Therapist's Emotional, Cognitive and Linguistic Responses to Patients with Borderline Personality Disorder in Psychotherapy.

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DOCTOR OF PHILOSOPHY

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by

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CERITIFATION

I, Marianne E. Bourke, declare that this thesis, submitted in fulfilment of the requirements of the award of Doctor of Philosophy, in the School of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. This document has not been submitted for qualifications at any other academic institution.

ABSTRACT

Clinical and theoretical literature frequently report that mental health professionals experience interpersonal challenges and emotional distress in providing treatment for patients with Borderline Personality Disorder (BPD). This thesis involved a series of four studies which compared therapists' (N = 20), responses to patients with BPD (N = 40) to patients with Major Depressive Disorder (MDD; N = 40). Study 1 aimed to investigate therapists' Core Conflictual Relationship Themes (CCRT; Luborsky, 1998a), elicited in narratives using the Relationship Anecdotes Paradigm (Luborsky, 1998b) interview method. Results from multilevel modelling analysis indicated that therapists differentially experienced patients, with negative valence scores on all CCRT components significantly related to patients with BPD. Study 2 aimed to investigate relational patterns expressed by patients towards their therapist using the Psychotherapy Relationship Questionnaire (PRQ; Westen, 2000). Dominant concepts and themes in therapists' verbal descriptions were examined using a content analytic approach, Leximancer (Smith & Humphreys, 2006). Results revealed that therapists perceived patients with BPD as presenting with higher hostile, narcissistic, compliant, anxious, and sexualized dimensions of interpersonal responses compared to patients with depression. Therapists reported greater emotional distress and an increased need for supportive supervision when working with patients with BPD. Study 3 further extended these findings through an examination of therapist's linguistic styles using the Linguistic Inquiry and Word Count (LIWC) content-analytic approach (Pennebaker, Chung, Ireland, Gonzales, & Booth, 2007). Results suggest that psychotherapeutic process with BPD patients induced in therapists a self-focused emotionally intense linguistic style, with disturbed reflective functioning and metacognitive processing.

Words denoting negative emotions, anxiety, anger and sadness, first person singular pronouns and adverbs were used frequently, together with fewer words suggestive of cognitive processes, insight and causation when discussing patients with BPD. Study 4 was a pilot study investigating one session with a patient with BPD and a patient with MDD. The observer rated coding system, Psychotherapy Process Q-set (PQS; E. E. Jones, 2000), was utilised to code a wide range of patient and therapist attitudes and behaviours, as well as therapist-patient interactions. In addition, the Therapeutic Cycles Model (TCM; Mergenthaler, 2008) provided framework in which to compare therapist and patient emotional tone and conceptual language. Results from this study indicated that the therapist intervened most to facilitate psychological change with patients with BPD, yet they gained less change in emotion-abstraction patterns. Taken together, findings from these four studies articulate specific ways therapists are challenged in their clinical treatment. The severity of interpersonal difficulties experienced by patients with BPD transfer in particular ways that disrupt the cognitive processing of therapists. Deficits were found in therapists' language fluency and emotional processing consistent with "countertransference" problems often discussed in clinical theory. This has utility in providing guidance for therapists in training and supervision.

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Bourke, M. E., & Grenyer, B. F. S. (*in press*) Therapists' accounts of psychotherapy process associated with treating Borderline Personality Disorder. *Journal of Personality Disorders*. Accepted 17th Nov 2012.

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Presentations

Bourke, M. E., & Grenyer, B. F. S. (2012). Therapists' Accounts of Psychotherapy Process: Revealing Linguistic, Affective, and Cognitive Processes in the Treatment of Borderline Personality Disorder. Poster presented to the *6th Annual Treatment of Personality Disorder Conference.* Wollongong, November.

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Bourke, M. E., & Grenyer, B. F. S. (2010*).* Understanding Countertransference: Psychotherapists CORE Conflictual Relationship Themes. *Society of Psychotherapy 41st Annual International Meeting,* Asilomar, California, June [ISBN 978-3-926002-32-7], p. 41.

Bourke, M. E., & Grenyer, B. F. S. (2009). Understanding therapist response patterns towards Borderline Personality Disorder: A comparative study of Core Conflictual Relationship Themes. *Society for Psychotherapy Regional Group Meeting*, Brisbane, December, p. 4.

“What we observe is not nature itself, but nature exposed to our method of questioning”- Werner Heisenberg, Physics and Philosophy (1959, p. 57).

CHAPTER ONE

BORDERLINE PERSONALITY DISORDER

1.1. CLINICAL PRESENTATION

The clinical presentation of Borderline Personality Disorder has been well documented and described since the 1930's by Stern (1938) and more recently by Linehan (1993a), Bateman and Fonagy (2004), Gunderson (2011), and others. It is well recognized that this disorder is characterised by a heterogeneity of features with chronic instability in a number of multifaceted domains including, emotion dysregulation, identity disturbances, impulsivity and self-harm, as well as patterns of maladaptive interpersonal behaviours (American Psychiatric Association, 2000; Putnam & Silk, 2005). Investigations continue into the causal factors, with current findings suggesting strong neurobiological underpinnings of the disorder (Leichsenring, Leibing, Kruse, New, & Leweke, 2011) . Genetic factors and childhood trauma such as physical and sexual abuse appear to be contributing factors in the development of this disabling condition (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004).

