M., Blazer, D., George, L., & Winfield, I. (1990). Estimating the prevalence of borderline personality disorder in the community. *Journal of Personality Disorders*, 4(3), 257-272. Retrieved 30 March 2008 from [www.wrongdiagnosis.com/artic/borderline_personality_disorder_NIMHE.htm#2#](http://www.wrongdiagnosis.com/artic/borderline_personality_disorder_NIMHE.htm#2#2)

2

Thompson, V. L., Bazile, A. & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*, 35. (1), 19-26.

Turpin, G., & Fensom, P. (2004). *Widening access within undergraduate psychology education and its implications for professional psychology: Gender, disability and ethnic diversity*. London: The British Psychological Society.

Vaillant, G., E., (1992). The beginning of wisdom in never calling a patient Borderline. In J., G., Gunderson (2001). *Borderline Personality Disorder, A Clinical Guide*. Washington DC: American Psychiatric Publishing, Inc.

- Verheul, R., Van Den Bosch, L., M., C., Koeter, M., W., J., De Ridder, M., A., J., Stijnen, T. & Van Den Brink, (2003). Dialectical behaviour therapy for women with borderline personality disorder. *British Journal of Psychiatry*. 182. 135-140.
- Vogel, P., A., Hansen, B., Stiles, T., & Gotestam, K., G. (2006). Treatment motivation, treatment expectancy and helping alliance as predictors of outcome in cognitive behavioural treatment of OCD. *Journal of Behavior Therapy and Experimental Psychiatry* 37, 247-255.
- Vontruss, C., E., (1988). An existential approach to cross-cultural counseling. In Farismadan, F. Draghi-Lorenz, R., & Ellis, J. Process and Outcome of Therapy in Ethnically Similar and Dissimilar Therapeutic Diads. *Journal of Psychotherapy Research*. 17, (5): 567-575.
- Whealin, J. M., & Ruzek, J. (2008). Program evaluation for organizational cultural competence in mental health practices. *Professional Psychology: Research and Practice*, 39(3), 320-328.
- Williams, P., E., Turpin, G., & Hardy, G., (2006). Clinical Psychology Service Provision and Ethnic Diversity within the UK: A Review of the Literature. *Clinical Psychology & Psychotherapy*. 13, 324-338.
- Wintersteen, M., B., Mensinger, J., L., & Diamond, G., S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment

retention in adolescents? *Professional Psychology: Research and Practice*, 36.
(4), 400-408.

Wood, D., J., Bruner, J., S., & Ross, G. (1975). A role of tutoring in problem solving. In
V., Lee & P., D., Gupta. (1995). *Children's Cognitive and Language
Development*. Blackwell. 15-16.

Yeomans, F. E., Gutfreund, J., Selzer, M. A., & Clarkin, J. F. (1994). Factors related to
drop-outs by borderline patients: Treatment contract and therapeutic alliance.
Journal of Psychotherapy Practice & Research, 3, (1), 16-24.

Zanarini M.C., Frankenburg FR. Treatment histories of borderline inpatients.
Comprehensive Psychiatry, in press. Retrieved 30 March 2008 from
[www.wrongdiagnosis.com/artic/borderline_personality_disorder_NIMHE.htm#2#](http://www.wrongdiagnosis.com/artic/borderline_personality_disorder_NIMHE.htm#2#2)

2

Zetzel, E., R., (1956). Current concepts of Transference. In F. Farismadan, R., Draghi-
Lorenz & J., Ellis. (2007). Process and Outcome of Therapy in Ethnically Similar
and Dissimilar Therapeutic Diads. *Journal of Psychotherapy Research*. 17, (5):
567-575.

Zetzel, E., R. (1956). Current concepts of Transference. In J., G., Gunderson (2001).
Borderline Personality Disorder, A Clinical Guide. Washington DC: American
Psychiatric Publishing, Inc.

Appendix A

Notes for Contributors

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations;
- Theoretical papers, provided that these are sufficiently related to the empirical data;
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications;
- Brief reports and comments.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Reviewing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in

addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').

4. Online submission process

- 1) All manuscripts must be submitted online at <http://bjcp.edmgr.com>.


First-time users: click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).

Registered users: click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

- 2) Follow the step-by-step instructions to submit your manuscript.

- 3) The submission must include the following as separate files:


- Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author - [Editorial Manager Title Page for Manuscript Submission](#)
- Abstract
- Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

- 4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors -  [Editorial Manager - Tutorial for Authors](#)
Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading

should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.



- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions:  [British Journal of Clinical Psychology - Structured Abstracts Information](#)
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc for which they do not own copyright.

For Guidelines on editorial style, please consult the *APA Publication Manual* published by the American Psychological Association, Washington DC, USA (<http://www.apastyle.org>).

6. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author and name and address are not included in the word limit.

7. Publication ethics

Code of Conduct -  [Code of Conduct, Ethical Principles and Guidelines](#)
Principles of Publishing -  [Principle of Publishing](#)

8. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication.

10. Copyright

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form.

11. Checklist of requirements

- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymised)
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs.

Tables, figures, captions placed at the end of the article or attached as separate files.

Appendix B

Table 1. Total Population of the UK

Source: Census (2001). Office for National Statistics.

Total Population of the UK:		Population by ethnicity
58,789,194		
Those who say they are white:		
White British:	87.5%	51,440,545
White Irish:	1.2%	705,470
White other:	2.6%	1,528,519
Total	91.3%	53,674,534
Those who say they are Asian:		
Indian:	2.0%	1,175,784
Pakistani:	1.4%	823,049
Bangladeshi:	0.5%	293,946
Other Asian:	0.5%	293,946
Total	4.4%	2,586,725
Those who say they are black:		
Caribbean:	1.1%	646,681
African:	0.9%	529,103
Other Black:	0.2%	117,578
Total	2.2%	1,293,362
Those who say they are mixed race:		
White/Black Caribbean:	0.5%	293,946
White/Asian:	0.4%	235,157
Other mixed:	0.3%	176,368
Total	1.2%	705,470
Other ethnicities:		
Chinese:	0.4%	235,157
Other ethnic groups:	0.4%	235,157
Total	0.8%	470,314

Fig 1. Minority Ethnic Groups within England and Wales.

Source: Census (2001). Office for National Statistics.

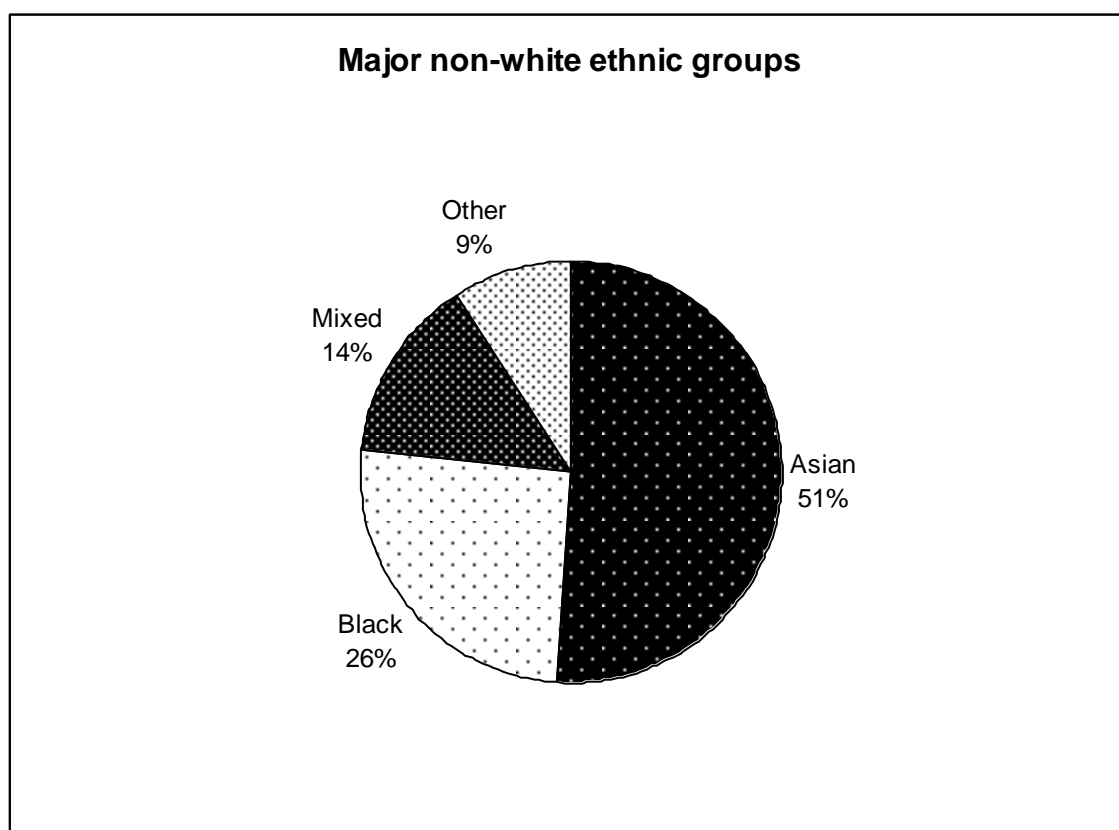


Table 2. The top twenty languages spoken by children in London.

Although English remains by far the most commonly spoken language, for one third of the Capital's children, it is not the language they hear or speak at home. (National Literacy Trust, 2008). The top twenty languages spoken by children in London were identified as follows:

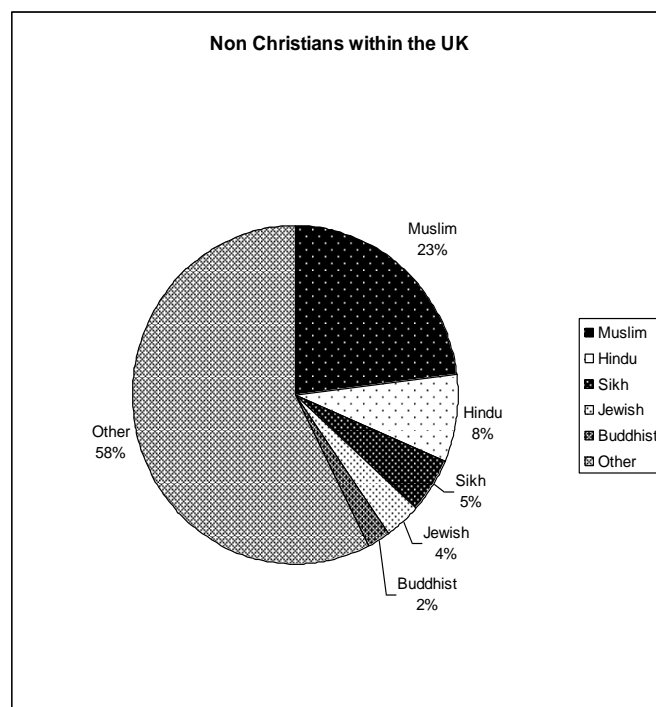
Language	Approximate number of children speaking the language
English	608, 500
Bengali and Sylheti	40,400
Punjabi	29,800
Gujarati	28,600
Hindu/Urdu	26,000
Turkish	15,600
Arabic	11,000
English - based Creoles	10,700
Yoruba (Nigeria)	10,400
Somali	8,300
Cantonese	6,900
Greek	6,300
Akan (Ashanti)	6,000
Portuguese	6,000
French	5,600
Spanish	5,500
Tamil (Sri Lanka, Tamil Nadu- India)	3,700
Farsi (Persian)	3,300
Italian	2,500

Source: National Literacy Trust, (2008).

Fig 2. Population of England by Religion

Christian	35,204,700	71.7%
Muslim	1,522,100	3.1%
Hindu	540,100	1.1%
Sikh	343,700	0.7%
Jewish	245,500	0.5%
Buddhist	147,300	0.3%
Other	3,780,700	7.7%
None	7,168,600	14.6%
	48,952,700	99.7%

Source: Census on behalf of the Office for National Statistics (2001).



The British Association for Counselling and Psychotherapy (BACP).

There is no published data relating to the gender and ethnic makeup of the BACP membership that could be quoted in the review. However, they were able to provide a verbal report of the data held on their management information systems.

- . The membership of the BACP is over 30,000.
- . As at 4th July 2008, 26,355 submitted demographic data to the BACP.
- . Of the membership who submitted data, 93% (24,432) reported being white with 7% (1,923) non white.
- . Approximately 16% of the membership declared themselves to be male and 84% female.

The results of this telephone enquiry would suggest that the BACP membership has a similar representation pattern to that of clinical psychology.

Table 3. Broaching and Racial Identity Development

Cross (1971; 1995) – developing a ‘Black’ identity.	Helms (1990) – developing a ‘White’ identity.	Day-Vines <i>et al.</i> (2007) - Attitude Toward Broaching
1. <i>Pre-encounter</i> . Uninformed opinions held.	1. <i>Contact</i> . A lack of racist awareness.	1. <i>Avoidant</i> <ul style="list-style-type: none"> • Avoiding broaching style • Refusal to broach • Broaching regarded as unnecessary • Adopts a posture of naïveté, resistance, and defensiveness when asked to broach • Refuses to consider contextual dimensions of race, ethnicity, and culture
2. <i>Encounter</i> . Recognition that previous opinions were flawed. Attempts to validate new perceptions are made.	2. <i>Disintegration</i> . Acknowledgement of their ‘whiteness’ in a racist society. Belief that all individuals should be treated equally.	2. <i>Isolating</i> <ul style="list-style-type: none"> • Vacillates between avoiding and isolating broaching style • Isolating broacher broaches only once • Does not recognize relationship between cultural factors and culturally appropriate counselling interventions • Recognizes the need for broaching but may avoid broaching because of discomfort, lack of skill, concern about negative reactions from client
3. <i>Immersion – emersion</i> . Old views abandoned and new constructed. Anxiety common.	3. <i>Reintegration</i> . A racist identity coupled with a belief that White privilege should be protected requiring a significant event for change to occur.	- <i>Isolating attitude continues</i> <ul style="list-style-type: none"> • Vacillates between avoiding and isolating broaching style • Isolating broacher broaches only once • Does not recognize relationship between cultural factors and culturally appropriate counselling interventions • Recognizes the need for broaching but may avoid broaching because of discomfort, lack of skill, concern about negative reactions from client
4. <i>Internalisation</i> . The	4. <i>Pseudo-independence</i> .	3. <i>Continuing/incongruent</i>

new identity is internalised and a new prominence is given to 'being black'.	Growing responsibility for racism at an intellectual level. Cultural difference may still be from a White perspective.	<ul style="list-style-type: none"> • Continuing/incongruent broaching style • May broach the subject of race several times, albeit mechanically • Cannot translate recognition of cultural factors into effective counselling strategies and interventions
<p><i>5. Internalisation – commitment.</i></p> <p>Openness about 'being black' with a positive self-esteem.</p>	<p><i>5. Immersion-emersion.</i></p> <p>Re-experience previous emotions that were once denied or distorted.</p>	<p><i>4. Integrated/congruent</i></p> <ul style="list-style-type: none"> • Integrated/congruent broaching style • Conscious understanding of need for broaching • Incorporates broaching into counselling efforts as appropriate • Accepts risks involved in broaching • Identifies culturally appropriate interventions
	<p><i>6. Autonomy.</i> The abandonment of personal, cultural and institutional practices. Greater acceptance of oneself and others.</p>	<p><i>5. Infusing</i></p> <ul style="list-style-type: none"> • Infusing broaching style • Considers broaching integral to effective counselling efforts with clients • Recognizes and acknowledges the impact of race on client's presenting problems

Selected extracts from:

Personality Disorder: No Longer a Diagnosis of Exclusion

Barriers to forming therapeutic relationships with PD patients:

Paragraph 14 - ‘Many clinicians are reluctant to work with people with personality disorder because they believe they have neither the skills, training, or resources to provide an adequate service. Clinicians may find the nature of interactions with personality disordered patients so difficult that they are reluctant to get involved.’

Views of Service Users:

Paragraph 40 - ‘No mental disorder carries greater stigma than the diagnosis “Personality Disorder”, and those diagnosed can feel labelled by professionals as well as by society.’

Paragraph 41 - ‘Those with personality disorder have been described as “the patients psychiatrists dislike”.....time-wasters, difficult, manipulative, bed-wasters or attention seeking.... They, (personality disordered patients), felt blamed for their condition and often sought basic acceptance and someone to listen to them.’

Paragraph 46 - ‘Users felt that there needs to be acknowledgement by professionals that personality disorder is treatable.’

Paragraph 47 - 'Users thought that staff need to be skilled to handle therapeutic relationships, particularly regarding attachment.....staff with their own experiences of mental health difficulties were perceived as having much more insight into the difficulties of patients... it was felt to be therapeutically important for there to be shared experience between patient and professional, and for professionals to be in touch with patient's distress but not overwhelmed by it.'

Table 4. Factor Structure of the Countertransference Questionnaire*The following were positively correlated for Borderline Personality Disorder***Overwhelmed/disorganized**

I feel resentful working with him/her	0.72
I wish I had never taken him/her on as a patient	0.71
My phone messages, I feel anxiety or dread that there will be one from him/her	0.69
S/he frightens me	0.67
I feel used or manipulated by him/her	0.62
I return his/her phone calls less promptly than I do with my other patients	0.61
I call him/her between sessions more than my other patients	0.60
I think or fantasize about ending the treatment	0.59
I feel mistreated or abused by him/her	0.55
I feel pushed to set very firm limits with him/her	0.54
I feel angry at him/her	0.52
I feel repulsed by him/her	0.50

Helpless/inadequate

I feel I am failing to help him/her or I worry that I won't be able to help him/her	0.84
I feel incompetent or inadequate working with him/her	0.80
I feel hopeless working with him/her	0.78
I think s/he might do better with another therapist or a different kind of therapy	0.67
I feel overwhelmed by his/her needs	0.62
I feel less successful helping him/her than other patients	0.62
I feel anxious working with him/her	0.61
I feel confused in sessions with him/her	0.52

Special/overinvolved

I disclose my feelings with him/her more than with other patients	0.64
I self-disclose more about my personal life with him/her than with other patients	0.64
I do things for him/her, or go the extra mile for him/her, that I don't do for others	0.52
I feel guilty when s/he is distressed or deteriorates, as if I must be responsible	0.39
I end sessions overtime with him/her more than with my other patients	0.39

Sexualized

I find myself being flirtatious with him/her	0.99
I feel sexually attracted to him/her	0.89
I feel sexual tension in the room	0.78
I tell him/her I love him/her	0.62

Disengaged

I feel bored in sessions with him/her	0.82
My mind wanders to things other than what he/she is talking about	0.72
I don't feel fully engaged in sessions with him/her	0.53
I tell him/her I love him/her	0.46
I watch the clock with him/her more than with my other patients	0.46
I feel annoyed in sessions with him/her	0.42

The following were negatively correlated for Borderline Personality Disorder

Positive

I look forward to sessions with him/her	0.69
S/he is one of my favourite patients	0.67
I like him/her very much	0.67
I find it exciting working with him/her	0.58
I am very hopeful about the gains s/he is making or will likely make in treatment	0.52
I have trouble relating to the feelings s/he expresses	-0.48
If s/he were not my patient, I could imagine being friends with him/her	0.44
I feel like I understand him/her	0.43
I feel pleased or satisfied after sessions with him/her	0.43

Section 2

RESEARCH REPORT

Please note that to be consistent with the documents relating to the application for ethical approval and the documents provided to participants the term ‘Chief Investigator’ is used throughout this report to refer to the researcher.