In clinical populations borderline personality disorder has a prevalence of approximately 10%, making it the most common personality disorder (Gunderson, 2009a). Based on peer-reviewed research evidence, the National Institute for Clinical Excellent (NICE) recommends treatment delivery to be intense and long-term, suggesting therapy to be twice weekly for a duration of 12 months. Symptomatic improvements are better than once thought with frequent reports of gains that have proven to be stable over time and remission common even for the most severely affected individuals (Hulbert & Thomas, 2007; Zanarini, Frankenburg, Hennen, & Silk, 2003). Therapeutic engagements are often emotionally intense with a common need

for crisis interventions. Patients often experience affect instability which can be reflected in behaviours such as suicidal tendency or self-injury and unstable relationships (Linehan, 1993b). It is not surprising, that difficulties may arise for both the patient and the therapist in establishing rapport and therapeutic alliance, resulting in conflict within the therapeutic relationship and overt or passive disengagement from therapy (Aviram, Brodsky, & Stanley, 2006; Conklin & Westen, 2005; Linehan, Cochran, Mar, Levensky, & Comtois, 2000). Thus, borderline personality disorder is considered a complex and severe mental health disorder which requires intense treatment and results in high emotional and monetary cost at an individual and societal level (Fanaian, Lewis, & Grenyer, 2013; Tyrer & Mulder, 2006).

1.2. CURRENT NEUROBIOLOGICAL EVIDENCE

Borderline personality disorder has been conceptualised as comprising phenotype components, namely disturbed relations, affect instability, and impulsivity (Gunderson, 2007; Lenzenweger, Clarkin, Yeomans, Kernberg, & Levy, 2008; Lewis, Caputi, & Grenyer, 2012). Research supports the notion that disturbed interpersonal hypersensitivity is reflected in discrete neural system dysfunction, and appears to be a result of interaction between neurobehavioural systems and environmental stressors (Leichsenring et al., 2011). A variety of cognitive activation paradigms using different imaging technologies and methodologies have been used to investigate brain structures and functions (Schmahl & Bremmer, 2006). Impairments in an extensive network of interconnected prefrontal structures, such as, the orbital, dorsolateral and medial regions (Chanen et al., 2008; Mensebach et al., 2009) have been reported. Additionally, impairments to the limbic system, including the amygdala, hypothalamus and hippocampus have been identified (Brambilla et al., 2004; Chanen et al., 2008; Garner

et al., 2007; Schmahl et al., 2003; Schmahl, Vermetten, Elzinga, & Douglas, 2003; Soloff, Nutche, Goradia, & Diwadkar, 2008; Whittle et al., 2009; Zetzsche et al., 2007). Hypometabolism in temporal and medial parietal cortical regions (Lange, Kracht, Herholz, Sachsse, & Irle, 2005), and increased activation of the hypothalamic-pituitary-adrenal axis (Jovev et al., 2008) have been related to the clinical features of borderline personality disorder.

1.2.1 The Neural Correlates of Interpersonal Patterns

Many neurobiological investigations of borderline personality disorder have focused on deficits in emotion regulation, cognition and inhibitory functioning (Ruchsow et al., 2006), however there is a growing body of research that has investigated neural correlates of interpersonal transactions and social decision-making (Imola, Unoka, & Keri, 2009). Novel neurobiological investigations using economic game theory have revealed deficits in interpersonal functioning in borderline personality disorder may be due to disruptions in the neurocircurity responsible for the processing of social signals (King-Casas et al., 2008). Buchheim and colleagues (2008) also suggest that neural mechanisms may underlie deficits in interpersonal functioning such as intense fear of aloneness and hypersensitivity in social situations. These findings are consistent with the current understanding of the aetiology of borderline personality disorder as comprising both biological (Silk, 2000), and psychosocial concomitants (Buchheim, Viviani, George, Kächele, & Walter, 2012; Leichsenring et al., 2011; Linehan, 1993a).

1.3. THE THERAPEUTIC RELATIONSHIP

Theoretical and clinical literature considers borderline personality disorder as one of the most challenging psychiatric disorders to treat (Bateman & Fonagy, 2004; Clarkin, Yeomans, & Kernberg, 1999; Gunderson, 2009b; Kernberg, 1968a; Linehan,