Section 2

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A study to explore the experience of therapists in the creation and maintenance of the therapeutic alliance with hard to engage clients: those diagnosed with Borderline Personality Disorder.

2.1 Abstract

Objective:

To explore the experience of therapists in the creation and maintenance of the therapeutic alliance with hard to engage clients: those diagnosed with Borderline Personality Disorder.

Design:

Qualitative Research – an interview based study.

Method:

A semi-structured interview of twelve therapists (from nursing, psychiatry and psychology) covered their personal experiences of forming therapeutic alliances with Borderline Personality Disorder clients. The interviews were audio recorded, transcribed and then analysed using Grounded Theory methodology.

Results:

A model was constructed which described the psychological aspects of forming a therapeutic alliance with Borderline Personality Disorder clients. The model comprised four main categories. Therapists had to manage ‘unavoidable influences’ from persons outside of the alliance, ‘cultural and gender differences’ that existed between the therapist and client and their own ‘emotional reactions’ evoked by interactions with the client. Key to their successful management was the effective use of ‘clinical supervision’. Clinical supervision was considered to provide protection and support for the therapist through the most challenging moments of the alliance. The model was independent of any therapeutic model of treatment.

Conclusion:

Through the lived experience of the therapists, the current study showed that the psychological engagement difficulties associated with Borderline Personality Disorder clients could be managed with the assistance of clinical supervision and that effective therapeutic alliances can be formed and maintained.

2.2 Introduction

Much has been written about how to treat Borderline Personality Disorder (BPD) with psychological therapies (e.g. Chatham, 1989; Dean, 2006; Sperry, 1999). The focus has been on how to conduct psychological therapy following specific therapeutic models. There appears to be limited evidence of how health care professionals actually go about building the alliance with BPD clients, and how they manage the emotional reactions and responses that such activity can generate. Furthermore, there is even less evidence of whether clinicians modify their approach to alliance building where the BPD client is of a different gender, culture or ethnic background to themselves.

Evidence in support of the therapeutic alliance.

Previous research has shown the therapeutic alliance to have a significant influence in producing positive outcomes in the psychological treatment of mental health difficulties (e.g., Bowers & Clum, 1988; Horvath & Symonds, 1991). Studies have indicated that the therapeutic alliance is an independent entity that has a positive impact on outcome irrespective of the therapeutic model being used (Betan *et al.* 2005; Bordin, 1994). An array of self-report measures exist which have been used to assess the quality of the alliance (e.g. Cecero *et al.* 2001) and more sophisticated instruments are being developed to predict whether premature breakdown in the therapeutic alliance is likely (Michalak *et al.* 2005).

Dealing with diversity when forming an alliance.

Beutler *et al.* (as cited in Spinhoven *et al.* 2007) highlighted the lack of attention that has been paid to the therapeutic impact of discrete therapist variables such as age, experience, training, ethnicity and gender and only a few studies have examined therapist variables in a relational or interpersonal context.

The majority of research has focused on gender and ethnicity. There are those who advocate the matching of therapist to client by race and gender, though the evidence for doing so in terms of positive therapeutic outcome is inconclusive (e.g. Cottone *et al.*, 2002; Maramba & Hall, 2002). Practical limitations, such as the current lack of clinical psychologists who are male or are from the minority ethnic groups, make matching highly improbable. One solution has been to provide education to clinicians to enable them to strive for cultural competency, which involves increased awareness and the confidence and skills to ask clients appropriate questions concerning their culture as the need arises (e.g. Day-Vines *et al.* 2007; Patel *et al.*, 2002; Whealin and Ruzek, 2008). There is a need for the initiatives which aim to raise cultural competency in the therapist to be evaluated.

Personality Disorder and the therapeutic alliance.

Views as to the potential of creating and maintaining a therapeutic alliance with clients diagnosed with a Personality Disorder (PD), and in particular Borderline Personality Disorder (BPD), are very much divided, ranging from those who think such alliances are unlikely to be developed at all (e.g. Clarkin *et al.* 1987; Norton & Hinshelwood,

1996) to those who think the alliance is key to helping such clients improve (e.g. Gabbard *et al.* 1994). Historically, there has been a reluctance to treat PD/BPD clients. However, attitudes have changed and PD/BPD is now a priority on the United Kingdom Government Health agenda, (NIMHE, 2003), although some mental health workers are still less likely to behave empathically toward a PD/BPD client (Forsyth *et al.* 2007).

Emotional responses from the therapist to the BPD client

PD and in particular BPD clients are renowned for evoking emotional reactions and responses in their therapists. Betan *et al.* (2005) has provided a useful way of identifying the clinician's reactions and responses to PD/BPD clients. They recognised that clinicians responded to the patient in a number of ways, conscious and unconscious, emotional and cognitive, intrapsychic and behavioural. Betan *et al.* described how the clinician's responses to the patient may provide insight into patterns the patient wittingly or unwittingly evokes from significant other people in their lives.

Betan *et al.* (2005) created a measure in the form of a countertransference questionnaire that therapists can use to compare their own cognitive, affective and behavioural responses with a set of normed data. Although the measure has its origins in psychodynamic theory, Betan *et al.* claimed it can be used by all therapists working with BPD clients, irrespective of the model of therapy employed.

This brief overview of the literature has identified the efficacy of the therapeutic alliance and the growing acceptance that an effective alliance can be built with BPD clients. There is scope to further explore how clinicians practically create and maintain the alliance with BPD clients and how they manage their emotional reactions and responses. There is a need for therapists to be culturally competent and again there is a scope to assess how much aspects of diversity are actually a consideration for therapists when embarking on the creation of a therapeutic alliance with a BPD client.

Purpose for the research

The principle purpose of the present research was to produce a model of engagement based on clinicians' actual experiences with clients. It was the intention that the model produced would provide a template, which clinicians in the future, including those new to the BPD client group, could choose to follow.

Research Aims

The following aims were at the heart of the study:

1. To identify therapists' understanding of how they achieve and maintain effective therapeutic relationships with difficult to engage clients, those diagnosed with a borderline personality disorder.
2. To identify how the therapist's approach differ if the client is from a different culture or ethnic background to his or her own.

2.3 Methodology

The following quote succinctly captures the essence of the current project and the choice of a qualitative research methodology to get to the heart of the clinicians' 'lived experiences' in engaging with BPD clients.

“The goal of qualitative research is the development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences, and views of all the participants” (Pope & Mays, 1995).

Grounded Theory

Overview

Grounded Theory methodology (Glaser & Strauss, 1967) is a proven method of abstracting theory from experience. Clinicians were the subject of an audio-recorded interview on a one to one basis with the Chief Investigator. The participants responses were then transcribed and analyzed using an open coding technique as described below. Questions for subsequent interviewees were tailored to take into account the analysis of preceding interviews. The coding of each interview was compared with those previously coded to confirm existing categories or to introduce new ones. These categories and the links between them emerged to produce the theory. As the process continued there reached a point where many of the views previously obtained were repeated with no new information being offered, a position which in grounded theory is referred to as saturation.

Epistemological Stance

This was the first major qualitative research project undertaken by the Chief Investigator and formed part of the academic requirements to qualify as a clinical psychologist. It was conducted within the time constraints imposed by the examining university. Initially, the Chief Investigator considered a positivist paradigm with the intention of achieving an accurate account of the process of forming a therapeutic alliance. However, during the process of formulating a coherent research proposal, the Chief Investigator became acutely aware of the different perspectives individuals would bring to the study and whilst remaining as objective as possible, the impact he himself would have on the process. As a consequence, a post-positivist epistemological stance known as Critical Realism was adopted.

Participants

With Grounded Theory it is expected that participants are selected purposefully because it is believed they can contribute to the topic being investigated (Lyons & Coyle, 2007). The current research was aimed specifically at clinicians and arrangements were made with a Community Personality Disorder Service and a High Secure Mental Health Hospital to interview sufficient numbers for this study. As the evidence emerged from the interviews, further participants were specifically selected for what they could bring to the study. All those interviewed, including the interviewee seen as part of the pilot interview, were practicing clinicians with over one year's experience of developing therapeutic relationships with clients who had been diagnosed with BPD. Twelve

interviews were conducted in total. A breakdown of the interviewees by health profession, gender and ethnicity can be found in Appendix A.

Procedure

Informed consent

Each potential participant was sent a series of papers (Appendices B & C) describing the aims of the study and the process to be undertaken. This was followed by a telephone call to agree a mutually convenient time for a semi-structured interview to take place. Written consent was obtained from each participant before the interview commenced (see Appendix D).

Confidentiality

Clinicians were advised before being interviewed that individual clients should not be named or discussed in a way that could identify them. Client's records were not examined by the Chief Investigator. All information gathered during this research project was anonymised. Names were removed from the transcripts of interviews. Interviewees were referred to by their job description and a number which related to their position within the sequence of interviews undertaken. For example: Interview 2, Counselling Psychologist, Community Team.

Participant distress

The clinicians interviewed were asked about their emotional response to this hard to engage client group. Participants were informed through the 'Participant Information

Sheet' provided (Appendix C) that should they experience any uncomfortable emotions during their research interview that they would be advised to seek supervision with their usual supervisor and that they would also be offered time at the conclusion of the interview to talk to the Chief Investigator should they feel that would be beneficial.

Ethical and Research Governance Approval

Following the submission of a peer reviewed research proposal, ethical approval was obtained from an NHS Local Research Ethics Committee (LREC) and a University Ethics Committee. Research Governance approval was obtained from the host and employing NHS Trust. As the research progressed and evidence emerged, it became necessary to extend the original ethics application to include a clinician based at third location (see Appendix E).

Pilot Study

A pilot interview was conducted to ensure the documentation provided to participants and the initial set of questions was fully understood. Analysis of this pilot identified a theme, "experiencing clinical supervision", which was not in the original set of questions and therefore the interview schedule was amended to include it. With the participant's permission the pilot data was incorporated into the study.

Data Collection

Initial interview schedule

Based on the research aims, an initial interview schedule was compiled (Appendix F). As noted, this was tested and amended following a pilot interview. The interview schedule was forwarded to each interviewee in advance to give the participants some notice of the areas to be discussed and formed the basis of the semi-structured interview. As evidence emerged, additional questions were added to the interview schedule. In addition, interviewees were allowed to develop their own areas of interest and in this way, the process was one of evolving enquiry.

Audio recording and transcription

All interviews were audio recorded and transcribed. In accordance with the conventions of transcribing in Grounded Theory analysis, the speech of interviewee and the Chief Investigator were transcribed. Unlike other qualitative methods such as discourse analysis, it was not necessary to transcribe prosodic (rhythm, stress, intonation) paralinguistic (non-verbal vocal nuances, e.g. tone of the voice) or extra-linguistic elements of the interviews (outside the realm of language, e.g. “ums” and “ahs”) (Lyons and Coyle, 2007). The Chief Investigator transcribed some of the interviews, however, due to reasons of security, it was not possible to remove the recording and transcribing equipment from the high secure hospital and therefore the transcribing process was undertaken by others. These were checked for accuracy by the Chief Investigator.

The transcriptions of the twelve interviews can be found in the separate Addendum to this report. Quotes referred to later in this report are referenced in the following format (interview number, line numbers, page number) so (6:401-403, p.143) refers to page 143 of the sixth interview with the quote to be found on lines numbered 401 to 403. A schematic presentation of the data collection, analysis and reporting procedures can be found at Appendix G.

Analysis

The qualitative data analysis software, NVIVO7² was used to assist in the analysis. This software allowed for the electronic storage³ of the transcripts and the manipulation of the data into the codes and categories as required by Grounded Theory methodology. Charmaz (2006) has provided guidelines and recommendations on how to conduct a Grounded Theory research study which were followed in order to produce a model or theory of engagement. A number of stages which are key, methodologically to the process are outlined below.

Initial coding

The transcripts were examined line by line and appropriate codes or meanings were attached to the line or sentence which captured the essence of what the interviewee had said. In accordance with the recommendations of Charmaz (2006), the codes were 'active' in their description. For example, a statement relating to feedback was encoded, 'Preparing people for feedback'. These initial codes were variously described as

² NVIVO7 – Trademark for Qualitative Software of QSR International Pty Limited.

³ All data held on computer was password protected.

categories (Lyons & Coyle, 2007), open coding (Strauss and Corbin, 1990, 1998) and substantive coding (Glaser, 1992). NVIVO7 refers to these initial codes as nodes.

Memo writing

After each interview the Chief Investigator wrote a memorandum summarising his thoughts of the process undertaken, highlighting the main themes discussed and in particular any new themes to be considered in subsequent interviews. This process charts the progress of the research and enables the researcher to begin the formulation of their ideas (Charmaz, 2006; Lyon and Coyle, 2007).

Constant Comparative Method

The constant comparative method (Glaser and Straus, 1967) involves, constantly comparing data with data, data with themes identified and themes with themes. The product of this is the generation of more abstract concepts and theories. After each interview, using NVIVO7 software, the initial codes were compared and where appropriate were grouped together into more focussed codes, clustered under headings which the software refers to as tree nodes. Similar initial codes were grouped together under unique headings. Inevitably, this process led to some codes to be amended, revised and in some cases re-coded. Eventually, all the initial codes were clustered under a small set of focussed codes (tree nodes). Similarities and differences between the focussed codes were noted and memoranda of the Chief Investigator's thoughts and considerations were recorded. In the worked example produced below, clinicians' views of the implications of diagnosis varied. By comparing and reflecting on these

differing views, initial codes were refined and revised until the final code of ‘unavoidable external influence’ was derived.

Table 5. Example of the constant comparative method.

Evidence	Initial codes	Revised code
“... the primary diagnosis was borderline PD”. (1:217, p.31).	Diagnosis	
“I think it can hinder clients that come along”. (6:242, p.136)	Diagnosis hindering clients	
“You get a diagnosis, you get a service. You don’t get a diagnosis, chances are you won’t get a service”. (7:214, p.158).	Diagnosis leads to a service.	
“the patients can see themselves as mad, bad, whatever” (9:585, p.208).	Labelled by diagnosis	
Memo Interviewees have described various views of the consequences of receiving a diagnosis. Some positive – you get a service, others stigmatising – you get labelled. They all have a common thread in that they all impact on the client in some way that the therapists will need to work with. Diagnosis can be considered as an unavoidable influence that is external to the process of building the therapeutic alliance.		Unavoidable external influence

Categories

Over time the focussed codes grew in number and they too were examined for similarity and difference which enabled them to be merged into yet higher order codes or categories. At periodic times the Chief Investigator drew models of the relationships between these high order categories and focussed codes to aid discussion with

supervisors and peers. These visual representations of the data were added to, amended and refined as the Grounded Theory analysis proceeded until a final model was derived from the 12 interviews which represent the ‘lived experience’ of the interviewees in the process of engaging BPD clients.

Theoretical sampling

Theoretical sampling is a method by which previously identified processes are tested, challenged, refined and reduced, a process which has been called ‘axial coding’ (Straus and Corbin (1990, 1998). Once interviews commenced and themes were emerging, individuals were selected for interview as they were known to have experience of the circumstances upon which the themes were based. For example, Interviewee 6 was specifically selected for it was known that this psychologist had strong held beliefs about the concept of diagnosis which differed from those already interviewed.

Theoretical sampling allowed for the testing and challenging of emergent themes.

Examples of theoretical sampling are provided below in Table 6.

Table 6. Examples of Theoretical Sampling

Interview Number	Process	Comment	Resultant evidence
6	'Diagnosis'	Interviewee selected as it was known he had strong views of the concept of diagnosis.	<i>"I would really take issue with the sense that just because people receive this diagnosis I I'm you know more upset or irritated or you know frustrated" (6:401-403, p.143).</i>
9	Concerns around the possibility of therapist and client getting 'too close'	Interviewee selected as it was known she worked in an area where there had been concerns about staff getting 'too close' to clients.	<i>"Well I think yes there's a possibility because I've seen it happen". (9: 323-328, p.198).</i>
10	Concerns around the possibility of therapist and client getting 'too close'	Interviewee was a manager of a service who had reported potential concerns with regard to this theme.	<i>"... what I think people are missing is that it's not that the psychologist or the nurse doesn't have any boundaries, it's simply that they have a better working alliance than other members of the team and I think there are jealousies that go on and there's a lack of understanding". (10: 303-308, p.221).</i>

2.4 Results

The twelve interviews conducted provided rich data of the experiences of clinicians who had formed therapeutic alliances with hard to engage clients, those with a diagnosis of BPD. The results of the current study indicated that the process of forming a therapeutic alliance is influenced well before the client and therapist meet and that other people have an influence on the attitude of both parties throughout the lifetime of the alliance. Each interviewee referred to the importance they attached to the psychological processes that can either undermine the therapeutic alliance or provide the 'glue' which binds the various procedures and processes together to form a therapeutic alliance which is a positive experience for both client and therapist. Of major significance to all those interviewed was the protection, guidance and support afforded by regular clinical supervision. Clinical supervision was found to be key in the way interviewees managed the psychological processes involved in the alliance. From the analysis of the data obtained; a model of engagement emerged that relates to the psychological and emotional aspects of forming a therapeutic alliance with BPD clients.

The refining of properties into sub-categories and finally main categories.

From the analysis of the data obtained, 24 properties were identified which were arranged into eight sub-categories. The eight sub-categories were refined further into four main categories which were the building blocks of the theory. The main categories, sub-categories and properties are outlined on page 102. They are described in full, with supporting evidential quotes, in the coming sections. Before doing so, the

overarching theory, in the form of a Process Model is explained, to set the four main categories into context.

Process Model and the four main categories

The theoretical links between the properties, sub-categories and the main categories can be found summarised in the Process Model, page 103. These main categories are now briefly described below:

Unavoidable influences.

The interviewees described how external influences impacted on the client before they met in therapy, for example the client's interactions with the initial referrer. Other health workers on the periphery of the client's care also imparted influence. These 'unavoidable influences' could be either encouraging or discouraging for both parties to the alliance.

Dealing with diversity.

The interviewees' considerations of diversity in terms of their client's gender and culture were explored. Gender differences in terms of emotional presentation, risk to themselves and other people and sexual attraction were raised. A lack of experience of dealing with cultural difference was highlighted along with the dangers associated with making assumptions about cultural issues. A strong desire to seek understanding was evident. The potential for matching clients to therapists by gender and cultural background was also considered by the interviewees.

Managing emotions.

The interviewees discussed the various emotional reactions they experienced and their response. Negative feelings such as hostility and failure were expressed. Key to the management of their emotions was having an acute sense of awareness.