1993a; Young, Klosko, & Weishaar, 2003). The complex nature of treating patients with personality disorders lies not only with patient's behaviour but also in the therapist's response (McWilliams, 1994). An example of this phenomenon being studied is where a patient repetitively apologises, for being late, for saying the wrong thing, for not preparing for the session. Over a number of weeks this pattern continues, with rising anger and frustration in the therapist who continually reassures the patient, until the patient declares, "You've never helped or supported me!" Here the therapeutic relationship is under continual pressure from the patient's interpersonal reactivity that swings from demands of supportive attention to attacking and confronting the therapist. The therapist's tolerance is tested not only at each stage, but when their overall care and concern is attacked in devaluative accounts of their abilities. Such maladaptive relational patterns enacted in the therapeutic relationship result in difficulties establishing rapport, high drop-out rates, pervasive non-compliance (Aviram et al., 2006; Conklin & Westen, 2005; Kraus & Reynolds, 2001; Paris, 2005), and intense polarised positive and negative emotional reactions (Gunderson & Lyons-Ruth, 2008; McCready, 1987). The emotional demands on therapists working with patients with borderline personality disorder are frequently recognised (Grenyer, 2012; McHenry, 1994; McWilliams, 1994), with therapists often reporting trepidation and concern at the prospect of working with this patient group (Brody & Farber, 1996; Greene, Rosenkrantz, & Muth, 1986; Linehan et al., 2000; Shachner & Farber, 1997).

A number of overlapping constructs conceptualise the therapeutic process as an interactional process between therapist and patient, including alliance rupture and repair (Safran, Muran, Samatag, & Stevens, 2001), pathways of emotional communication (Bucci, 2001), and transference-countertransference (Freud, 1901). Kiesler (2001) refers to the complementary pattern of therapist-patient interactions stating that the

therapist can become ‘hooked’ by the “patient’s rigid and extreme maladaptive game of interpersonal encounter” (Kiesler, 2004, p. 2). Likewise, the evolving construct of countertransference, has led to contemporary definitions that emphasise the two-person pattern of interaction whereby emotional and cognitive responses in the therapist may be evoked by the patient’s transference (Guy & Brady, 2001a; E. E. Jones, 2000; McWilliams, 1994). While there is scant empirical research into two-way interactional patterns, findings reported by Holmqvist and colleagues (2002) are encouraging and point to similarities in the emotional reactions of both therapist’s and non-therapist towards a patient. Furthermore, in this study therapist and patient emotional reactions were similar. From this perspective the responses evoked in the therapist are considered a common experience shared by all who interact with the patient, and thus may provide important clinical information about the patient’s interpersonal problems (Anchin & Kiesler, 1982).

The therapeutic relationship is often the milieu in which relational deficits are enacted by individuals with borderline personality (McWilliams, 1994). Neurobiological research may shed light on this observation. Findings suggest that the neuropeptide oxytocin may mediate the relationship between attachment and mentalisation (Fonagy, Luyten, & Strathearn, 2011). This has lead Fonagy and colleagues (2011) to propose that oxytocin has a mentalisation-enhancing function in caregiver/infant relations. Here the activation of the caregiver’s attachment system raises the oxytocin levels, which in turn, promotes sensitivity to the mental state of the infant. Thus, the secure attachment of the child and caregiver may promote the infants developing theory-of-mind. By way of the same mechanisms strong maternal bonding may inoculate against conditions that interfere with mentalisation processes such as care-giver maltreatment (Cicchetti, Rogosch, Maughan, Toth, & Bruce, 2003; Pears &

Fisher, 2005). Additionally, oxytocin has been identified in the modulation of approach or trust behaviour (Baumgartner, Heinrichs, Vonlanthen, Fischbacher, & Fehr, 2008; Kosfeld, Heinrichs, Zak, Fischbacher, & Fehr, 2005). While oxytocin has been found to promote pro-social behaviour in healthy adults, recent results suggest that the effect of this neuropeptide on individuals with borderline personality disorder may differ (Bartz et al., 2011). Bartz and colleagues (2011) reported that increases in oxytocin through intranasal administration decreased trust and cooperative responses in individuals with borderline personality disorder. One explanation for these findings is that oxytocin increases the salience of social cues and therefore may also be responsible for triggering negative emotional arousal in individuals that have interpersonal dysfunctions. Moreover, these results highlight the complex interaction between environmental and neurobiological factors in the presentation of borderline pathology. It stands to reason that in relationships that activate the attachment system such as the therapist-patient relationship, individuals with borderline personality disorder experience disturbances in approach and trust behaviour (Baird, Veague, & Rabbitt, 2005) along with disturbances in expressive language (Carter & Grenyer, 2012), social cognitions (Jennings, Hulbert, Jackson, & Chanen, 2012), and reflective functioning (Fonagy & Bateman, 2006).

1.4. PREVIOUS RESEARCH

In general, review articles that examine countertransference literature make comment on the need for further empirical investigations (Fauth, 2006; Harris, 1999; Hayes, 2004; Najavits, 2000; Rosenberger & Hayes, 2002; Schwartz & Welding, 2003). More specifically, the lack of empirical research is surprising given consistent theoretical and clinical reports that therapists experience negative automatic, and predictable emotional reactions when working with patients with borderline personality disorder. The small

body of research in this area can be divided into analogue design studies in a laboratory, field experiments in real-world clinical settings and case studies.