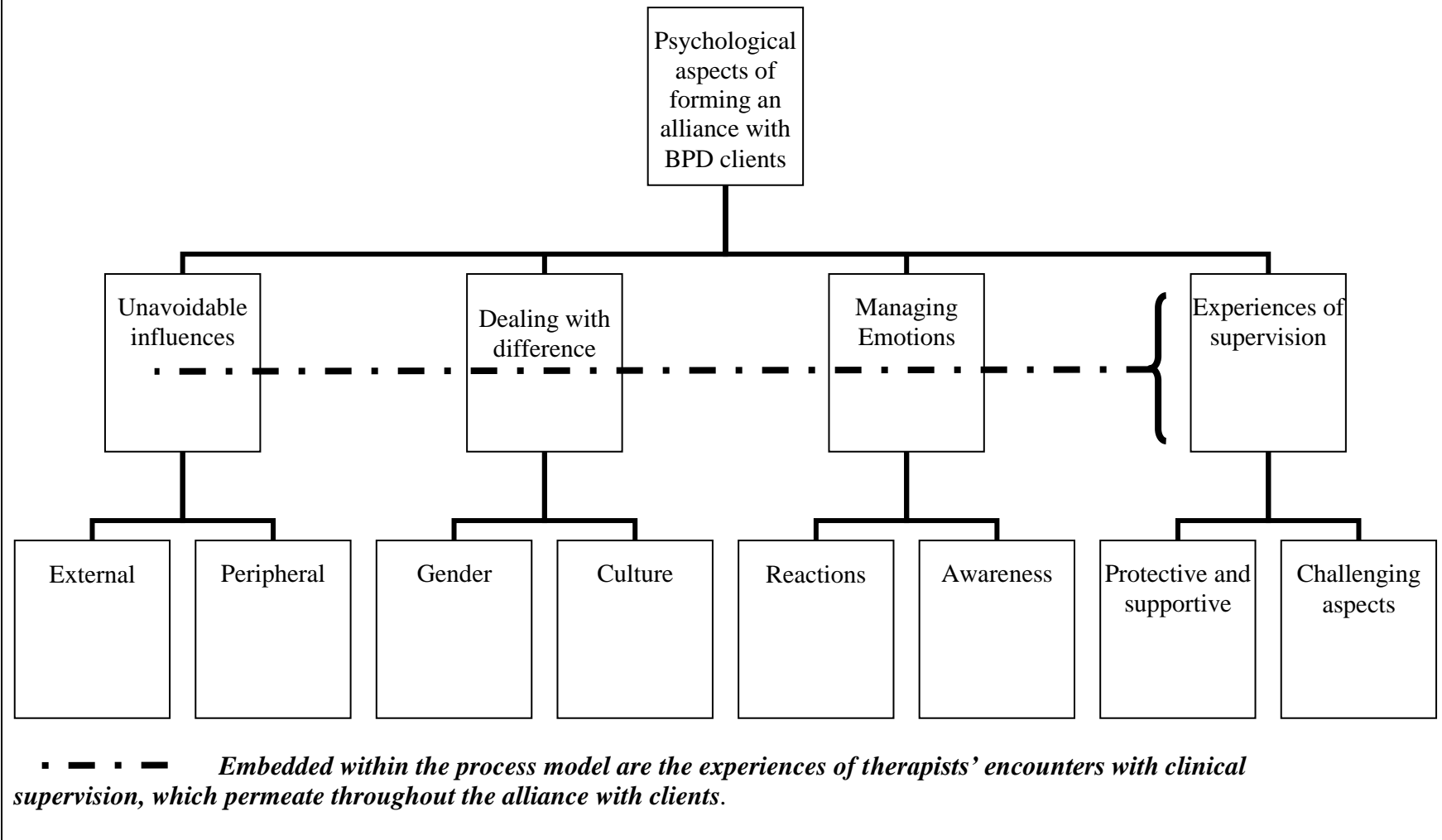
Clinical supervision.

Interviewees described how clinical supervision permeated through all aspects of the creation and maintenance of the therapeutic alliance. It was mainly considered as protective and supportive, though there were some exceptions.

Table 7. Categories, Sub Categories and Properties

<i>Main category</i>	<i>Sub category</i>	<i>Properties</i>
Unavoidable influences	External	<ul style="list-style-type: none"> – Client’s previous experiences – Impact of Diagnosis – Inhibited referrers
	Peripheral	<ul style="list-style-type: none"> – Others negativity – Perceived ‘too close’
Dealing with Difference	Gender	<ul style="list-style-type: none"> – Emotional presentation – Risk – Matching for clinical reasons – Modelling behaviour – Sexual attraction
	Culture	<ul style="list-style-type: none"> – Lack of experience – Seeking understanding – Dangerous to assume – Matching for clinical reasons – Experiencing discomfort
Managing your emotions	Reactions	<ul style="list-style-type: none"> – Emotional response – Experiencing hostility – Feelings of failure
	Awareness	<ul style="list-style-type: none"> – Identifying triggers – Reflecting back
Experiences of clinical supervision	Protective and supportive	<ul style="list-style-type: none"> – Keeping safe – Assisted reflection
	Challenges	<ul style="list-style-type: none"> – Personally difficult – Cultural barriers – Limited access

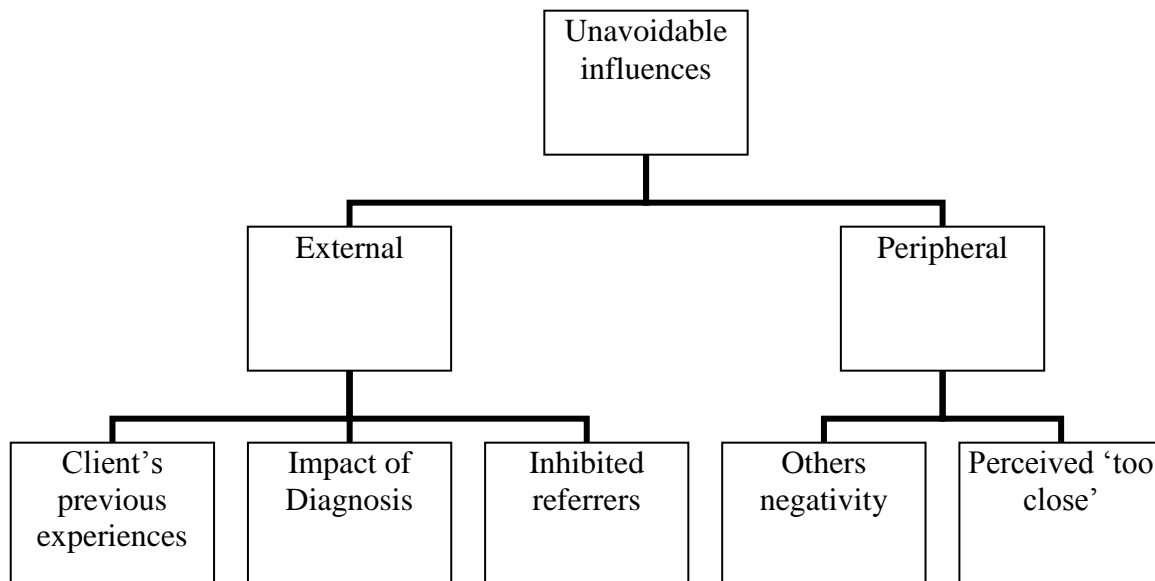
Fig 3. Therapists' lived experiences of forming therapeutic alliances with BPD clients - a Process Model



Evidence for the main categories

Each of the four main categories, their sub-categories and their properties are presented together with the evidence in the form of quotes from the interviewees. At the beginning of the presentation of each category, the relevant section of the Process Model is presented in an extended form to include the relevant properties.

Fig 4. ‘Unavoidable Influences’ section of the Process Model – extended to include five properties.



Main category ‘Unavoidable influences’.

This main category related to the impact that activities not directly related to the relationship between the therapist and the client could have on the therapeutic alliance. Two sub-categories were derived from the data. The ‘external’ sub-category related to three properties which occurred prior to the therapist and the client meeting. The

‘peripheral’ sub-category concerned three properties relating to other peoples’
perceptions.

Properties of the ‘external’ sub-category.

Clients previous experiences of therapy.

Interviewees noted that many of their BPD clients had previous histories of therapeutic engagement which had the capacity to influence any future therapeutic relationship. One therapist considered researching the client’s therapeutic past as valuable preparation before meeting the client.

“... look back through peoples’ previous experiences of therapy and of relatedness. I think that’s a really useful strategy to use, particularly as the guys that we work with have often been through serial therapeutic relationships, some of which they speak quite well of, many of which they speak about in terms of not just a rupture that’s been repaired but they’ve ended inappropriately or in a way that’s not been felt constructive”. (11:111-116, p.237).

Diagnosis

Diagnosis was a controversial subject for the interviewees. For some it was considered as a necessity to enable access to services.

“You get a diagnosis, you get a service. You don’t get a diagnosis; chances are you won’t get a service. It’s just as simple as that for me”. (7:213-215, p.158).

“... it’s a gateway diagnosis, in that you have to have the diagnosis to access the service.” (8:69-71, p.169).

Others interviewed found the process of diagnosis to be irrelevant to their therapeutic practice.

“I don’t focus on the label at all. I talk about how that individual may see the world and how they may well feel that people will react against them and how they defend against that, so I talk about that individual’s function, rather than anything else”.
(9:588-590, p.208).

“I would really take issue with the sense that just because people receive this diagnosis I I’m you know more upset or irritated or you know frustrated than with it the potential for any client group I might work with”. (6:401-404, p.143).

However, some interviewees felt very strongly that diagnosis could have negative consequences for the alliance. Some considered that a diagnosis of BPD could trigger negative pre-conceived ideas in others who also work with the client; other interviewees had experienced clients feeling stigmatised through their diagnosis. Both were considered to have the potential to negatively impact on the client’s willingness or confidence to engage in a therapeutic alliance.

“...personality disorder has replaced mental illness as a the kind of stigma whatever”.
(4:503-504, p.87).

“I don’t think it’s useful at all because when you say borderline personality disorder one of the first things that people (staff) think about is suicide and self-harm”. (12: 85-89, p.258).

“I think that sometimes the patients can see themselves as mad, bad, whatever and I think that those labels don’t help so I would suggest that labels aren’t particularly helpful for the alliance”. (9:588-590, p.208).

Referrer

Interviewees described vivid experiences of how the lack of information and preparation of the client by the referrer was an initial barrier to successful engagement.

“... some people don’t even know they’ve got a PD before they they⁴ even come in”.
(2:87-88, p.26).

“... there’s something about the preparation and what people, how informed they are about what they’re being referred to that has a big part to play in engagement I I believe”. (4:501-504, p.87).

⁴ Speech has been transcribed verbatim. Duplicated words are not typing errors.

Some wondered if the referrers were too busy to spend the time with the client and explain their diagnosis and reasons for the referral.

“They (patients) often expressed concerns around – what is a PD? Does it mean I’m mad? Will the PD service work – nothing else has? I just keep getting passed on to different services – this just seems to be another one”. (1:399-402, p.22).

“... but sometimes the worst referrers are the are the mental health professionals who possibly because they’ve got too much work don’t spend the time talking through the rationale for the referral and how it might help them”. (4:548-550, p.89).

The possibility that the referrers were inhibited in some way from giving full information was contemplated.

“I think the worse thing they can do is not to give any information or hide it from from people and say oh there’s this service down the road I’d like you to go oh we get lots of that and you get lots of that from mental health professionals cos of their difficulty with the whole PD issue”. (4:559-562, p.89).

One interviewee described how she tried to address the lack of preparation of the client by the referrer by providing an encouraging introductory letter.

“The letter often has been written in a way that kind of is more welcoming and we do things like kind of say to people if you’d like to bring someone to support you that’s OK, so just to kind of make it sort of quite accessible”. (2:90-92, p.26).

Properties of the ‘peripheral’ sub-category.

Others’ negativity.

A number of interviewees referred to the impact they experienced from other staff on their therapeutic relationship with their client. This was particularly evident in the secure hospital setting where others were responsible for the 24 hour care of clients.

Due to this level of contact, care staff had significant influence on the client and therefore it was essential for the benefit of the alliance that the day to day contact with staff was as therapeutic an experience for the client as possible. However, there were institutional requirements such as the management of risk that also influenced the interactions between staff and clients.

“working with just personality disorder full stop in this unit we provide an induction programme but unfortunately words like splitting, grooming, manipulation, etc, feature in that induction. ... so then whenever a patient asks for something in the unit, the assumption is that dynamic is playing out ... in this sort of environment the approach, as you can imagine, is quite punitive, it’s about risk reduction”. (12:228-234, p.264).

“... she had different relationships with different members of her care team and I think that impacts on her relationship with me because how can, she almost expects me to be a bit punitive towards her”. (2:463-464, p.41).

However, one interviewee experienced positive benefits in terms of the clients becoming more appreciative of the therapist as a consequence of what some might perceive as the less therapeutic treatment clients can experience from other staff members.

“I become someone they can talk to because they (staff) can’t talk to them, you know, the patient can talk to me because they don’t understand, they won’t give them time”. (12:253-256, p.265).

Other’s perceptions of getting ‘too close’.

It became apparent that there were possibilities of negative aspects to the alliance, for example, where the therapist became ‘too close’ to the client, leading to clouding of judgment, the conferring of preferential treatment or at least the accusation of favouritism from other clients or staff members. Following the Grounded Theory principle of theoretical sampling, the last four interviewees were specifically selected for their knowledge in this area. The interviewees recognised that therapists can get ‘too close’ to their clients.

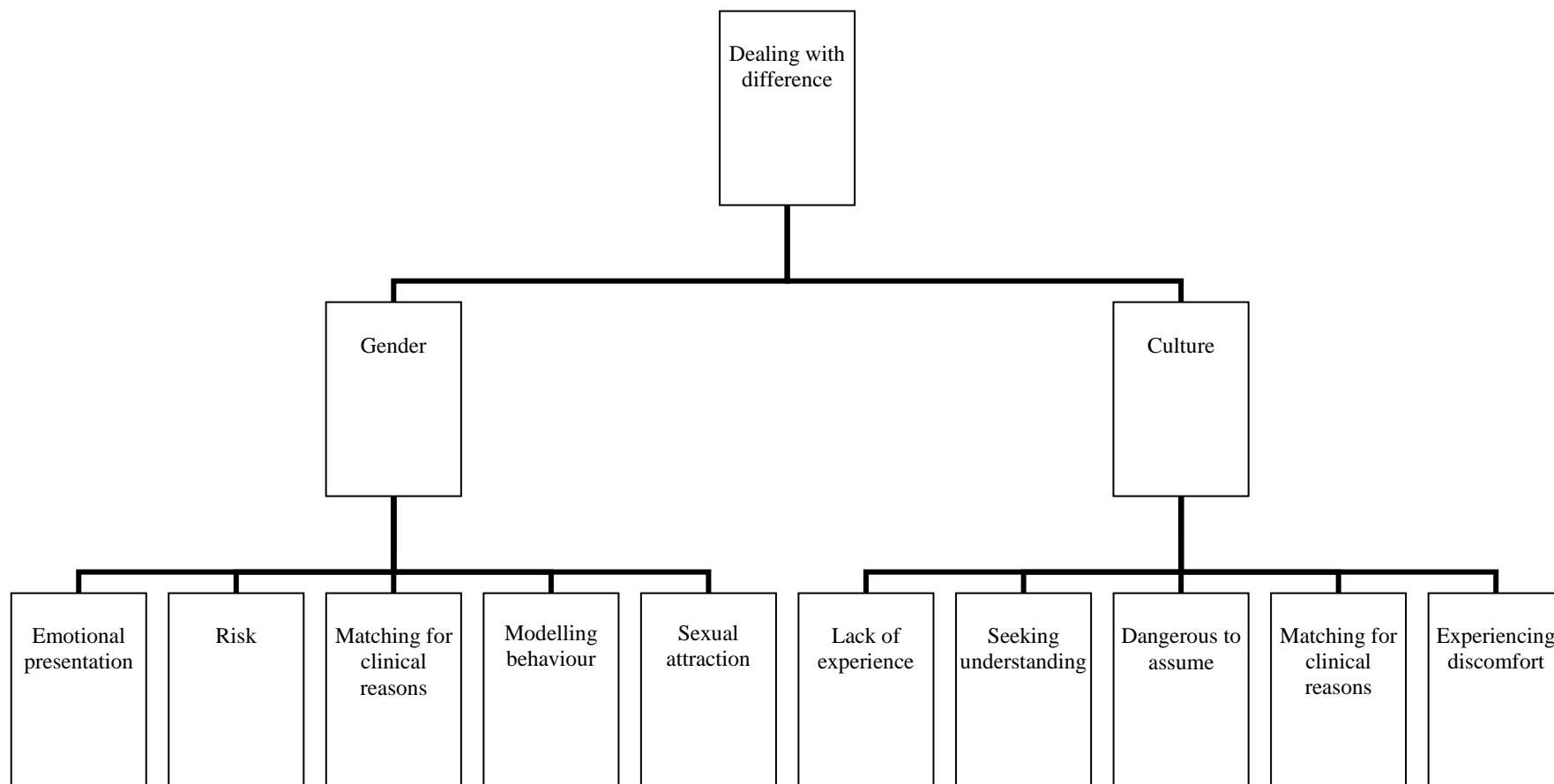
“Well I think yes there’s a possibility because I’ve seen it happen, I’ve worked with people that I would never have expected to get too close, that have got too close. (9: 323-328, p.198).

However, the most common response was that the ‘too close’ suggestion came from other staff working with the client who perceived the close working relationship of a therapeutic alliance as an indication of something less appropriate.

“... what I think people are missing is that it’s not that the psychologist or the nurse doesn’t have any boundaries, it’s simply that they have a better working alliance than other members of the team and I think there are jealousies that go on and there’s a lack of understanding”. (10: 303-308, p.221).

“... construed as having been pulled into inappropriately close relationships by clinical teams that don’t buy into the same model or can’t make sense of, because if we think about the training here for security, you know, it’s all about grooming and watch out for anyone getting too close to a patient because that’s high risk”. (11:458-460, p.251).

Fig 5. Dealing with difference section of the process model – extended to include ten properties.



Main category ‘Dealing with Difference’.

This main category related to the difficulties and complexities, interviewees faced when dealing with difference. Difference was defined by the two sub-categories, ‘Gender’ and ‘Cultural Diversity’.

Properties of the ‘gender sub-category’.

Differences in emotional presentation.

Interviewees described how the emotional presentation might differ depending on the gender of the client, with men more likely to act out in an aggressive manner towards others, whereas, women were more likely to injure themselves.

“... there’s more I think aggression to self in the female ... with men ... there’s often a lot of acting out outside of the therapy programme and that is more difficult to manage”.

(4:376-379, p.82).

These differences would impact on the therapist’s approach to building the alliance.

“So when a person, particularly a female, is in a, how shall I say, an aroused negative emotional state, there’s little point, I think, going in and trying to be sort of therapeutic and so forth at that time. You know you have to bide your time as it were”.

(7:68-71, p.152).

“... with men, I mean there are flashes of emotion which reaches a crescendo and comes down”. (7:64-65, p.152).

Risk to the therapist.

There was a presumption that there was increased risk of males becoming aggressive in therapeutic settings than females, which could be anxiety provoking for the therapist. Males were also considered to be more challenging and confrontational, which would have implications for the therapists working with them.

“that does affect the way you feel in a room with somebody if they’ve been violent to other people then I guess you’re more anxious than if someone’s been violent only to themselves”. (5:337-339, p.104).

“(With males) there’s a much more confrontational boundary, there’s much more boundary violations if you like, much more challenges”. (4:380-382, p.82).

“You know they (male PD) do sort of externalise the anger and they do present it aggressive so how’s that going to work within a group”. (3:235-236, p.55).

Gender matching.

The decision whether to gender match was often taken in the interests of the client.

“I suppose I think with a lot of the female clients there’s issues of sort of abuse as well, I mean a lot of these sort of females have a history of abuse from a male abuser so that I mean that’s something that needs to be borne in mind I suppose”. (3:247-249, p.55).