1.4.1. Analogue Studies

Two analogue studies have used emotion evoking stimuli (in contrast to actual patients). Brody and Farber (1996) measured 336 therapist reactions to written clinical vignettes representative of a diagnostic description of Major Depression, Borderline Personality Organisation and Schizophrenia. Therapists' responses were measured using a 20-item Vignettes Rating Scale (VRS). Therapists reported emotions that differed significantly based on patient diagnosis, with the vignette of a patient with depression elicited feelings of nurturing, compassion and empathy; whereas the schizophrenia vignette was associated with reactions of anxiety and hopelessness. In contrast, therapists' reported that borderline pathology evoked negative reactions of irritation, frustration and anger. Furthermore, positive reactions such as liking the patient, empathy, and nurturance were significantly lower towards borderline stimulus than those reports towards schizophrenia and depression stimuli. Reactions also differ as a function of experience, with students and interns reporting significantly higher ratings of envisaged depression and irritation compared to licensed practitioners. These results provide some indication that the more experienced the therapist, the more proficient they are at managing their emotional reactions, are more comfortable with strong emotions expressed by their patients, and are less likely to consider their reactions as a disruptive influence on the therapeutic relationship. An alternative and equally plausible explanation is that experienced therapists were less likely to disclose feelings of self-doubt. This study however, has a number of notable limitations, some of which considerably compromise external validity. First, all instruments were specifically designed for this investigation and were

not supported with established construct validity. Second, the results reflect the therapists' perception of what they imagine working with the fictitious patient would be like, not the dynamics of an actual therapeutic relationship therefore, limiting the ecological validity of these results.

The second analogue study investigated differential therapist emotional reaction towards Borderline Personality Disorder and Major Depressive Disorder stimuli (McIntyre & Schwartz, 1998). In this study audio taped interviews were played to 155 therapists who subsequently completed the Impact Message Inventory (IMI; Kiesler, 1987) and the Stress Appraisal Scale (SAS; Carpenter & Suhr, 1988). Participants reported significant differences in feeling dominated and defensive in response to the characteristic borderline stimulus, in contrast to feelings of submissiveness and friendliness in relation to the depressive disorder stimulus. Furthermore, there was a significant negative correlation between increased years of experience and decreased perception of therapeutic difficulty. Again, the analogue design of this study prevents results being generalised to actual therapeutic settings.

1.4.2. Field Experiments

In addition to analogue design studies, six experiments have used natural settings to investigate therapists' feelings towards their patients diagnosed with borderline personality disorder. Eleven therapists who facilitated a specialised day treatment program gave self-report ratings on the Feeling Word Checklist-58 (FWC-58; Whyte, Constantopoulos, & Bevans, 1982) towards 71 patients. Ratings were taken two weeks after program commencement and two weeks before termination of 18 weeks of group therapy (Rossberg, Karterud, Pedersen, & Friis, 2007). Reactions towards patients with Cluster A and B Personality Disorder (mainly borderline personality disorder) evoked

therapist feelings of rejection, of being on guard, and being inadequate, compared to patients with Cluster C Personality Disorder (mainly avoidant personality disorder). Therapists reported feeling more confidence in treating patients with Cluster C than Cluster A and B personality disorder. This study can claim to have strong external validity due to the investigation of actual therapist-patient relationships however these dyads were in a group milieu and thus the findings cannot be generalised to individual psychotherapy settings. As with other studies that have used simple affect checklists to measure therapist's responses, the FWC-58 limits the therapists' range of responses and may represent only a partial view of many responses that the therapist experiences. It is arguable that comparing and contrasting therapists responses to patients with personality disorders defined at a cluster level takes a broad brushstroke approach, assuming that interpersonal interactions are consistent within clusters. Moreover, excessive variance in interpersonal responses at a cluster level prevents the narrowing of these results to any one diagnostic group.

In another study, 124 milieu therapists rated their feelings using a checklist of 30 feeling words as descriptors of responses towards 101 patients diagnosed with either an Axis I disorder (N = 66) or Axis II disorder (N = 20) or both an Axis I and II disorder (N = 15). Ratings were made twice a year for five years across 17 treatment units (Holmqvist, 1998). This dataset was hierarchically structured, with therapists' measures dependent on each other due to the commonality of the same treatment unit. When variance nested within diagnoses was accounted for, results suggested that therapists experienced similar intrapersonal reactions to the same patient (Holmqvist & Armelius, 1996), nevertheless the patient's diagnosis was not a significant influence (Holmqvist, 1998). One explanation for these findings is that therapists experience 'objective' reactions that are a function of the direct interpersonal interactions not as a function of

diagnosis characteristics per se. In another study by Holmqvist (2001) results suggested that in general therapists experience their own response style which is a consistent and stable patterns however, these patterns may also interplay with evoked responses by particular patients. However, measuring responses with an itemised checklist substantially limits these findings by providing a narrow lens on the specific nature of therapists' responses. It is also noteworthy that therapist-patient interactions in these studies are in a residential environment and not representative of individual therapeutic relationships.

Two small-scale studies have investigated therapists' reactions when working with patients with borderline personality disorder in an inpatient environment (Greene et al., 1986; McCready, 1987). McCready (1987) provided a case illustration, commenting that the patient, the therapist and milieu were adversely influenced by "destructive countertransference reactions in staff evoked by the patient's defenses" (p. 727). Greene and colleagues (1986) conducted a limited investigation with 20 patients with borderline personality disorder and two group therapists. Results from this study suggested that the more the patient used splitting defences, that is characterising the therapist as either *good* or *bad*, the more the therapist experienced disagreement in clinical judgements involving the patient's level of depression and suicidality.