“... many of our clients have had very difficult relationships with their mothers and some will be in denial about that ... and others will be sort of hatred and cut off and don’t want to go near a woman”. (5:407-410, p.107).

Occasionally, the therapist’s best interests would be the deciding factor.

“... where we’ve had a sense that you know if a female staff member is likely to be abused or whatever else, we’ve consciously made a decision for the key worker to be a male and conversely for exactly the same reason for the key worker to be a female”. (7:347-350, p.164).

There was clear evidence of the interviewees having considered the merits of matching the therapist to the client by gender. On occasions the need to consider the gender of the therapist was outweighed by the quality of the existing relationship with the client.

“... would she be happy talking to me (male) about abuse issues and and her response was well you know I’ve built up a relationship with you talk about other things and I wouldn’t really like to start all over again with somebody else”. (3:262-265, p.56).

Modelling behaviour.

There was also evidence for a different view about gender matching. There were occasions when our interviewees thought a male therapist would be more appropriate for a female client and that there were a number of occasions when the therapist could be a 'role model' for the client.

"... it's probably useful actually to have the experience with a man, I think one of the things lots of clients here learn is that ... you can have a relationship with a man and not be abused". (5:411-414, p.107).

The determining factor on whether to gender match should be a clinical decision based on what is in the best interest for the client.

"I think there can be difficulty with someone who's offended against a woman, working with a woman, but it actually also gives you an awful lot of material to work with. I don't actually agree in gender matching". (9:452-454, p.203).

"I've got a patient who's had abnormal attachments to female therapists before ... we're trying to get him to work through with his current female therapist, so it's actually a treatment target". (8:301-304, p.178).

However, there was acceptance that irrespective of the merits of matching client and therapist by gender, this may not always be possible due to the lack of male therapists.

“... often there’s limited scope, so we probably work at a level of an awareness, rather than actually make wholesale changes”. (8:299-301, p.177).

Sexual attraction.

When considering if gender made a difference in the process of building an alliance, one interviewee highlighted the potential for sexual attraction.

“I’m not aware of a major difference in building an alliance, I guess apart from being more aware of things like sexual attraction, but that’s not necessarily gender determined because women ... may well also develop a a sexualised attachment... I’m a bit more aware of that in the earlier stages with with men... it’s about holding that in mind and being aware that that could be part of what’s going on and making sure that doesn’t get acted out on”. (5:362-370, p.105).

Another interviewee felt that wherever there was a close therapeutic relationship between a man and a woman there was the possibility that others would assume it could be inappropriate, but this assumption would not be made if both parties were male.

“I think that sometimes there seems to be the assumption that if a woman has a close therapeutic relationship with a man, then it runs the risk of becoming sexually inappropriate. I think a man can meet a man and there isn’t the perception that it becomes sexually inappropriate and sexuality isn’t necessarily taken into context. It seems far more to be gender specific”. (9:465-469, p.203).

Irrespective of other people's assumptions, there was evidence of male clients being attracted to male therapists.

"Gay as is attracted to a male therapist, yes, I've seen that too or to a lesser extent". (8:294, p.177).

Another interviewee described personal experiences of finding themselves attracted to their client and how they dealt with it appropriately by talking the issue through in clinical supervision.

"I guess what I have had experience of is having, at various points in my career, just simply found some clients, if you like, attractive, purely in a physical sense, ... and (through clinical supervision) being able to voice that in some way". (12:284-296, p.266).

"I don't think anyone would openly admit finding a patient attractive generally, I think it's quite unusual". (12:299-300, p.266).

Properties of the 'cultural diversity' sub-category.

The second sub-category related to the difficulties therapists experience when they are trying to build alliances with clients who are not of the same culture. Five properties made up this sub-category.

Lack of experience.

All interviewees described the difficulties brought about by the lack of cultural diversity experience, due to an under representation of people from black and minority ethnic populations engaging with PD services.

“... highlighted numerous times that you know there are very few black and Asian patients referred and that has also brings up well what’s the staff population mainly white it’s all that kind of and we’re in a you know a pretty multi-cultural city. (4:424-427, p.84).

“... the majority of my patients ... are Caucasians and I am, of course, non-Caucasian, ... I haven’t really dealt with that many people from ethnic minorities, including my own”. (7: 100-103, p. 154).

Attempting to understand.

Many interviewees described how they made attempts to understand diverse cultures despite the minimal experience.

“I was working with a particular gentleman from Pakistan who never, ever gave me eye contact and initially I perceived that as quite dismissive, quite avoidant, but then actually it’s very respectful not to look a woman in the eye, so I think I’d be aware of those things and I’d explore those things within the session. (9: 477-482, p. 204).

Although their cultural experiences may be very different, the client's psychological distress would still be very evident and warrant psychological intervention.

"... when people are talking about oppression you you need to take that seriously, you need to know that that means something that perhaps is outside of your own experience that you haven't necessarily been able to kind of access in your own". (5: 452-455, p. 109).

Dangerous to assume.

Many of the interviewees were aware of the dangers of making assumptions when unsure of the nuances of their client's culture.

"...you have to be careful that doesn't kind of bring in a whole set of assumptions about what that means about them". (5: 446-450, p. 108).

Whilst accepting and acknowledging the cultural difference and the uncertainty that it can bring, there was also an awareness of individuality and individual uniqueness that has to be embraced by the therapist.

"... everybody's experience is is is unique to their family whatever culture they're they're in so I think the the danger is always about making assumptions". (5:475-478, p.110).

Cultural matching.

As with gender matching there was evidence for and against the practice of trying to match the therapist and client by culture and ethnicity. However, the difficulty of matching the therapist to the client by culture/ethnicity due to the lack of therapists from diverse backgrounds was acknowledged.

“... although we have a choice agenda these days, often there’s very limited choice, you know, if you were from Kashmir say, the chances of you getting a Kashmiri therapist or someone who knows all of the ins and outs of your background are pretty limited really”.

(8:335-338, p.179).

Therapists discomfort.

One interviewee described the discomfort felt when accused of being racist.

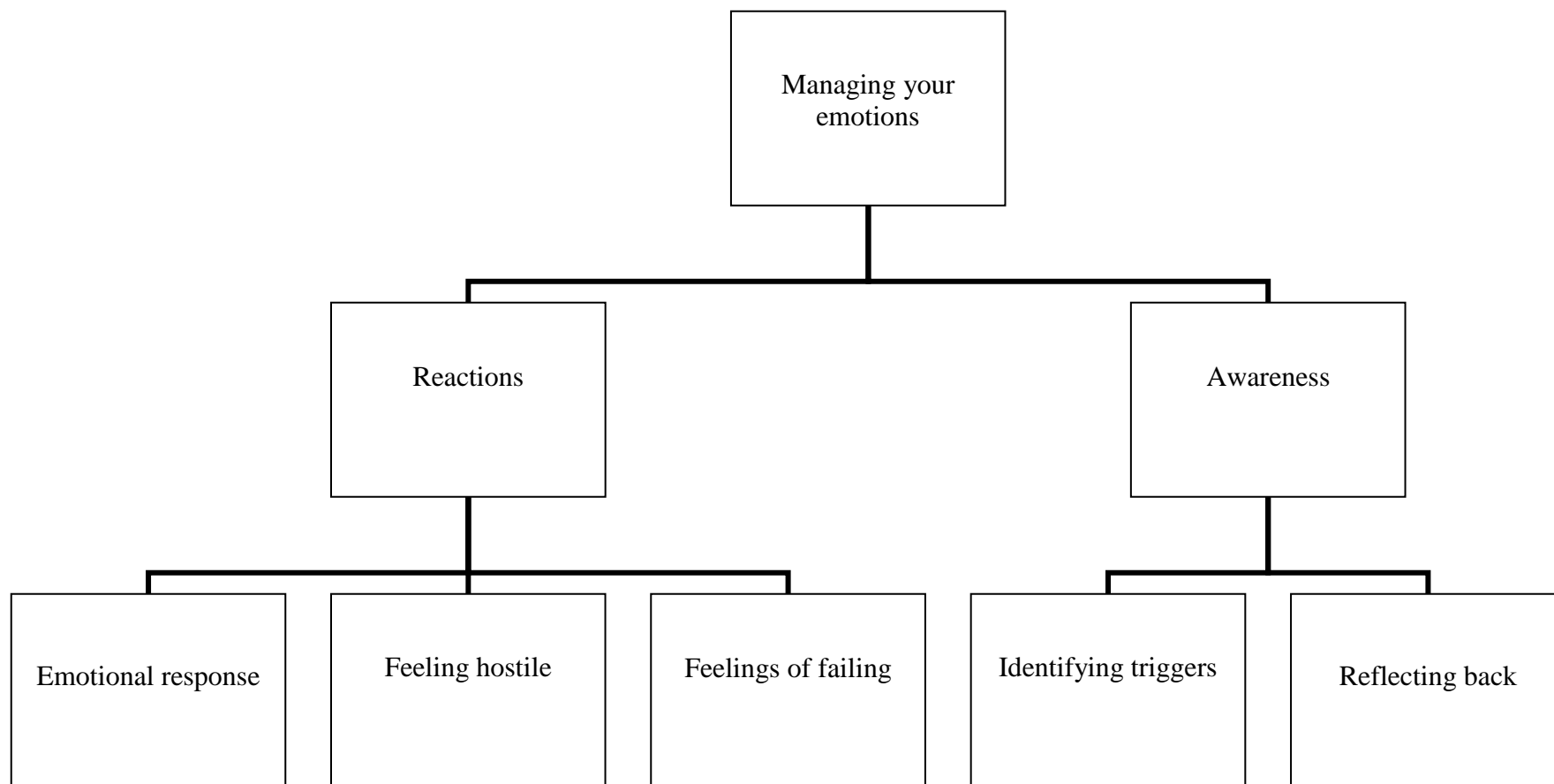
“... closer in the relationship, the paranoia takes over and he starts to reject that relationship and what he does is he rejects it based on racial or cultural grounds, so he has accused a lot of people of being racist”. (2: 223-225, p.32).

“I actually feel it coming from him quite strongly as well. It’s because I was a white, middle-class professional and this you know it kept getting fired back at me, it was really difficult”. (2:229-231, p.32).

However, despite the acknowledged difficulties, these were not insurmountable and successful therapeutic engagement was achieved.

“... the whole culture was entirely different but you know we I think we did reach a shared understanding”. (3:325-328, p.59).

Fig 6. Managing your emotions section of the process model – extended to include five properties.



Main Category ‘Managing your emotions’.

This main category related to the emotions experienced by interviewees in their relationships with clients. Two sub-categories were identified from the data. The therapist’s reactions to the alliance are described in the three properties within the ‘reactions’ sub-category. The therapist’s understanding of their own reactions are captured in the two properties of the ‘awareness’ sub-category.

Properties of the ‘reactions’ sub-category.

Emotional response

Interviewees recognised that on occasions their emotions affected their behaviour within the alliance.

“I think there is a tendency to either want to comfort or withdraw or something depending on your own emotional responses”. (7:72-73, p.152).

“I mean when you see overt expressions of distress, I mean the human reaction I think is to try and comfort in some ways”. (7:76-77, p.153).

“Now unless you’re seriously, you know you have that at the forefront of your mind when you are dealing with people with borderline personality disorder, this ambivalence on the one hand needing, on the other hand rejecting, I think leads to serious emotional responses within the therapists”. (7:145-149, p.155).

There was also recognition that the same client may evoke different emotions and behavioural responses with different therapists.

“... three therapists in there and there’ll be one patient with a particular issue and sometimes the three of us will come away with entirely different emotions you know somebody will be angry, somebody will think they’re progressing quite well and somebody might be a bit frustrated or you know, it’s it’s quite strange”. (3:396-400, p.62).

Feeling hostile

There was recognition that the BPD client group can evoke negative and even hostile feelings in the therapist. The therapist needs to develop a strong sense of self awareness in order to respond appropriately when negative emotions are experienced. Without this awareness, the emotions could lead to behaviours in the therapist, such as avoidance, which obviously would be very detrimental to the alliance.

“ The other response may be to say look this is too difficult and I just need to withdraw, I can’t handle this and within that there may be elements of anger, you know, why is it that this person who I am trying to do so much for is rejecting me at the same time, so anger, resentment and so forth and I think we just have to be very careful in terms of looking at our own emotional responses when dealing with this kind of population, it’s alive you know you can feel it, but you have to be conscious of it”. (7:152-157, p.156).

“And and it’s simple things like if you find yourself not wanting to see a client or forgetting to cancel or forgetting them to tell, forgetting to tell them that you’re on holiday for three weeks, those kinds of things, then you have to think well you know is there a part of me that’s feeling quite hostile towards these this client, am I kind of wiping them out somehow and what’s that about”. (5:210-215, p.99).

Feelings of failing

The final property within this sub-category related to the feelings therapists had when the alliance was not experienced in a positive way, which could discourage the therapist from persevering with efforts to engage the client.

“I think with psychologists particularly there seems to be this sort of failure thing. You know you have to succeed and I think sometimes with you know with this sort of patient group sometimes that doesn’t always feel like you are doing and I think that can get quite frustrating at times”. (3:347-351, p.60).

I suppose that kind of makes me feel like you know a bit of a a bit of an incompetent therapist ‘cos I can’t do it for her, so she’s evoking all those sort of failing schemas in me if you like. (2:325-327, p.36).

Properties of the ‘awareness’ sub-category.

Identifying triggers.

Interviewees reported the need to be able to identify what triggered the negative emotions and reactions they experienced with this client group from time to time.

“All sorts of feelings and emotions. Frustration, anger ... I think it’s quite useful to be aware of your own sort of triggers”. (3:342-344, p.59).

Reflecting back.

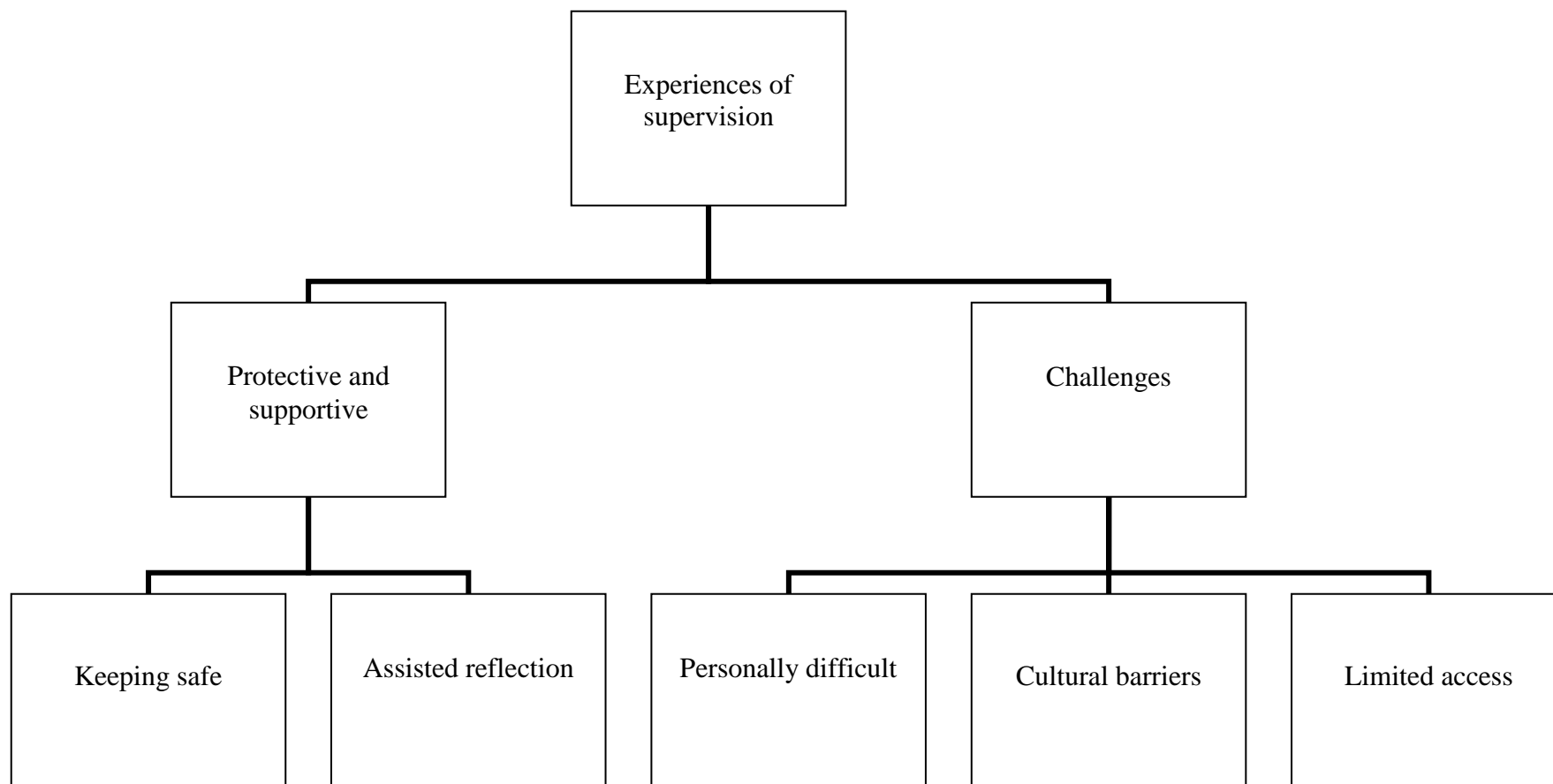
Having established an awareness of their own triggers and responses to this client group, interviewees reported the potential therapeutic benefits of reflecting back to the client some of the emotional responses they evoked in the therapist.

“you know I’m feeling quite quite frustrated you know, how’s what’s that what’s happening then and I actually reflect the feelings back and get them to to kind of understand what’s happening and use the relationship to sort of work through those difficulties”. (2:252-255, p.33).

Managing emotions, understanding them and being able to use them therapeutically is difficult. The final main category, ‘clinical supervision’, is where the therapists sought the assistance of others to help them make sense of the alliance, to manage their

emotions and to formulate strategies to take the relationship forward, to maximise the chances of an improved therapeutic outcome.

Fig 7. Experiences of clinical supervision section of the process model – extended to include five properties.



Main Category ‘Clinical supervision’

Clinical supervision permeates through all of the other main categories. It provides the support for the therapist as they work through the various practical and emotional hurdles of the alliance. All twelve interviewees stressed the crucial role clinical supervision plays in the creation, maintenance and ending of the therapeutic alliance. Two sub-categories were identified as the key aspects of clinical supervision.

Properties of the ‘protective and supportive’ sub category.

Keeping safe

This property emphasises the key role played by clinical supervision in ensuring the therapist practices safely and is helped through any emotionally difficult processes within the alliance.

“I mean what’s crucial I think in the work is is supervision and on-going supervision”.
(4:247, p.76).

“... an essential part of keeping people safe working with personality disordered individuals”. (9:364-365, p.199).

“I mean what’s crucial I think in the work is is supervision and on-going supervision”.
(4:247, p.76).

“I think you can’t do this kind of work without group, team, individual supervision”.
(8:263-264, p.176).

“... the staff who work with BPD have to be contained and they have to have access to supervision. And it’s pretty intense and takes up a lot of resource and staff burn out”.
(4:274-275, p.78).

“... just keeping check really because I think people can get into a mess around boundaries with this client group ... even the most experienced therapist can find themselves in a mess and I think that’s the danger if you don’t have supervision”.
(5:172-175, p.97).