Betan, Heim, Conklin, and Westen (2005) tested the clinical application and validity of a new instrument, the Countertransference Questionnaire, on a random sample of 181 North American psychiatrists and clinical psychologists. Betan and colleagues reported an eight factor structure of patient induced behavioural, cognitive and affective responses. Results indicated statistically significant patterns of association between Criticised/Mistreated factor scores and patients with Cluster A Personality Disorder. Strong positive correlations were reported between Overwhelmed/Disorganised,

Disengaged, Sexualised and Mistreated factors in relation to patients with Cluster B symptomology. This study provides initial psychometric properties of the Countertransference Questionnaire, thus further replication is required to establish the validity and reliability of this instrument and to provide confirmatory results.

Thylstrup and Hesse (2008) recruited addiction counsellors, social workers, nurses and psychologists from workshops providing education on personality disorders. Treating staff completed the Feeling Word Checklist-58 in relation to patients in inpatient and outpatient substance abuse treatment facilities. Patients provided a self-report of personality pathology as indexed by the DSM-IV and ICD-10 Personality Disorder Questionnaire (DIP-Q; Bodlund, Grann, Ottoson, & Svanborg, 1998). Findings suggested that Cluster A Personality Disorder features engendered no significant reaction in the treating staff. Antisocial Personality Disorder symptoms influenced feelings of distance, of being on guard and feeling overwhelmed. Surprisingly, patients with BPD traits were related to therapists' feelings of wanting to help. This study may be the first to assess patients' personality disorder features and staff reactions separately, reducing confounding between the dependant and independent variables. However, the validity of self-report personality disordered pathology is questionable, given the possibility of impaired introspection. Furthermore, there may be a tendency not to disclose symptomology or to respond in a socially desirable manner to avoid a further diagnosis that may affect their treatment progression and program completion. Additionally, the methodology used in this study is ambiguous, with a lack of information about: the number of staff recruited, how many patients each staff member reported their reactions towards, the amount of contact and the degree of interpersonal interaction between patients and staff members. Regardless, it can be assumed that treating staff were

relatively inexperienced due to their attendance at a training workshop on personality disorders.

1.4.3. Limitations of Previous Research

A number of limitations exist within this small pool of research. First, the ecological validity is low in analogue studies, preventing findings from being generalized to real-world clinical settings. To date, the focus of field research has been on therapist working in a group milieu (Rossberg et al., 2007). Given that individual psychotherapy is a recommended treatment modality for borderline personality disorder (Levy, Yeomans, Denning, & Fertuck, 2010) with treatment effectiveness documented in a number of reviews and meta-analyses (Bateman & Fonagy, 2000; Leichsenring & Leibing, 2003; Perry, Bannon, & Ianni, 1999), the absence of studies relating to individual psychotherapy is a substantial limitation. It is also important to note that studies that use cluster level diagnoses cannot be considered representative of a single diagnostic group as there are a broad range of relational characteristics at a cluster diagnostic level. In addition, previous research has relied heavily on simple affect checklists, requiring therapists to make forced responses when reporting their emotional experiences. Lastly, instruments without established psychometric properties have also been used (Brody & Farber, 1996). Given these limitations, it is clear that new studies are required to examine therapist's response to actual patients, with greater diagnostic specificity, using more sophisticated measures that are designed to explore the dynamics response patterns of therapists.

1.4.4. Defining Therapists' Cognitive and Emotional Responses

Freud first coined the term countertransference in reference to therapists' cognitive and emotional experiences (Freud, 1901). Since then the focus on therapists' intrapersonal

responses has garnered interest from many differing theoretical perspectives. For example, interpersonal-communications theory (Anchin & Kiesler, 1982), feminist social constructionism (Brown, 2001); contemporary psychoanalysis (S. H. Jones, 2012), Kohutian self-psychology (Guy & Brady, 2001b), and Rational Emotive Behavior Therapy (Ellis, 2001), have all purported that therapist responses to their patient are an important aspect of the therapist-patient relationship and are deemed valuable clinical information. Few constructs however, in the psychological lexicon generate disagreement and definitional diversity as countertransference. A history comprising nearly a century of ideological debate has been comprehensively reviewed by Geddes and Pajis (1990). While Freud (1910/1959) is most frequently cited in relation to the term countertransference, he nevertheless did not provide a precise definition. Moreover, Freud made few explicit references to the term countertransference (gugenübertragung), leaving ambiguity and confusion as to what is and what is not classified as countertransference. Freud did however articulate for the first time the influence of the patient upon the therapist in the emotional realm, particularly in relation to feelings that are not necessarily consciously acknowledged. He stated:

> We have become aware of the 'counter-transference', which arises in him [the therapist] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognise that counter-transference in himself and overcome it (p. 144-145).