Assisted reflection

Interviewees were well aware of their own emotional sensitivities and used the clinical supervision process to assist them to reflect on the engagement of clients and enable them to better manage through the potential difficulties.

“... you are in a therapeutic relationship, you’re feeling some form of emotion that you haven’t processed. It’s really good to be able to share that in a supervisory sort of relationship with somebody else that knows and has experienced that”. (7:170-172, p.156).

“we’ve all got emotional baggage, so what is tolerable for one person wouldn’t be tolerable for another, so I need to know what buttons are likely to get pressed in a situation with me because I will react because it’s my stuff and not their stuff, so I need to be very cognisant of that and make sure that my buttons get protected so I don’t over react”. (10:60-64, p.211.)

Properties of the ‘challenges’ sub-category.

Personally difficult.

Interviewees recognised that clinical supervision can be very difficult for the therapist.

“...you hopefully then can bring the different bits and projections together and try and think about them but it’s hard it’s hard work and I think you know clinicians struggle with that”. (4:250-252, p.77).

Institutional cultural barriers

The culture of the work place may go against the reflective nature and the sharing of emotions, which are central to effective clinical supervision.

“There’s a very macho old school culture here that makes it very difficult for people to say ‘I’m really being affected by this person’, ‘I’m scared’, ‘I don’t know what to do with this individual’, ‘he’s making me feel like this’, ‘she’s making me feel like this’, so I think there’s lots of problems with supervision in the sense of actually people seeing it

as something to access, which is good and useful and essential and the norm”. (9:165-169, p.191).

There was recognition that to overcome the cultural barriers in the work place, support and encouragement from managers within the organisation was essential.

“... very difficult for staff to give feedback to each other and I don’t think there’s been the support structures there to encourage that”. (9:361-363, p.199).

“I think that people often feel that they will be, I don’t know, that there may well be very negative outcomes for them talking about how they’re being impacted on by the patient group”. (9:162-164, p.191).

Limited access

The lack of support associated with the cultural barriers to supervision may not be overtly demonstrated but implied through the lack of importance associated with prioritising time for clinical supervision.

“... people don’t have access to supervision and people are left to deal with this kind of work on their own and I’m not surprised they’re sick and, you know, attrition rates for staff are high”. (9:175-178, p.192).

Postscript

Many interviewees stressed the challenges of clinical supervision; however, at times it can be made relatively simple.

“Talking to other staff who have worked with this client group also helps to reduce anxiety and frustration”. (1:403-404, p.22).

“Yeah having a life, I think that outside of work (laughing) you know”. (5:747, p.121).

2.5 Discussion

Summary of findings

The current research study set out to explore the lived experiences of therapists engaged in the treatment of clients diagnosed with Borderline Personality Disorder (BPD). In particular it focussed on how they created and maintained a therapeutic alliance with BPD clients who by the terms of their diagnosis were considered difficult to engage and had a history of mistrusting people and poor maintenance of personal relationships. The responses from the participants demonstrated how challenging and personally demanding working with this client group can be. A model emerged from the data, which highlights the psychological and emotional aspects of creating and maintaining a therapeutic alliance with BPD clients and represents the most challenging aspects of the engagement process for the therapists.

Therapists' experiences and the literature

There has been much debate over whether a literature review should be carried out before or after a qualitative research study using Grounded Theory methodology has been undertaken. Willig (2001) advocated a brief awareness of the literature to confirm that there was scope for further research and that the topic is not already fully developed and understood. In this instance a preliminary review of the literature was conducted for the purposes of justifying the research proposal and ethics applications. This initial review covered the practical aspects of the engagement process. It was not until after the data collection and analysis were complete that the literature was revisited and the

psychological and emotional aspects were added to the search criteria. Many aspects of the categories that emerged from the data to produce the psychological model were mirrored in the published literature:

Unavoidable Influences

Interviewees reported influences that could affect the alliance that were beyond their control. One such influence was the impact of diagnosis. For some it was seen as a label which stigmatised their client (Forsyth *et al.* 2007). For others, diagnosis was seen as a gateway to treatment, which reinforced the position that Personality Disorder (PD) was no longer a diagnosis of exclusion (NIMHE, 2003).

Dealing with Difference

The evidence in the literature was inconclusive concerning the benefits to therapeutic outcome of matching client to therapist by gender or ethnicity (e.g. Cottone *et al.*, 2002; Maramba & Hall, 2002). For the interviewees, the decision whether there was a necessity to attempt matching by gender or ethnicity would be based on clinical need and the best interest of the client. Deciding what would be best was never straightforward. An example was given where a female client had been the subject of abuse from a male. The instinctive choice was to provide a female therapist; however, to form a therapeutic relationship with a male may have been clinically desirable as it would model for the client a non threatening relationship with a man. Others described their lack of experience dealing with clients from a different culture to their own and presented a need for cultural competency training (e.g. Day-Vines *et al.* 2007; Patel *et al.*, 2002; Whealin and Ruzek, 2008).

Patel *et al.* (2000) advocated the use of Racial Identity models to assist the therapist in learning to recognise the individual differences between people whether they are the same or different 'racially' or culturally. However, Robinson, as cited in Patel *et al.* (2000) pointed out that although the models may go some way to address issues of 'race', other areas of difference such as gender, social or class distinction and age are not considered. Mama, also cited in Patel *et al.* (2000), considered that by omitting issues of gender and class, Racial Identity models do not consider the Black client as an individual.

The Process of Cultural Competence in the Delivery of Healthcare Services, (Campinha-Bacote, 2002) is a model that considers cultural competence as an ongoing process where the therapist continuously strives to achieve effective working within the cultural context of the client on an individual, family and community basis. The model encourages the integration of five key areas of cultural significance:

1. *Cultural awareness* - the self-examination and in-depth exploration of the therapist's own cultural and professional background, including any prejudices or assumptions they may hold about the client.
2. *Cultural knowledge* - the seeking of knowledge relating to diverse cultural and ethnic groups. It includes obtaining knowledge of the client's health related beliefs and values and how they affect the client's interpretation of their difficulties and their thinking.
3. *Cultural skill* - the ability to conduct a culturally based assessment, attending to cultural data regarding the client's presenting problem.

4. *Cultural encounters* - the process that encourages the therapist to directly engage in cross-cultural interactions with clients.
5. *Cultural desire* - the level of motivation of the therapist to want to, rather than to have to engage in the four cultural processes above.

Campinha-Bacote (2002) developed a 20 item instrument to measure the four constructs of cultural awareness, knowledge, skill and awareness entitled the Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals (IAPCC). Unfortunately, the IAPCC does not have the capability to measure the therapists 'cultural desire' or motivation. Equally, this measure does not consider the patient's perception of the therapists' level of cultural competency (Lucas, 2008).

The Interlocking Paradigm of Cultural Competence (IPCC) is a best practice model, consisting of five stages developed from the work of Peplau, Leininger, Nichols, Campinha-Bacote and Purnell as cited in Warren (2002). The five stages are:

1. *Therapeutic factor* is grounded Peplau's Interpersonal Relations in which the ability to interact and relate to the client is key to the therapist's development of successful interventions. This is the foundation upon which to build cultural competence.
2. *Value factor* relates to Leininger's assertion of the therapist's need to value and incorporate cultural knowledge into their education, therapeutic practice and research.
3. *World View factor* is based upon the work of Nichols and suggest that people from diverse racial and ethnic groups hold diverse views of the world and how they

function within that world. However, world views blend when persons from different racial and ethnic groups work, interact and live with each other. A practical issue for the therapist would be to determine what constitutes the blended world view and how that impacts on their client.

4. *Process factor* is a development from Campinha-Bacote's cultural competency model described above. The IPCC incorporates the first four stages of Campinha-Bacote's model. 'Cultural Desire' stage was not included. The Process Factor stage emphasises that its level of implementation is determined by the therapist's evaluation of their level of cultural competence. Warren (2002) describes the Process Factor as a synchronisation of the client's needs and the therapist's beliefs and actions through the stages of therapy, assessment and goal setting, intervention and outcome evaluation.
5. *Orientation factor* has evolved from the work of Purnell who considered a number of domains which need to be considered when assessing clients, for example; heritage, communication, family roles, work-force issues, biocultural ecology, high risk behaviours, nutrition, pregnancy practices, death rituals and spirituality.

Warren (2002) maintains that the IPCC encourages a partnership approach to mental healthcare between the therapist and the client and recognises the importance of the client's culture, healthcare beliefs and practices.

There is very little in the literature in terms of empirical research evaluating Cultural Competency models (Lucas *et al.* 2008). Citing Satel and Forster (1999) and Weinrach and

Thomas (1997), Sue (2003) suggested that a lack of funding (in the USA) had led to a paucity of research studies into the effectiveness of cultural competency training and that the lack of an evidence base had led to some seeing it as motivated by 'political correctness'. Hwang and Wood's (2007) summary of the literature relating to cultural competency made no reference to the existence of Cultural Competency models. Hwang (2006) asserted that there was no uniform framework for the adaption of treatment interventions for ethnic minority groups and stressed the need for the therapist to understand their own culture as much as that of the client. Chu (2007) suggested the use of single case studies may be the most appropriate method of highlighting the level of cultural competency of a therapist.

Hadwiger (1999) reported finding that nursing students introduced to Campinha-Bacote's model became more aware of their own culture and how it impacted on their nursing care, and through the use of hypothetical cases and narrative writing were able to refine their cultural competency skills. Beach *et al.* (2005), in a review of the literature relating to the evaluation of interventions designed to improve the cultural competency of health professionals found 34 studies completed between 1980 and 2003. Beach *et al.* found evidence indicating that training improves the knowledge, attitude and skills of health professionals in relation to cultural competency and has positive impacts on patient satisfaction. However, none of the studies evaluated patient treatment outcomes. Encouragingly, Callister (2005) found that culturally competent care does favourably impact on outcomes.

A number of self-assessment tools are available for the therapist to assist in them to evaluate their levels of cultural awareness and competency (e.g. Doorenbos *et al.* 2005; National Centre for Cultural Competence, 2004).

Bhui *et al.* (2007) conducted a systematic review of evaluated Cultural Competency Models in terms of their impact in professionally educating therapists and service delivery. They reviewed 109 potential studies. Only 9 studies were found to include the evaluation of the model in terms of cultural competency practice and service delivery. Bhui *et al.* (2007) concluded that the evidence on the effectiveness of cultural competency training and service delivery to be limited and that further research was required.

Day-Vines *et al.* (2007) described how the ultimate in cultural competence is achieved when the therapist recognizes and acknowledges the impact of ‘race’ on client’s presenting problems and has the skill and the confidence to raise the issue of ‘race’ with the client when necessary.

Many Cultural Competency models are restricted to the relationship between the therapist and the client. Whealin and Ruzek’s (2008) model is an example where the requirement for cultural competency is extended beyond the therapist to include non clinical staff who may come into contact with the client and other organisational issues which may have an influence on the therapeutic relationship.

In another area of difference, four interviewees referred to the issue of sexual attraction between the therapist and the client as a possibility. This reflects the study by Betan *et al.* (2005) where ‘sexual attraction’ was identified as a significant countertransference issue for the therapist.

Managing emotions

It was clear that interviewees had good insight of their emotional responses and reactions evoked by BPD clients. In recognition that the therapeutic alliance is likely to mirror clients’ other relationships, reflecting back the emotions engendered in the therapist was seen as potentially therapeutic for the client. The current study has confirmed the countertransference phenomenon is an aspect of every therapeutic alliance and not just those connected with psychodynamic models of therapy (Betan *et al.* 2005).

Clinical supervision

The final main category, clinical supervision was not expressly referred to in the literature. However, the importance of this category cannot be overstated. Clinical supervision is the glue that holds the process of creating and maintaining the therapeutic alliance together, providing guidance and support to the therapist as they encounter challenging moments in the relationship with the client.

2.6 Clinical Implications

The current study has highlighted that the creation of the therapeutic alliance requires much effort and intelligent reflection on behalf of the therapist. The therapist should be supported

through the process by receiving regular clinical supervision, however, this study revealed that clinical supervision was often cancelled or for some, did not happen at all.

General Practitioners and others who may refer PD/BPD clients to PD services should be aware of the influence the manner in which they refer clients can have an impact on the client and potentially for the alliance. Referrers should ensure their referral letters are written appropriately and that the client is fully informed of the reason for the referral and nature of the service he/she is being sent to. Other staff, who also have care of the client, should be made aware of the influence, positive or negative on the alliance, through their attitude and behaviour toward the client.

In the absence of sufficient black and minority ethnic (BME) therapists to enable the matching of client to therapist by race, the white therapist must demonstrate cultural competence to encourage the small number of BME clients who do seek help to engage and stay engaged in their therapy until a satisfactory conclusion is reached. It is important for therapists to work with difference rather than ignoring it. They need to be willing and capable of integrating issues of 'race' into their therapy (Day-Vines *et al.* 2007). Racial Identity models are useful tools to aid the therapist in recognising the individual differences between people (Patel *et al.* 2000), however, therapists also need to consider other areas of difference such as gender, social or class distinction and age. There are a number of self-assessment tools available to assist therapists in evaluating their cultural awareness and competency (e.g. Doorenbos *et al.* 2005; National Centre for Cultural Competence, 2004). Therapists can improve their cultural competence through having a thorough understanding

of the numerous cultural competency models available (e.g. Campinha-Bacote, 2002; Warren, 2002). However, there is a paucity of evidence regarding the effectiveness of cultural competency training and service delivery and further research is required (Bhui *et al.* 2007).

The decision whether to match the client to therapist by gender should be considered on clinical grounds and in the best interests of the client.

The possibility of sexual attraction on behalf of one or both parties to the alliance was considered by some of the interviewees as a possibility. This view was supported by Betan *et al.* (2005). The consideration of sexual attraction within the therapeutic alliance and its management should part of therapists and supervisory training. Therapists should be made aware of the countertransference questionnaire which can be used to help identify the emotions, including sexual attraction, the BPD client group can evoke in them.

Clinical supervision was considered by all those interviewed as having a significant contribution to the therapists' ability to manage the practical and emotional demands of difficult to engage clients. Supervision can provide the support and guidance essential to enable the therapist to work through personally difficult situations and to reflect on their therapeutic practice. Chernis and Egnatios (1977) identified five styles of clinical supervision practiced within community mental health programs:

1. Didactive-consultive – the supervisor offers advice, suggestions and interpretations concerning techniques and therapist/client dynamics.

2. Insight orientated – the supervisor stimulates reflective practice and encourages the therapist to derive their own solutions.
3. Feelings orientated – the supervisor encourages the therapist to examine their emotional responses to the client.
4. Laissez faire – the therapist is predominantly left to work on their own with the supervisor rarely available for consultation.
5. Authoritative – the supervisor adopts an autocratic style with little autonomy afforded to the therapist.

Supervisees preferred Didactive-consultive, Insight orientated and Feelings orientated styles with Didactive-consultive being the most common. Chernis and Egnatios (1977) pointed out that individual therapists have preferred styles and the ideal supervisor is one who can utilise all five of the styles identified dependent on therapist preference and individual case need. Clinical supervisors need to be aware of these different styles and reflect on their own supervisory practices. The current research study identified negative practices such as institutional cultural barriers and limited access to supervision. These are issues that must be addressed by managers if therapists are to work safely and productively with their clients.

Few studies have examined whether clinical supervision has an impact on the clinical outcome of therapy (Holloway & Newfeldt, 1995; Lambert & Ogles, 1997). Ellis and Ladany (1997) concluded that research into the effectiveness of supervision had been substandard. More recently, competency based approaches to supervision may enable

more effective evaluation of the provision of clinical supervision in the future (Falender & Shafranske, 2008).

Bland & Rossen (2005) suggested that as clients with Borderline Personality Disorder can be among the most challenging and difficult to deal with, nursing staff who provide for their day to day care should receive regular clinical supervision. The current research identified that those who are responsible for the day to day nursing care of the client can have an influence on the therapeutic alliance between the client and their therapist. Clinical supervision for the nursing staff may provide an opportunity to encourage their positive support for the therapeutic alliance.

There is a need for clinical supervisors to become culturally competent if they are to provide effective clinical supervision to therapists working with clients who are culturally different to themselves. In addition, supervisors will have to be culturally competent if their supervisees are culturally different by virtue of their ethnicity, gender or sexual orientation (Gatmon *et al.* 2001).

2.7 Strengths and limitations of the study

The scope of the literature review was very broad and covered the efficacy of the therapeutic alliance, its measurement and the ability to predict breakdowns and the impact of difference in terms of gender and race. PD and BPD were defined, the initiatives promoting their treatment described and the potential for the therapeutic alliance with this

group explored. The breadth of the coverage was a strength. Narrowing the focus of the review would have allowed a greater depth of analysis of the literature.

Interviewee's accounts were based on their lived experiences of forming alliances with BPD clients. Although there was an interview schedule, interviewees were encouraged to develop their own areas of interest and in this way the process was one of evolving enquiry. Typed transcripts were provided to interviewees so they could clarify aspects of the information provided or add additional comments. As a consequence, one interviewee provided a two page typed clarification which was coded and added to the analysis.

By providing interviewees with an interview schedule prior to conducting semi-structured interviews, gave them with an indication of the topic areas to be covered. This allowed time for the interviewees to think and prepare for the interview and helped to ensure the aims of the study were met. However, there was a tension between giving interviewees sufficient information to facilitate a productive interview and ensuring their answers were not unduly influenced by this information. To control for this, interviewees were asked to ground their answers with real examples (whilst ensuring anonymity) from their experience in engaging BPD clients.

The Chief Investigator was surprised to find a difference in the ability to comprehend information provided verbally in the interview to when it was transcribed, which supports the view that a lot of communication and meaning is non verbal. Transcriptions indicated

many repetitions, use of abbreviated words and staccato patterns of speech, all of which challenged the coding process.

A specific aim of the study was to identify whether therapists made any changes in their approach to building and maintaining an alliance if the client was from a different culture to their own. The experience of working with clients from differing cultures, race and ethnicity was very limited. Despite this limitation very useful evidence was obtained which informed the psychological model of engagement.

2.8 Future research

Though not specific to PD/BPD, psychological services exist that are dedicated to BME client groups. A qualitative study designed to identify how they approach therapeutic engagement with BME clients would be useful.

There are a number of instruments designed to measure cultural competency. There are publications designed to be used as training aids to help therapists learn to be culturally competent. Research to evaluate the take up of these resources and their effectiveness would inform future strategies for the psychological care of PD/BPD clients from BME groups.

There is a dichotomy relating to the treatment of BME clients. BME clients are known to be over represented in acute psychiatric and forensic mental health settings but under

represented in the diagnosis and consequently treatment of BPD. A research study could be conducted to identify the causes of these representation differences.

Evidence from the current study has identified a perception from some staff members that therapists can get inappropriately 'too close' to their clients. This is defended as a misunderstood, close therapeutic relationship which is not inappropriate. This situation warrants an independent research study.

The current study has concentrated on the experiences of the therapists involved in the therapeutic alliance. Consideration should be given to studying the lived experiences of the clients diagnosed with PD/BPD in relation to the therapeutic alliance.