Indeed the classical view of countertransference conceptualises the therapist's responses as unconscious and conflict-based "displacements onto the patient of emotional material which in actuality stems from the therapist's internal representations of important persons from his (or her) own past" (Reid, 1980, p. 78). In contrast, the

totalistic view of countertransference incorporates all of the therapist's emotional, cognitive and behavioural reactions towards the patient (Kernberg, 1965; M. Klein, 1946; Little, 1951). Countertransference has also been differentiated into subjective responses attributable to the therapist's unresolved conflicts and anxieties (Spotnitz, 1969) or objective responses evoked by the patient's interpersonal relating style (Anchin & Kiesler, 1982; Kiesler, 2001; Winnicott, 1949). Melanie Klein (1951) emphasised the transference dynamics within the therapeutic relationship whereby "the patient is bound to deal with conflicts and anxieties re-experienced towards the analyst by the same methods he used in the past" (p. 209). Similarly, Kiesler refers to the complementary pattern between the interactions of the therapist and the patient.

As exemplified by the above brief overview that addresses only a portion of all conceptualisations, the term countertransference is marked by a lack of consistency as to the basic features of the construct and a general consensus that powerful and often unconscious emotional influences transfer between patient and therapist. The outcome of such ideological diversity is that the concrete experiences of the therapist within the therapeutic relationship remains empirically illusive, and without consistent operational definitions. The current series of studies take an atheoretical approach with reference to therapists' cognitive and emotional responses, in order to operationalise all intrapersonal responses that reside in both the overt and covert experiences of the therapists working in a clinical environment. The term interpersonal refers to interactions between individuals, whereas the term intrapersonal relates to the internal reactions within the individual. Whilst acknowledging the significant and important history of countertransference, the decision to adopt a theory-neutral empirical approach in this research has the advantage of ensuring the results may have currency for therapists and researchers from a broad spectrum of diverse theoretical perspectives.

1.5 THESIS AIMS

The four studies that make up this thesis investigated psychotherapy process from the therapist's perspective, with patients with borderline personality disorder compared to major depressive disorder.

The aims were as follows:

1. To identify therapists' Core Conflictual Relationship Themes when recalling psychotherapy with actual patients (Study 1).
2. To identify the valance of the emotional tone of therapists' responses (Study 1).
3. To investigate relational patterns expressed by patients towards their therapist (Study 2).
4. To analyse prominent concepts and themes discussed by therapists towards their patients (Study 2).
5. To investigate the interconnectedness of lexical terms in therapists' narratives (Study 2).
6. To identify linguistic, affective and cognitive processes in therapists' natural language when recalling their experiences of the therapeutic process (Study 3).
7. To describe a range of patient and therapist attitudes, behaviours and therapist-patient interactions identifiable during a psychotherapy session (Study 4).
8. To identify patient and therapist emotion-abstraction patterns in a therapeutic session that differs as a function of the patient's diagnosis (Study 4).

CHAPTER TWO

STUDY 1: THERAPISTS' CORE CONFLICTUAL RELATIONSHIP THEMES: RELATIONAL PATTERNS IN THE TREATMENT OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER[1]

2.1. INTRODUCTION

As identified by Gelso and Hayes (2007), the direct association between therapist's countertransference enactments and the therapeutic relationship has undergone limited empirical investigation. There is growing evidence that suggests countertransference behaviour negatively affects working alliance (Ligiero & Gelso, 2002) and outcome (Gelso, Latts, Gomez, & Fassinger, 2002). Furthermore, factors such as self-insight or attunement to ones thoughts and feelings appear to contribute to the effective management of intrapersonal responses (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). Taken together, this evidence suggests that both recognition and understanding of the processes affecting therapist's emotional and cognitive responses are essential factors underpinning effective psychotherapy process and outcome. Therefore, further research is needed to support therapists in conceptualising and managing emotional experiences, which may directly and indirectly impact upon therapeutic outcome (Fauth, 2006; Harris, 1999; Hayes, 2004; Najavits, 2000; Rosenberger & Hayes, 2002; Schwartz & Welding, 2003).

To date both analogue and field research has drawn attention to therapist's differential emotional as a factor of patient diagnosis. However, previous studies have relied heavily on simple affect checklists, have predominately investigated group

[1] This study has been published in Psychotherapy Research.

therapeutic setting and are inherently limited with poor ecological validity. As previously highlighted by Singer and Luborsky (1977), the task of operationalising interpersonal interactions without removing the complexity and relational dynamics is a challenge for quantitative research. In an effort to address this issue as well as the previous limitations of poor ecological validity and the prescriptive nature of affect check-lists, we proposed to empirically investigate therapists' responses towards their actual patients using a semi-structured interview procedure.