2.9 Conclusion

The present report has described a Grounded Theory qualitative study that explored the experiences of therapists who engage in therapeutic relationships, clients diagnosed with Borderline Personality Disorder. The results have indicated similar approaches are taken by therapists to engage clients. The participants recognised the challenges associated with managing unavoidable influences from others and the need to increase their cultural competence and awareness in general of matters relating to race and gender. It was recognised that the BPD client can evoke emotional reactions and responses in the therapist which have to be managed. However, the emotions generated in the therapist can be clinically helpful, diagnostically and therapeutically when worked through with a client. Key to managing all of these challenges for the therapist was the effective use of clinical

supervision which was seen as providing protection and support throughout the life of the therapeutic alliance.

The current study found no discernable difference in the experiences of the clinicians interviewed despite being from different work settings – community outpatients and inpatient forensic services or from the various clinical disciplines represented i.e. nursing, psychiatry and psychology.

2.10 References

- Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A. et al. (2005). Cultural competence: A systematic review of health care provider education interventions. *Medical Care*, 43(4), 356-373.
- Betan, E., Heim, A., K., Conklin, C., Z., & Westen, D. (2005). Counter-transference Phenomena and Personality Pathology in Clinical Practice: An Empirical Investigation. *American Journal of Psychiatry*, 162, 890-898.
- Bhui, K., Warfa, N., Edonya, P., McKenzie, K. & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC Health Services Research*. 7:15.
- Bland, A., R., & Rosen, E., K., (2005). Clinical supervision of nurses working with patients with borderline personality disorder. *Issues in Mental Health Nursing*, 26: 507-517.
- Bordin, E., S. (1994). Theory and research on the therapeutic working alliance. In J., D., Safran & C., Muran. (1996). The Resolution of Ruptures in the Therapeutic Alliance. *Journal of Consulting and Clinical Psychology*, 64, (3): 447-458.
- Bowers, T. & Clum, G., 1988. *Relative Contribution of Specific and Non-specific Treatment Effects: Meta- Analysis of Placebo-Controlled Behaviour Therapy Research*. *Psychological Bulletin* 1988, Vol 103, No 3, 315-323.

- Callister, L. C. (2005). What has the literature taught us about culturally competent care of women and children? *American Journal of Maternal Child Nursing*, 30(6), 380-388.
- Campinha-Bacote, J. (2002). The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. *Journal of Transcultural Nursing*, 3, 181-184.
- Cecero, J., J., Fenton, T., L., Nich, N., Frankforter, T., L., & Carrol, K., M. (2001). Focus on the therapeutic alliance: The psychometric properties of six measures across three instruments. *Psychotherapy* 38, 1.
- Charmaz, K., (2006). *Constructing Grounded Theory – a practical guide through qualitative analysis*. London: Sage.
- Chatham, P., (1989). *Treatment of Borderline Personality*. New Jersey: Jason Aronson Inc.
- Cherniss, C., & Egnatios, E. (1977). Styles of clinical supervision in community mental health programs. *Journal of Consulting and Clinical Psychology* 45 (6), 1195-1196.
- Chu, B., (2007). Considering culture one client at a time: maximizing the cultural exchange. *Pragmatic Case Studies in Psychotherapy* 3 (3-2), 34-43.

- Clarkin, J. F., Hurt, S. W., & Crilly, J. L. (1987). Therapeutic alliance and hospital treatment outcome. In J. G., Gunderson, L. M., Najavits, C., Leonhard, C. N., Sullivan & A. N. Sabo, (1997). Ontogeny of the therapeutic alliance in borderline patients. *Psychoherpy Research*, 7 (3), 301-309.
- Cottone, J. G., Drucker, P. & Javier, R. A. (2002). Gender differences in psychotherapy dyads: Changes in psychological symptoms and responsiveness to treatment during 3 months of therapy. *Psychotherapy, Theory, Research, Practice, Training*, 39 (4), 297-306.
- Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., et al. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, 85(4), 401-409.
- Dean, M., (2006). *Borderline Personality Disorder: The latest assessment and treatment strategies*. Missouri: Compact Clinicals.
- Doorenbos, A. Z., Schim, S. M., Benkert, R., & Borse, N. N. (2005). Psychometric evaluation of the cultural competence assessment instrument among healthcare providers. *Nursing Research*, 54(5), 324-331.
- Ellis, M., V., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: an integrative review. In Fleming, I., & Steen, L., (2004).

Supervision and Clinical Psychology; theory, practice and perspectives. Brunner-Routledge. Hove.

Falender, C., A., & Shafranske, E., P., (2008). *Best practices of supervision.* American Psychology Association. Washington DC.

Forsyth, A. (2007). The effects of diagnosis and non-compliance attributions on therapeutic alliance processes in adult acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing*, 14(1), 33-40.

Gabbard, G., O., L. Horwitz, *et al.*. (1994). Transference Interpretation in the Psychotherapy of Borderline Patients - a High-Risk, High-Gain Phenomenon. *Harvard Review of Psychiatry* 2 (2): 59-69.

Gatmon, D., Jackson, D., Koshkarian, L., Martos-Perry, N., Molina, A., Patel, N., & Rodolfa, E., (2001). Exploring ethnic, gender and sexual orientation variables in supervision: Do they really matter. *Journal of Multicultural Counselling and Development*. 29: 102-113.

Glaser, B. G. and Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research.* New York: Aldine.

Glaser, B. G. (Ed.) (1994). *More Grounded Theory.* Mill Valley, CA: The Sociology Press.

- Hadwiger, S., (1999). Cultural Competence Case Scenarios for Critical Care Nursing Education. In Bhui, K., Warfa, N., Edonya, P., McKenzie, K. & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC Health Services Research*. 7:15.
- Holloway, E. L., & Neufeldt, S. A. (1995). Supervision: Its contribution to treatment efficacy. In Fleming, I., & Steen, L., (2004). *Supervision and Clinical Psychology; theory, practice and perspectives*. Brunner-Routledge. Hove.
- Horvath, A., O., & Symmonds, B., D., (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. In Summers, R., F. & Barber, J., P. (2003). Therapeutic Alliance as a Measurable Skill. *Journal of Academic Psychiatry* 27:160-165.
- Hwang, W., (2006). The Psychotherapy Adaption and Modification Framework (PAMF): Application to Asian Americans. *American Psychologist*, 61, 702-715.
- Hwang, W., & Wood, J., J., (2007). Being culturally sensitive is not the same as being culturally competent. *Pragmatic case studies in Psychotherapy* 3 (3-3) 44-50.
- Joffe, H. and Yardley, L., (2004). Content and Thematic Analysis. In Lyons, E., and Coyle, A., (2007). *Analysing Qualitative Data in Psychology*. London: Sage.

- Lambert, M., J., & Arnold, R., C., (1987). Research and supervisory process. In Fleming, I., & Steen, L., (2004). *Supervision and Clinical Psychology; theory, practice and perspectives*. Brunner-Routledge. Hove.
- Lucas, T., Michalopoulou, G., Falzarano, P., Menon, S. & Cunningham, W., (2008). Healthcare provider cultural competency: Development and initial validation of a patient report measure. *Health Psychology* 27(2): 185-193.
- Lyons, E., and Coyle, A., (2007). *Analysing Qualitative Data in Psychology*. London: Sage.
- Maramba, G. G. & Hall, G. C. N. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology*, 8, (3), 290-297.
- Michalak, J., Wiethoff, M., & Schulte, D., (2005). Therapeutic Alliance and behaviour inhibition. *Psychotherapy Research*, 15:3, 334-338.
- Morrow, S., L., (2005). Quality and Trustworthiness in Qualitative Research in Counselling Psychology. *Journal of Counselling Psychology*, 52, 2, 250–260.
- National Center for Cultural Competence. (2004). *Cultural Competence Health Practitioner Assessment*. Retrieved 10th October, 2008, from <http://gucchd.georgetown.edu/nccc/pa.html>.

National Institute for Mental Health in England, (2003), *Personality Disorder: No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder*. Department of Health.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., & Nadirshaw, Z. (2002). *Clinical psychology, 'race' and culture: A training manual*. Leicester, British Psychological Society.

Pope, C., and Mays, N. (1995). Qualitative Research: Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *British Medical Journal*; 311:42-45.

Sperry, L., (1999). Cognitive Behaviour Therapy of DSM-IV Personality Disorders: Highly effective Interventions for the most common personality disorders. London: Brunner-Routledge.

Sue, S., (2003). In defence of cultural competency in psychotherapy and treatment. *American Psychologist* 11: 964-970.

Warren, B., J., (2002). The interlocking paradigm of cultural competence: A best practice approach. *Journal of the American Psychiatric Nurses Association*. 8 (6): 209-213.

Whealin, J. M., & Ruzek, J. (2008). Program evaluation for organizational cultural competence in mental health practices. *Professional Psychology: Research and Practice*, 39(3), 320-328.

Willig, C. (2001). Introducing Qualitative Research in Psychology: Adventures in Theory and Method. In Lyons, E., and Coyle, A., (2007). *Analysing Qualitative Data in Psychology*. London: Sage.

Appendix A

Table 8. Breakdown of the Interviewees by Health Profession, Gender and Ethnicity

<i>Interviewee</i>	<i>Trainee Clinical Psychologist</i>	<i>Clinical Psychologist</i>	<i>Forensic Psychologist</i>	<i>Clinical / Forensic Psychologist</i>	<i>Counselling Psychologist</i>	<i>Nurse Specialist</i>	<i>Psychotherapist – Nurse Trained</i>	<i>Psychiatrist</i>	<i>Male</i>	<i>Female</i>	<i>White - English</i>	<i>White - Irish</i>	<i>BME</i>
<i>1</i>	*									*	*		
<i>2</i>					*					*	*		
<i>3</i>		*							*		*		
<i>4</i>							*			*		*	
<i>5</i>							*			*	*		
<i>6</i>		*							*		*		
<i>7</i>								*	*				*
<i>8</i>								*	*		*		
<i>9</i>			*							*	*		
<i>10</i>				*						*	*		
<i>11</i>				*					*		*		
<i>12</i>						*			*		*		
<i>Total</i>	<i>1</i>	<i>2</i>	<i>1</i>	<i>2</i>	<i>1</i>	<i>1</i>	<i>2</i>	<i>2</i>	<i>6</i>	<i>6</i>	<i>10</i>	<i>1</i>	<i>1</i>

Participant invitation letter - Version 1 18.4.07 (to be delivered by email)

Dear Colleague

What constitutes an Effective Therapeutic Alliance for those with Borderline Personality Disorder?

My name is Graham Lowings. I am a trainee clinical psychologist with the University of Leicester. I am carrying out a research project as part of my doctoral training and I am writing to ask you if you would take part in this project.

It is my intention to interview clinicians who have over a years experience working therapeutically with clients who have a diagnosis of borderline personality disorder. The interview is likely to take between 45-60minutes. The interviews will be audio recorded and can take place where you work or at alternative location convenient to you. The clinical directors of the Personality Disorder Directorate, Rampton Hospital and the Nottingham Community Personality Disorder Service have authorised me to conduct this research within their respective services and for me to approach you direct. This project has received authorisation from the Research Ethics Committee and the Trust's Research and Development Department.

Should you agree to take part in this project your name will be placed in a pool of participants and you will be selected at random for interview. You will be asked to refrain from naming any other persons during the interview to preserve confidentiality. To help you decide I have enclosed a Participant Information Sheet and an example of an Interview Schedule.

If you would like to be involved in this project please return this email with your details including your work telephone number and extension within 10 working days of its receipt. Should you wish to discuss this project further before making your decision please either send me your query by email or by telephoning me at the university on 0116 223 1639.

Thanks very much for considering this request. I look forward to hearing from you.

Yours sincerely

Graham Lowings - Clinical Psychology Trainee

Title of Study:

A study to establish what constitutes an effective therapeutic alliance and how this can be achieved and maintained with a difficult to engage client group, those with a diagnosis of Borderline Personality Disorder (BPD).

Chief Investigator:

Graham Lowings, Trainee Clinical Psychologist
University of Leicester, School of Psychology, Clinical Section, 104 Regent Road,
Leicester, Telephone 0116 2231639.

Please take time to read the following information carefully, and ask if there is anything that is not clear, or if you would like more information.

1. What is the purpose of the study?

The purpose of the study is to establish how clinicians set about creating and maintaining an effective therapeutic alliance with a difficult to engage client group, those with a diagnosis of Borderline Personality Disorder.

Although there is much evidence of the clinical efficacy of the impact of the therapeutic alliance there is a paucity of evidence relating to how health care professionals build the alliance with hard to engage clients. Furthermore, there is even less evidence of how clinicians modify their approach to alliance building where the client is of a different culture and ethnic background to themselves. The proposed research aims to produce a model of engagement based on clinician's actual experiences with clients.

2. What will be involved if I agree to take part?

The Chief Investigator will contact you to arrange a convenient time for the interview to take place. The Chief Investigator is interested in talking to you about your experiences in creating and maintaining therapeutic alliances with hard to engage clients such as those diagnosed with borderline personality disorder. The interview will be audio recorded and the Chief Investigator may take notes throughout the meeting. Pilot studies have shown the interview is likely to take approximately 45 minutes. An example of an interview schedule is attached so you can read about the types of questions you are likely to be asked if you agree to participate.

3. Will the information obtained in the study be confidential?

At the beginning of the interview you will be asked to sign a form consenting to the interview being audio-taped. All the information you share with the Chief Investigator will be kept strictly confidential during the course of the research. When the interview is written up, any information that that could be used to identify you will be removed. However, the Chief Investigator would have a duty to break confidentiality if he became aware of any risk of harm to yourself or others. Only clinicians are being invited to participate and you will be asked not to divulge any details of clients you may have seen.

4. Who is being asked to take part?

The participants will be experienced in working with clients diagnosed with borderline personality disorder and will be drawn from the following professional groups:

- Clinical Psychology
- Forensic Psychology
- Counselling Psychology
- Psychiatry
- Nursing Profession

Participants will respond individually and their views reported anonymously.

5. What are the possible disadvantages and risks of taking part?

Participants interviewed will be asked about their emotional response to hard to engage clients. Clinicians have been known to feel emotions such as frustration and anger toward clients. Where such emotions are raised during an interview the clinician will be advised to seek supervision with their usual supervisor. The participants will also be offered time at the conclusion of the interview to talk to the Chief Investigator should they feel that would be beneficial.

6. What if I am harmed by the study?

It is highly unlikely you will be harmed by the study. Compensation is only available if negligence occurs.

7. Who is organising and funding the research?

The study is being organised by Graham Lowings, Trainee Clinical Psychologist at the University of Leicester, employed by the Leicestershire Partnership Trust who are funding the research. Clinically relevant research is a requirement of the training for NHS clinical psychologists.

8. What happens after the interview?

The information taken from the interviews will be analysed and written up as a research thesis and submitted to the University of Leicester. The interviews will be treated as confidential. You will not be identified in the thesis written.

9. Do I have to take part?

You do not have to take part if you do not wish to do so. If you do take part you will be asked to sign a consent form. If at any point you wish to withdraw from the study you may do so.

10. How do I get further details?

If you would like to discuss this study further the researcher can be contacted at the University of Leicester on 0116 223 1639.

Participant information sheet (Version 1 18.4.07)

Consent Form Version 1, dated, 18.4.07

Title of study:

A study to establish what constitutes an effective therapeutic alliance and how this can be achieved and maintained with a difficult to engage client group, those with a diagnosis of Borderline Personality Disorder (BPD).

Chief Investigator: Graham Lowings, Trainee Clinical Psychologist

**Please read this form in conjunction with the Participant Information Sheet,
version 1, dated, 18.4.07**

Please indicate your response by placing a '✓' in the appropriate box for each statement.

- I agree to take part in the study as described in the Participant Information Sheet.

Yes ☐

No ☐

- I have read and understood the Participant Information Sheet and have had the opportunity to ask questions and discuss the details with the Chief Investigator. The nature and purpose of the interview to be conducted, and my involvement in it are understood.

Yes ☐

No ☐

- I understand that I am free to withdraw from the study at any time, without justifying my decision.

Yes ☐

No ☐

- I understand that the information I share will be treated as confidential. I understand that no information that may identify me such as my name, address or workplace will be contained in any report.

Yes ☐

No ☐

- I understand that at no time shall I disclose any detail of clients currently or previously in my care which could lead to them being identified.

Yes ☐

No ☐

- I agree to the research interview with me being audio recorded on the understanding that the information will be treated as confidential and will only be used for this study.

Yes ☐

No ☐

- I understand that any audio recording of interviews with me will be destroyed if I withdraw from the project and in any case upon satisfactory completion of the study.

Yes ☐

No ☐

- I understand that compensation for any harm that arises from the project will only be available in the case of negligence.

Yes ☐

No ☐

Signature of participating clinician Date
Name (In block capitals)

I have explained the study to the above clinician who has indicated their willingness to take part.

Signature of Chief Investigator Date
Name (In block capitals)

Ethics approval from NRES

07/Q2501/96 – revised 14 June 2007 to include approved protocol



National Research Ethics Service
Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1

1 Standard Court
 Park Row
 Nottingham
 NG1 6GN

Telephone: 0115 9123344 68575
 Facsimile: 0115 9123300

15 May 2007

Mr Graham Lowings
 Clinical Psychology Trainee
 University of Leicester
 104 Regent Road
 Leicester
 LE1 7LT

Dear Mr Lowings

Full title of study: A study to establish what constitutes an effective therapeutic alliance and how this can be achieved and maintained with a difficult to engage client group, those with a diagnosis of Borderline Personality Disorder.

REC reference number: 07/Q2501/96

The Research Ethics Committee reviewed the above application at the meeting held on 04 May 2007. Thank you for attending to discuss the study.

Ethical opinion

Discussions: Mr G Lowings confirmed the following;

- Staff who agree to participate will enter a pool of potential interviewees, as and when required, staff will be drawn at random firstly from the Nottingham Community then Rampton
- Lead Clinicians have been provided with copies of the research proposal through presentations and email
- Supervision support will be available to the therapist
- Data disposal – transcripts will be destroyed after 5 years, all other data will be destroyed as soon as it has been analysed

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Ethical approval from the University of Leicester

-----Original Message-----

From: De Lillo, Dr C.

Sent: 18 October 2007 17:59

To: 'grl7@ntlworld.com'

Subject: FW: PC_ethics2006 - Graham Lowings

Dear Graham Lowings,

Your project "A study to establish what constitutes an effective therapeutic alliance and how this can be achieved and maintained with a difficult to engage client group, those with a diagnosis of Borderline Personality Disorder (BPD)" has been approved by the Psychology Research Ethics Committee.

This e-mail is the official document of ethical approval and should be printed out and kept for your records or attached to the research report if required - this includes all undergraduate and postgraduate research.

We wish you every success with your study.

Carlo De Lillo

Acting Psychology Research Ethics Committee Chair

Dr. Carlo De Lillo

University of Leicester

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Web-page: <http://www.le.ac.uk/pc/cdl2/>

Amended Ethics Approval



Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1

1 Standard Court
Park Row
Nottingham
NG1 6GN

Tel: 0115 9123344 ext 39435
Fax: 0115 9123300

31st August 2007

Mr Graham Lowings
Clinical Psychology Trainee
104 Regent Road
Leicester
LE1 7LT

Dear Mr Lowings

Study title: A study to establish what constitutes an effective therapeutic alliance and how this can be achieved and maintained with a difficult to engage client group, those with a diagnosis of Borderline Personality Disorder.