The CCRT method is a clinically relevant instrument designed to measure pervasive and often problematic relationship themes (Luborsky, 1998c). It has been extensively applied to evaluating interpersonal processes in clinical and non-clinical populations (Chance, Bakeman, Kaslow, Farber, & Burge-Callaway, 2000; Cierpka et al., 1998; de Roten, Drapeau, Stigle, & Despland, 2004; Drapeau, de Rotten, & Körner, 2004; Drapeau & Perry, 2004; Popp, Luborsky, Andrusyna, Cotsonis, & Seligman, 2002). The development of the Core Conflictual Relationship Theme-Leipzig/Ulm Method (CCRT-LU) category system provides a comprehensive approach to scoring Core Conflictual Relationship Themes (Kächele et al., 2002). The adjustment to the method presented here, which involves coding therapist interviews, allows the therapist's repertoire of emotional and cognitive responses to be interrogated as: a) what the therapist wanted to do in the interaction—their intent, desire or expectations towards the patient and for themselves; b) how the therapist experienced the patient—their perceptions of the patient's response; c) and what they did and felt— their responses to the patient's response (RSO, Response of Self to Other; RSS, Response of Self to Self; Book, 1998; Kächele et al., 2002).

The decision to use Major Depressive Disorder as a comparative group was based on the rationale that such a clinical comparison has precedence in studies examining

therapists' responses (Brody & Farber, 1996; Holmqvist, 1998; McIntyre & Schwartz, 1998). There are only a small number of studies examining countertransference responses in relation to borderline personality disorder, and to date none of these studies use the CCRT to understand these responses.

2.1.1. Aims

The aims of Study 1 were:

1) To investigate therapists' responses towards their actual patients diagnosed with borderline personality disorder, using major depressive disorder as a comparison.

2) To investigate therapists' ratings of patients' response patterns.

Specifically we addressed the following questions: Do therapists' cognitive and emotional responses differ as a function of patient diagnosis? The current study took an exploratory approach. Hypotheses were very general in nature, based on the above mentioned clinical and empirical findings. First, we expected that therapist would identify the relational patterns of patients with borderline personality disorder to be more conflictual and less compliant in nature than patients with depression. We also predicted that the valence of the emotional tone of therapists' towards their patients with borderline personality disorder would be more negative in content compared to their responses towards their patients with depression. Lastly, we expected that the therapists' accounts of their own emotional and cognitive responses would be more negative when associated with patients with borderline personality disorder compared to their responses when associated with patients with depression.

2.1. METHODS

2.2.1 Participants

Therapists.

The 20 therapists in Study 1 were recruited using a snowball sampling technique (Goodman, 1961) from community health facilities linked to a university health service. This meant that therapists initially recruited to the study were asked for further contacts and then these therapists were asked to participate. By using a small pool of initial informants to nominate prospective participants that met the inclusion criteria, this study targeted therapists that were actively engaged in therapeutic practice in the treatment of borderline personality disorder and major depression. This made recruitment both cost and time efficient. Seventeen doctoral-level and three masters-level clinical psychologists volunteered to be involved, of these 13 were female. There was a range of post-internship experience from 2 to 14 years, with a mean of 6.5 years (*SD* = 3.28). Therapists had a mean age of 34 years (*SD* = 7.52), and identified their theoretical orientation as cognitive-behavioural (14) and interpersonal-dynamic (6).

Patient Inclusion Criteria

Therapists were required to select patients with whom they were currently engaged in psychotherapy or had terminated within the previous 12 months and had treated for a minimum of eight sessions.

Patients.

The 80 patients selected were assessed and diagnosed in accordance with a manualized DSM-IV (APA, 2000). Forty patients had a diagnosis of borderline personality disorder (borderline group), 35 (87.50%) were female and had a mean age of 32.75 years (*SD* = 9.00). These patients had been in individual treatment for a mean of 11.64 months (*SD* = 8.24); starting treatment with a mean Global Assessment of Functioning (GAF) of 39.05 (*SD* = 14.19). The remaining 40 patients with Major Depressive Disorder (depressed group) had a mean age of 42.10 years (*SD* =13.11), with 27 being female. They had a mean pre-treatment GAF of 49.60 (*SD* = 11.84), and had received a mean of 8.93 months (*SD* = 11.84) of individual therapy. Nineteen patients from each group were still receiving therapy. For those in the borderline group no longer engaged in therapy, a mean of 7.88 months (*SD* = 4.08) had elapsed since termination, while on average 6.11 months (*SD* = 4.24) had passed for those in the depressed group. After individual review two cases (5% of total cases) in the depressed group were deleted from the dataset. The first case was not representative of the clinically depressed population that the current study intended to sample. This was due to personality disorder characteristics that did not meet diagnostic criteria. The second patient was in treatment for depression related to a conviction of paedophilia and was also an atypical case.

2.2.2. Measures

Core Conflictual Relationship Theme-Leipzig/Ulm Method (CCRT-LU).