REC reference: 07/Q2501/96

Protocol number: 3

Amendment number: Amendment number 1

Amendment date: 30th August 2007

Thank you for your email of 30th August 2007, notifying the Committee of the above amendment.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Document	Version	Date
Notification of a Minor Amendment	Amendment number 1	30 August 2007

Trust Approval

Nottinghamshire Healthcare 
NHS Trust

E-mail: shirley.mitchell@nottshc.nhs.uk

Research & Development
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

Tel: 0115 969 1300
Fax: 0115 993 4549

Our Ref: FOR/26/06/07

26 June 2007

Mr Graham Lowings
Clinical Psychology Trainee
University of Leicester
104 Regent Road
Leicester
LE1 7LT

Dear Graham


A study to establish what constitutes an effective therapeutic alliance and how this can be achieved and maintained with a difficult to engage client group, those with a diagnosis of Borderline Personality Disorder

I am writing to confirm that the above study is authorised to take place within our Trust.

This is a very interesting and important field of study. The Trust R&D Department follows up such work to assess its impact and influence on practice and policy. All research registered with the R&D Department is automatically included in the National Research Register (www.update-software.com/national/) and information on all projects is updated quarterly. Therefore, I have enclosed the National Research Register Information Sheet for your completion.

Please note that you cannot commence your research without a Trust honorary contract in place.

Yours sincerely


pp Shirley Mitchell BSc (Hons), RICR
Research Governance Lead & Business Manager

Enc

SKM/R&D Approval Letter

Introduction

- Reminder of the research project and its purpose
- Consent and confidentiality explained
- Structure of the interview explained

A number of standard questions will be posed to each participant to establish biographical data and their level of clinical experience. For example:

- How long have they worked with BPD clients?
- What training have they received?
- To which clinical discipline do they belong? (E.g. Psychology, Nursing).
- Their current role?

The first participant will be selected at random and will be asked:

- What do they think make for an effective therapeutic alliance?
- How do they go about creating a therapeutic alliance?
- Does their approach differ depending on the gender of the client?
- What feelings/emotions can this process generate in themselves and how do they manage them?
- In what ways, if any, does their approach differ if the client is from a different culture and ethnic background to their own?
- What do they do if they suspect the alliance is beginning to fail?

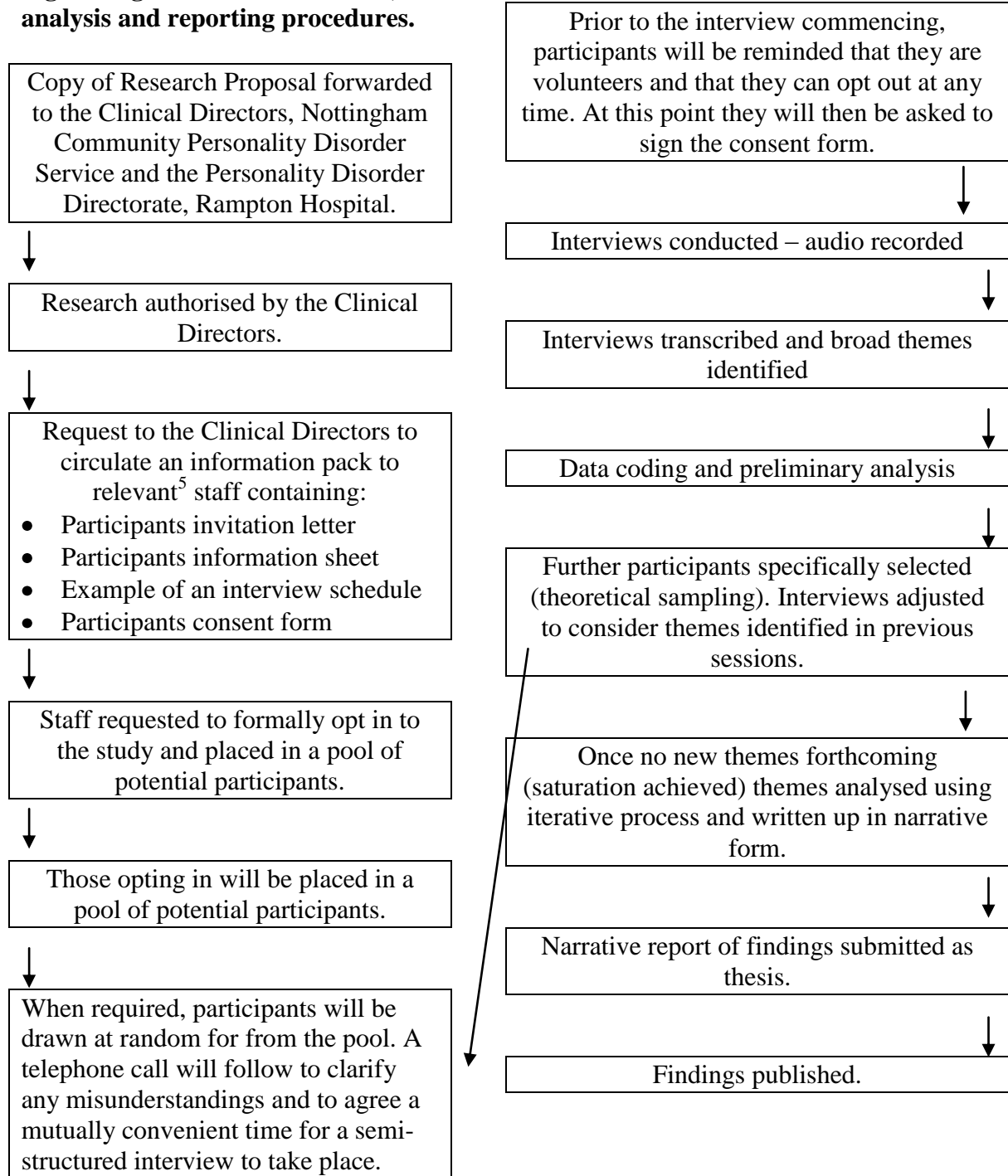
Ending

- Remind participants that they will be provided with a copy of a feedback report outlining the main findings of the research.

The participant's responses will be transcribed then analysed using an open coding technique. Questions for subsequent interviewees will be tailored dependant on the analyses of preceding interviews.

Appendix G

Fig 8. Diagram of data collection, analysis and reporting procedures.



⁵ Psychiatrists, psychologists, nursing staff and any others who regularly deliver therapeutic interventions to those diagnosed with Borderline Personality Disorder.

Section 3

3.0 CRITICAL APPRAISAL

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3.0 Critical Appraisal

3.1 Development of the research project

Choice of research topic

Clinical psychology is my second career, having retired from the police service in 2004. Upon retirement I had a year employed as a Graduate Mental Health Worker. During this time I became aware of a group of patients that some of the nursing staff found very difficult to engage and work with and for some actively disliked. I was amazed at the emotions generated in some staff at the prospect of having to deal with someone with a Personality Disorder (PD) diagnosis. I was also aware of a trend for some to suggest someone might be PD just because the clinician was finding the therapeutic relationship difficult. I began to realise that throughout my police service I had come into contact with many people who, in all probability would have been classified as having a PD. My experiences of PD, though I did not know of the term at the time, were of a group of people who could be volatile and unpredictable making them a difficult to manage set of individuals. However, underneath the veneer they were often very frightened and troubled.

A real learning point for me occurred whilst I was employed as a Graduate Mental Health Worker. I was interviewing a man for his suitability to take part in an Anger Management Group. Initially, he was very hostile and aggressive but whilst I was taking a detailed history he became very emotional indeed and set about describing a very troubled childhood. I thought then that this group of people, designated as difficult to engage, were

worthy of much empathy and consideration. My experiences later as a trainee clinical psychologist confirmed this view. Due to their particular difficulties surrounding trust and the maintenance of relationships I decided that the therapeutic engagement of Borderline Personality Disorder specifically would make a very practical and worthwhile research study.

Choice of methodology

The principle purpose of my research was to produce a model of engagement based on clinicians' actual experiences with clients. Grounded theory was selected as it is a proven method for abstracting theory from experience (Glaser & Straus, 1967) and for its ability to seek a richer understanding from the participant's perspective rather than some form of objective measure (Henwood & Pidgeon, 1992; Guba & Lincoln, 1994).

3.2 Conducting research

Epistemological Stance

A research paradigm describes the belief system embraced by the researcher which is evident from the manner in which they carry out their research activity. Two concepts help define a research paradigm: ontology, a description of how reality is perceived and our beliefs about the nature of reality; and epistemology, which defines the relationship and the potential for influence the researcher has with the researched material and consequently research outcomes. Guba and Lincoln (1994) have described four research paradigms, each with its own unique ontology and epistemology (see Appendix A). The four paradigms sit

on a continuum ranging from a total objectivity and single truth (positivism) and a subjective, changeable and socially constructed reality (constructivism).

My initial thoughts were that it would be possible to follow a positivist paradigm with the intention of achieving an accurate account of the mechanisms that underpin the forming of a therapeutic alliance. However, during the process of formulating a coherent research proposal, I became acutely aware of the different perspectives individuals would bring to the study and whilst remaining as objective as possible, the impact I myself would have on the process. My research has been conducted from a post-positivist position known as Critical Realism. I would argue that this position was not adopted but rather emerged over time through the process of formulating and reflecting on my research proposal and through discussion and debates with peers and supervisors.

There appears to me to be a tension between the concept of Grounded Theory being firmly based on the ‘lived experiences’ of the participants and my personal involvement through the initial choice of questions, my approach to coding and my final choice of main categories. The model or theory developed is, therefore, a combination of the participants’ accounts and my interpretation of those accounts, which, despite a strong desire to remain objective will have been influenced by my own beliefs.

Ethics, Research Governance and Participants

Ethical and Research Governance approval was a very straight forward process due to the participants being clinicians and not patients. As the research progressed and evidence

emerged it became necessary to extend the original ethics application to include a clinician based at third location. Again this was easy to achieve.

There were no problems in securing sufficient participants for the study. I believe speaking personally to clinical directors, lead clinicians and then the selected participants encouraged co-operation. PD services in the county selected for the research study were situated in the community on an outpatient basis and within an inpatient High Secure Hospital. This enabled a breadth of experience of therapists who treat BPD to be interviewed. I suspected there would be differences in the accounts of the experiences between in and out patients and between the different clinical disciplines; nurses, forensic and clinical psychologists and psychiatrists. However, their experiences were surprisingly similar.

Interviewing

I have had years of experience in putting people at ease in an interview situation in order to maximise the quality and quantity of information an interviewee may wish to impart. I have learnt that the most revealing information comes from letting people speak, following their own agenda if need be, whilst ensuring you cover all the points you wish to explore. The interview schedule ensured what needed to be covered and my style of interviewing allowed interviewees to develop their own areas of interest and in doing so the process was one of evolving enquiry rather than answers to direct questioning.

The style of interviewing could have led to tensions between subject containment and exploration. However, all twelve interviewees were so enthusiastic about the subject of the alliance and the BPD client group that this was rarely a difficulty. I felt confident that should they stray too far from the topic that I could diplomatically draw the interview back, however, in actuality it was the interviewees in the main who ensured they were focused on the subject.

Analysis and write up

Before commencing the study I sought out a two day training course in research methods. I thought it would be useful for the future to learn to use the NVIVO7 qualitative research software with this study and utilised my study budget to buy a student licence and attend a one day introductory course. This was later to become a very important decision.

NVIVO7 is a versatile software tool which enables the transcribed interviews to be coded and re coded. There are facilities for maintaining research journals and reflective diaries and for the writing of memos in accordance with Grounded Theory methodology. This facilitates a very neat self contained data set and audit trail for the researcher. There are many different types of printed reports that can be produced but unfortunately, you can not print out a transcribed piece of text with the codes shown as you can with a manual system. As a quality control measure, I shared examples of my coding with research supervisors and peers.

Embryonic models began to emerge, as interviews and coding progressed. On reflection, I became too concerned with the mechanics of forming the alliance and early coding and analysis resulted in models which emphasised the practices and tactics employed by therapists with the emotional and psychological aspects being secondary. This is best explained with examples of the early versions of the process models drawn for the purposes of supervision with tutors and peers.

The first model created from the emerging data, ‘Creating a Positive Experience’, encapsulated all the processes identified through the initial analysis. However, it was too linear and did not represent the interconnectedness of the psychological and practical aspects of the reality of the alliance (see Appendix B). The second model was an attempt to visually describe the fact that the tactical processes were in the main linear in nature with the psychological aspects pervading throughout. This model was on reflection two discrete models which required merging into a single construct (see Appendix C). I made an attempt to conceptually merge the two models into one with what I termed ‘duality’. Appendix D is a schematic depiction of the tactical model, influenced by the psychological aspects inherent in the creation and maintenance of the therapeutic alliance, which gave rise to a third model (see Appendix E).

A number of difficulties became apparent. Although I believe the concept of duality effectively merged the tactical and psychological, the model still appeared as two discrete elements. I began to question whether the tactical, practical emphasis to my coding was straying from pure Grounded Theory. Further reading identified the description of

behaviours, perceptions and experiences as more akin to thematic analysis (Joffe & Yardley, 2004).

At this point I was grateful for having invested the time in learning to use NVIVO7 as this enabled me fairly quickly to go back one layer of coding, to review and recode those aspects of the data which related only to psychological aspects of the therapeutic alliance. A psychological process model emerged from this second round of coding and analysis.

Supervision

As with the findings from my research, supervision was absolutely essential. An academic supervisor advised on the write up of the three reports. A second supervisor provided support with my understanding of Grounded Theory methodology and peers provided quality control in relation to my coding. Incidental conversations with others knowledgeable about Grounded Theory were also informative.

Reflexivity

When reflecting on the research process I have undertaken, the setting of the overall research question, the selection of participants, the interview schedule and the coding and analysis of the data I realised how much I was a part of it, which confirmed for me the critical realist position I had adopted. Reflective practice is a key part of clinical psychology training which I have developed not only in my academic studies but equally so on clinical placement. In addition, the NVIVO7 software encouraged the researcher to record regularly and systematically. It provides an easy method of capturing reflective

thoughts whilst still engaging with the data. It is possible to switch between coding, arranging and managing data, to writing memorandums, research journal and reflective diary entries.

My capacity to reflect on the research process developed over the duration of the study. Appendix F is a collection of extracts from my reflective diary. The extract dated 22nd November 2007 is a very detailed overview of the second interview conducted. There is some evidence of ‘constantly comparing’ the data and an awareness of the differences between this and the previous interview but in the main it is very descriptive. The next extract dated 17th January 2008 is much more reflective in its style and includes a record of some learning. The extract dated 25th February 2008 is an example of using the diary in a proactive way. It is a collection of my thoughts concerning the evidence so far, together with the intention to test emergent themes in subsequent interviews. A summary of some of the themes and some evidence of ‘constantly comparing’ the data appears in the extract dated 14th April. The final extract in this collection, dated 3rd June 2008, is perhaps the most personal record of reflection and captures my frustration when I realised that my ‘duality model’ was not sufficient for the thesis and that recoding and further analysis of the data was needed.

Most useful was the reflection conducted after supervision. The input from a supervisor not so close to the research prompted me to think more widely and to see the possibilities for additional areas for investigation with interviewees and other ways of considering the data.

Development of research knowledge and practice.

I found myself being driven by curiosity and the desire to complete the whole scope of research possibilities in one study. After eight interviews I would have had sufficient data to analyse and formulate a psychological model of engagement from the experiences of clinicians. However, I was aware of the emergence of a new property, that of therapists being perceived as ‘too close’ to clients and decided to conduct four more interviews. At the time, I viewed the additional four interviews as providing the ‘icing on the cake’ but on reflection, although they have added an additional dimension to the study and improved the overall scope of the model, it was at a cost in terms of reducing the time to write the final report. On reflection, it may have been better to have dealt with the ‘too close’ concept as an area for future research.

I had invested a lot of time on creative thinking and reflection trying to create an all encompassing model of engagement. Though very challenging at the time, the whole process was very rewarding and I have personally gained a tremendous amount of practical knowledge of how to manage therapeutic alliances with the BPD client group from twelve very experienced clinicians.

At the outset, the goal of achieving a model of therapeutic engagement with BPD patients seemed very achievable. There was a naivety around the complexity and the potential scope of the research. This current study has ultimately concentrated on the psychological and emotional implications for the therapist. At some point in the future, I would like to revisit the data obtained and produce a model of engagement which combines the tactical

and practical with the psychological. Finally, this study has not explored the ‘lived experiences’ of the patients themselves, which is a future research opportunity.

This study has provided me with the opportunity to learn much about qualitative research methodology. I have learnt the importance of continually checking that you are sticking to the chosen method and that each research step you take is driven by that method. Grounded Theory has shown me that by following its systematic procedures much more can be found in the data than compared to reading an interview transcript. Time management and self discipline are key skills for qualitative researcher. Although I had a research plan with milestones to achieve at specific times they were disrupted by competing priorities. In hindsight it may have been useful to have thought hard about the possibility of competing demands and written them into the plan.

Although an experienced interviewer, I have developed this skill further by adding, where appropriate, those counselling skills normally reserved for therapy to maximise the amount of information obtained and to clarify its accuracy. For example, summarising to show the interviewee I was listening and to confirm my understanding of the content of the interview. BPD clients have the potential to trigger emotional responses. I have developed empathic responses that are appropriate for fellow clinicians. I have learnt new analytical skills, used qualitative research software, experienced the process of conducting a literature review and practiced academic report writing.

This has been one of the most challenging tasks I have undertaken but also one of the most rewarding.

3.3 References

Glaser, B. G. and Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine.

Guba, E. G. and Lincoln, Y. S. (1994). *Handbook of Qualitative Research*. In K. Charmaz, (2006). *Constructing Grounded Theory – a practical guide through qualitative analysis*. London: Sage.

Henwood, K. and Pidgeon, N. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, 83: 97-111.

Joffe, H. and Yardley, L., (2004). Content and Thematic Analysis. In Lyons, E., and Coyle, A., (2007). *Analysing Qualitative Data in Psychology*. London: Sage.

Table 9. The ontological and epistemological positions within the four paradigms.

Paradigm	1. Positivism	2. Postpositivism	3. Critical Theory	4. Constructivism
Ontology	Only one reality, one truth that can be known and understood.	Reality exists but it is acknowledged that our understanding will be inexact, an approximation.	Reality is defined within its historical context and is shaped by social, political, cultural, and ethnic and gender values.	Reality is a fluid concept which changes through social interaction. It is socially constructed.
Epistemology	Researcher is independent, totally objective and exerts no influence on the researched material or the findings.	Though attempting to be objective, there is recognition that the researchers own values and belief system will have an influence.	Researcher and researched material are inextricably linked and influenced by researcher's values.	There is interdependency between the researcher and the researched material rendering the results totally subjective.

Fig 9. Creating a positive experience

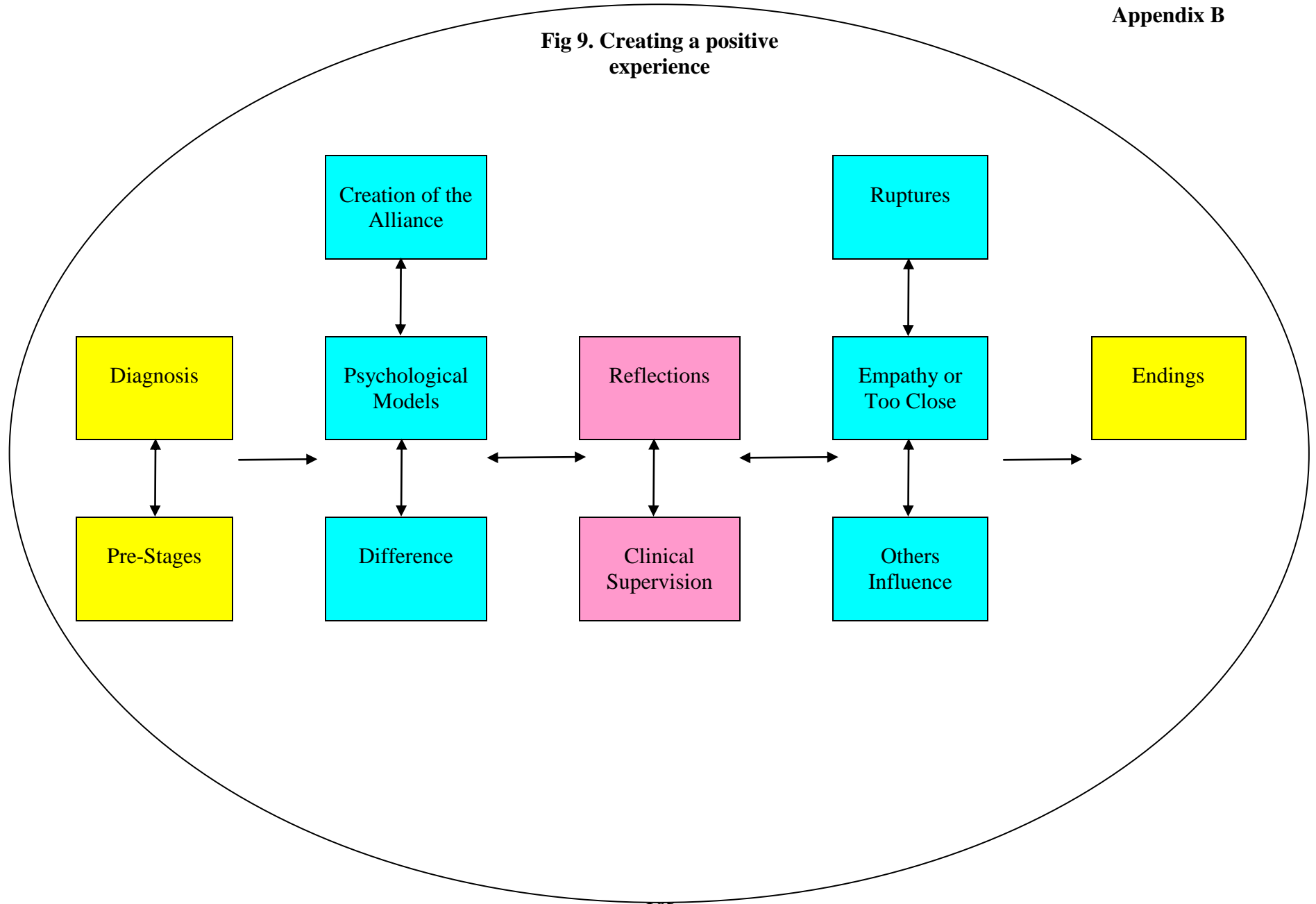
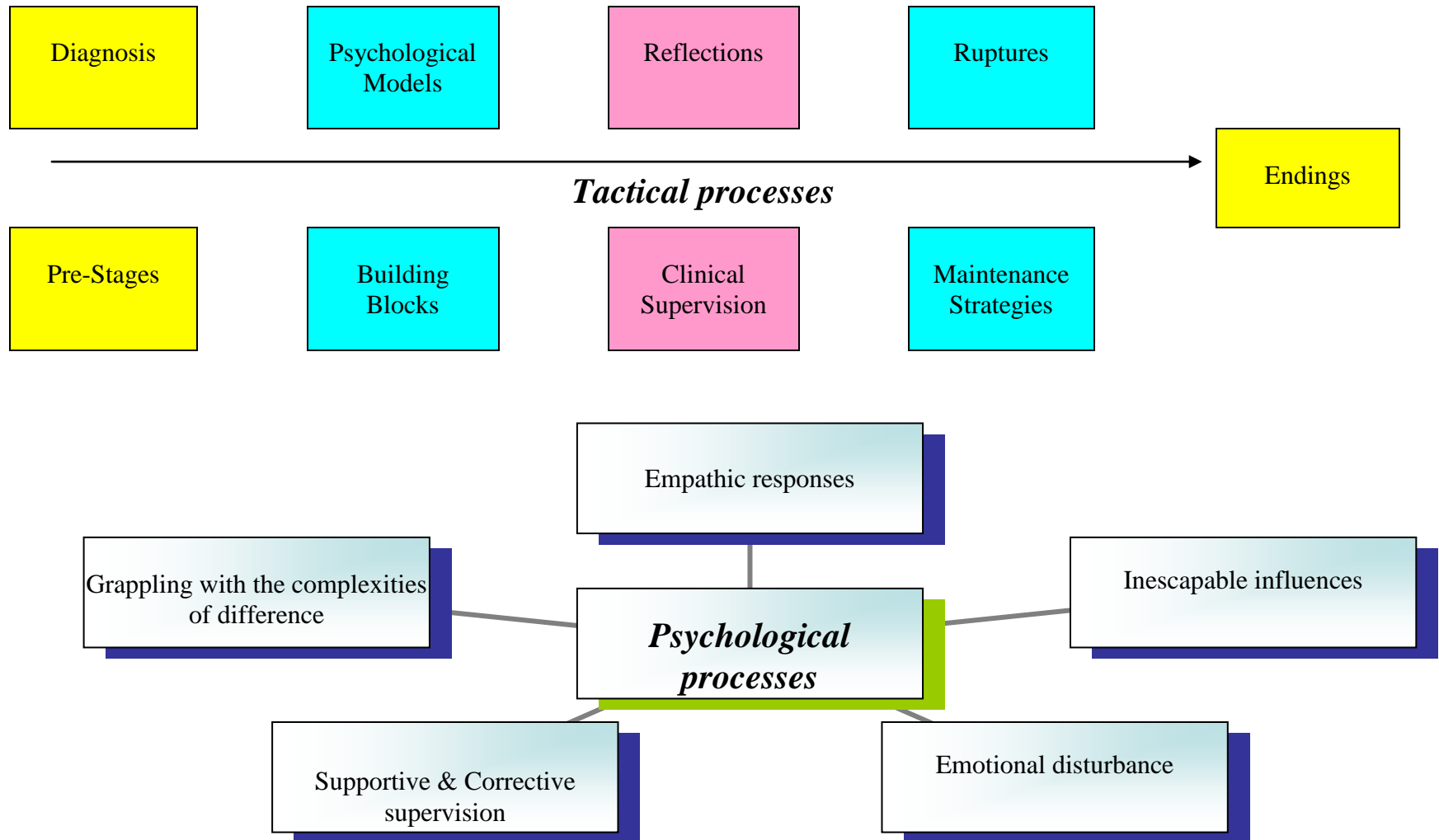


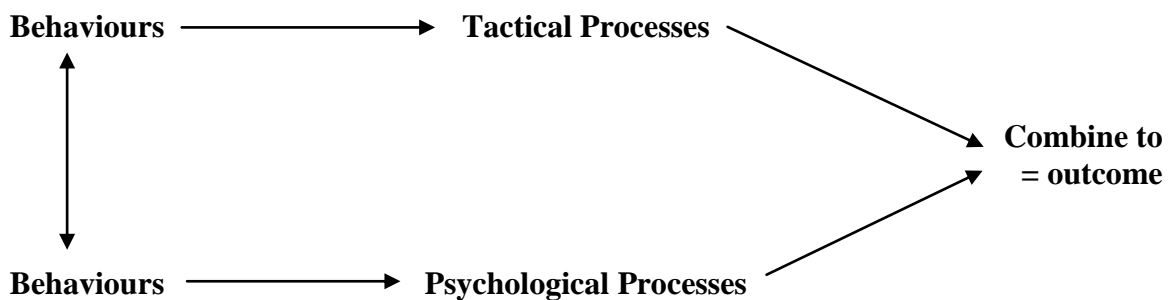
Fig 10.
Therapeutic Alliance – A combination of inextricably linked tactical and psychological processes.
Appendix C



Combining the Tactical and Psychological Processes

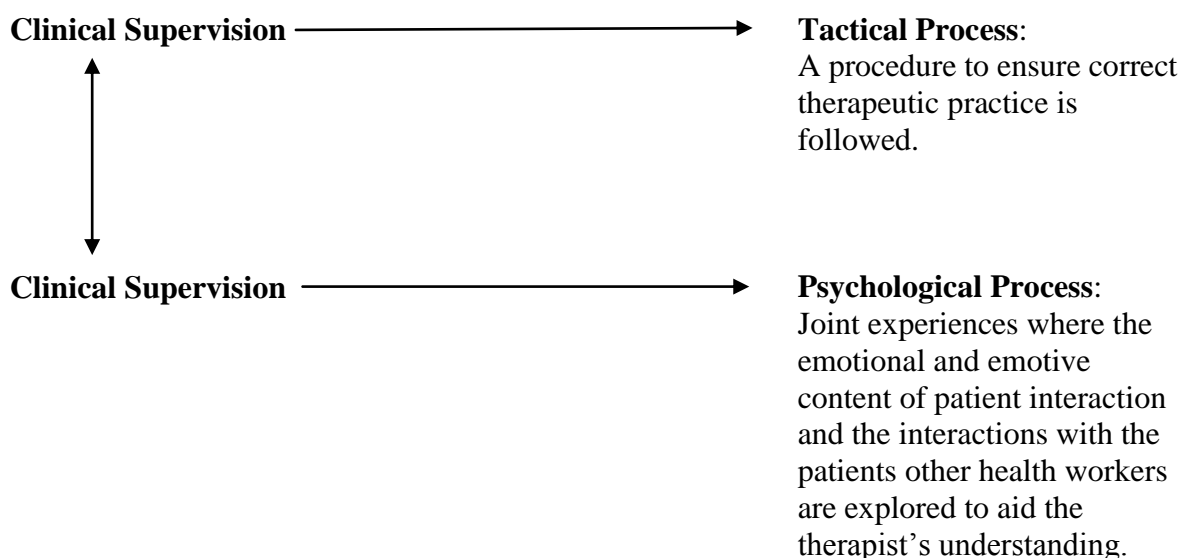
As described previously, the therapeutic alliance appears to be a collection of behaviours involving tactical and psychological processes that work together to produce the outcome which may be positive, negative or a mixture of both. In recognition of the two fold nature of the interconnectivity the behaviours are considered to have a duality to their nature (Fig 4).

Fig 11. The Duality of Behaviours – Tactical and Psychological Processes combine and outcome is achieved.

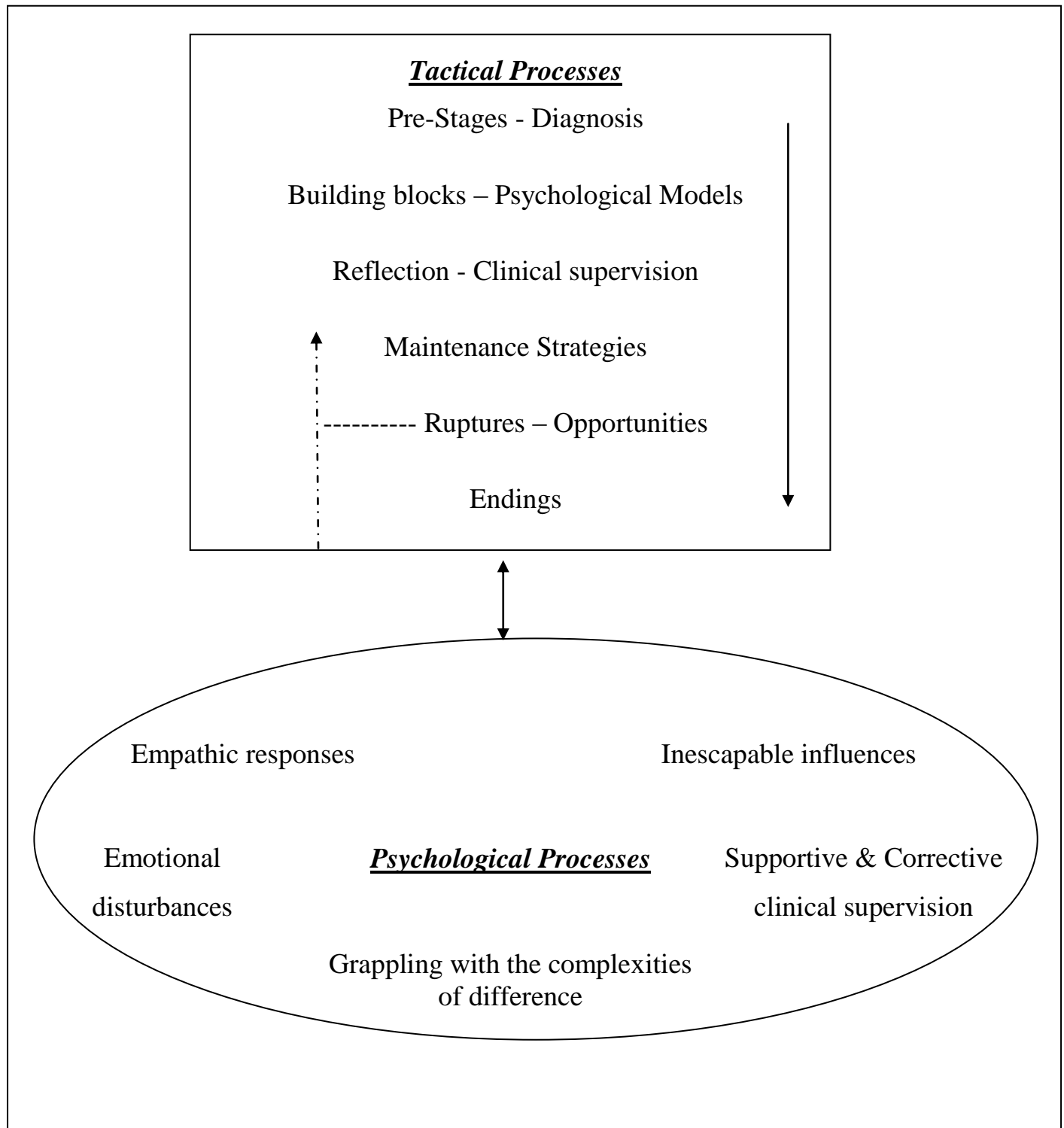


A hypothetical example will help to illustrate the two fold nature of engagement. Clinical supervision may be regarded as a requirement to ensure correct procedures are followed but equally it will provide psychological support and containment for the therapist (Fig. 5).

Fig 12. The Duality of Clinical Supervision – an example of the interconnectivity of the Tactical and Psychological Processes involved in the Therapeutic Alliance.



**Fig 13. Therapeutic Alliance: –
A combination of inextricably linked tactical and psychological processes (revised).**



22nd November 2007

One of the most striking differences with this second interview was the importance attached to preparing the client for the therapeutic process. For example, a lot of thought went into the letter sent out. Educational material provided if knowledge of PD was poor or unheard of. Gentle, slow paced and non-judgemental first session. Emphasis on being made welcome and supported, encouraging the client to engage from the off.

The difficulties of diagnosis, particularly when the client had no knowledge or understanding of the terms/labels. However, diagnosis was helpful when it explained behaviour. E.g. Paranoia

This is the first time client's having choice and control of their therapy has been mentioned.

Ethnicity - interviewee recognised the need to adapt according to cultural dimensions. Client accused therapist of being racist and withdrew from treatment. (Was there a racial issue here or was a means of withdrawing from treatment at point when it was painful).

Relationship breakdown seen in terms of 'which schemas being activated'.

The therapist introduces transference and countertransference concepts. Using the emotions in the room to mirror what happens outside for the client. Reflecting back to the client used as a form of challenge as well as being informative for the client. Therapist identifies that she has strong emotional responses to this client group on occasions.

This interviewee includes feelings of incompetence and the potential for manipulation in a catalogue of negative emotions evoked by this patient group. Coping strategies include reflecting, which this interviewee refers to as 'internal supervision', supervision with a more experienced clinician, peer supervision and joint working. Interviewee sights the discussions with a joint worker after a session as evidence of the power of projection from the client.

Other merits of joint working are highlighted such as having an observer who can give an alternative view of the process, to take sessions in her absence and to facilitate discussions such as 'what would she say if she were here do you think'?

The impact of other healthcare professionals were discussed. If others are negative toward the client they are less likely to trust the therapist and prevent a therapeutic alliance. Therapist works with others to help them cope better and to prevent negativity spreading and impacting on the alliance. Also works with the client to problem solve the situation.

17th January 2008

Three interviews (formerly) coded. Two other interview transcripts were scan coded in order to be informed for a sixth interview. Need to resist the temptation and possibly pressure to interview before the coding process has fully run its course.

Now feel strongly that I should consolidate and fully understand the nodes/tree nodes at this stage before going on to code further interviews. New interviews will only be contemplated once coding process has been completed to date. I think if the process is not adhered to, the richness of the potential data may be compromised. Do not want to go off on my own voyage! Interviewees should lead the direction.

25th February 2008

1. Explore the concepts of dependency and reassurance vs challenge. Client stating they do not wish to return to sessions when in truth they are seeking reassurance and support to return to therapy. Are they considered to be responding naturally in the circumstances?
2. Further examination of the therapists awareness of why clients are difficult to engage and manage.
3. Any differences between the views of inpatient and outpatient staff?
4. When do the next interviewees believe the therapeutic engagement commences?
5. Is the rupture a breakdown or an opportunity?
6. What significance are psychological models to the building of the therapeutic alliance? Do you use any specific models of engagement?
7. Importance of diagnosis?
8. Significance of diversity, culture, ethnicity and in particular gender mapping?
9. What impact does feeding back to the client therapist's formulation/diagnosis have on the therapeutic alliance?
10. Any thoughts about the emotions evoked in the therapist before or during the first session?
11. What are the interviewees thoughts about the use of self disclosure?

14th April 2008

This interviewee is aware that treatments are working and therapeutic alliances are productive within the High Security setting as patients improve and move down to medium secure and some to the community. However, lack of evidence of what happens long term with people. Believes we need long term follow up studies.

Contrast this with interviewee 11 who discussed the notion of therapies and the TA working well at the time but holds a belief that once the patient is removed from the therapeutic environment they will revert to how they were pre treatment.

The interviews to date have in the main rejected the notion of the therapeutic alliance following a particular therapeutic model. Rather, the TA stands outside and independent to the psychological treatment model, be it DBT, CBT or CAT. The exception being psychodynamic theory where interviewees have commented on the concepts of transference and counter transference being apart of the TA process - what is happening in the room.

Although not based upon a particular psychological model and that the interviewees come from different clinical disciplines and philosophies they all seem to agree and use the same building blocks that go towards the creation and maintenance of the TA.

3rd June 2008

Terrible feeling - the penny has dropped - my analysis is far too practically based and relates to the how to and not the 'lived experience' and 'what is it like to' engage with this group. The task is to move from the descriptive directives to the psychological and emotional experiences without moving away too much from the original objective of how do you engage and how would that differ etc.? Feels impossible at the moment.

Very little time left, the pressure is on but there is a much better way of understanding what is going on for the therapist and a much richer psychologically way of presenting this and I have the data!

Following day - feeling better as the model is developing.