The CCRT-LU (Kächele et al., 2002) is a clinical-quantitative method used to code patterns found in relational narratives. This is done by first identifying Relationship Episodes (RE) within the narrative—stories of interpersonal relationship interactions,

that progress through beginning, middle and end stages of story development (Luborsky, 1998a). The RE is then delineated into CCRT-LU components which include a wish or intention of self, ‘Wish of Self for Self’ (WSS) and ‘Wish of Self for Other’ (WSO), and other ‘Wish of Other for Self’ (WOS) and ‘Wish of Other for Other (WOO); the response of the other person, 'Response of Other to Self' (ROS) and ‘Response of Other to Other’ (ROO); and the response of the self, ‘Response of Self to Other’ (RSO) and 'Response of Self to Self' (RSS). The main CCRT components (WOO, WOS, WSO, WSS, ROO, ROS, RSO, and RSS), from each narrative are documented using the literal words (responses) of the speaker (called the 'tailor made method'). These components are then converted into standardised CCRT-LU category words. The categories are organized in the CCRT-LU system into four levels of specificity. The first level differentiates harmonious words from disharmonious, the second into 13 response types (high-level clusters), the third into 30 mid-level categories, and the final into 119 very specific sample phrases.

The reliabilities for high and middle-level categories have been established with fair to good interrater agreement (weighted kappa range 0.66 – 0.56; Albani et al., 2002). Parker and Grenyer (2007) reported perfect agreement of 70.80 % at high-level cluster (e.g., Cluster C), in a quantitative assessment of the CCRT-LU system. Validity has been shown through the relationship between treatment progress and CCRT modification in patient populations (Barber, Luborsky, Diguer, & Crits-Christoph, 1995; Crits-Christoph & Luborsky, 1990). The CCRT components can be further assessed for valence dimensions that reflect the extent that responses relate to wish fulfilment (positive) or wish denial (negative); 1 = very negative; 2 = negative; 3 = positive; 4 = very positive (Albani et al., 1999; Grenyer & Luborsky, 1998). Interrater reliability of judges’ scoring of the four categories of negative and positive valence has been found to be high for the

RO ($r = .77$, $p < .001$) and RS ($r = .93$, $p < .001$) components (Grenyer & Luborsky, 1998). Both clinical (Eckert, Luborsky, Barber & Crits-Christoph, 1990; Grenyer & Luborsky, 1996; Popp et al., 1998) and non-clinical samples (Luborsky et al., 1998; Thorne & Kiohnen, 1993) have been studied. Validity has been shown through a correlation between negative valence dimensions and severity of psychological disorder (Albani et al., 1999).

Global Assessment of Functioning (GAF).

The GAF is a clinical assessment tool used by therapists to quantify Axis V of the DSM-IV (APA, 2000). Scores range from 1 to 100, with higher scores representing greater overall mental health functioning. Interjudge reliability has been established to be in the excellent range, with Intraclass Correlation Coefficient (ICC) > .80 (Hilsenroth et al., 2000; Söderberg, Tungström, & Aemelius, 2005). Validity has been shown through a positive correlation with separate ratings of support needs, symptoms and disability, and changes to antipsychotic medication (S. H. Jones, Thornicroft, Coffey, & Dunn, 1995). The GAF provides a measure of psychological disturbance that has clinical significance in predicting treatment outcomes (Luborsky et al., 1996), and symptom severity (Kopera, 2002).

2.2.3. Procedure

Recording of narratives. Approval for study 1 was obtained through the associated Institutional Review Board. Subsequently, therapists gave informed consent to participate in a recorded interview regarding their relational experiences with four of their patients, two patients with a primary diagnosis of Borderline Personality Disorder and two patients with a primary diagnosis of Major Depressive Disorder. Therapists

were asked to select patients that were representative of their caseload and the studies inclusion criteria. Prior to the scheduled interview patient and therapist demographic questionnaires were provided to therapists to enable an accurate file review of patient characteristics and diagnoses. Therapists were initially given an overview of the interview procedure, the Relationship Anecdotes Paradigm (RAP; see details below Luborsky, 1998b). The interview question was read verbatim by the interviewer, instructing the therapist to answer in regards to the first patient diagnosed with depression. This procedure was repeated for the next patient with depression and two subsequent patients with borderline personality disorder. The recorded interviews were transcribed verbatim following the published rules for transcription of verbal samples (Grenyer, 2002). Two judges trained in the use of CCRT-LU method independently coded the complete data set, representing some 3,800 clause comparisons. Each interview narrative was considered an entire RE with the focus being on the therapist's relations with a specified patient. In order to derive a consensus code for all CCRT components and valence scores, judges meet and discussed disagreements in coding. Agreement was reached on all discrepant component ratings without assistance from a third rater.

Relationship Anecdotes Paradigm (RAP). A semi-structured face-to-face interview procedure developed by Luborsky (1998b), known as the Relationship Anecodotes Paradigm, was used to encourage therapists to elaborate on incidents or events involving themselves and their patient. Modified interview instructions were given as the original RAP assumes the patient is the interviewee. The instructions were given as follows: "Please tell me what seeing this patient was like for you, what you wanted out of therapy and how they responded to you. Please elaborate, if you can give me a

specific situation of something that happened between you. What they said and what you said?" To generate specific examples or further detail components of this request were repeated as follow-up prompts.

2.3. RESULTS

Therapists' Cognitive and Emotional Responses

As presented in detail in Table 1 the percentage frequency of therapists' CCRT-LU categories were assessed for each diagnostic group. Therapists expressed a common wish (WSS) to be confident (Cluster D, self-determined) in their therapeutic role, regardless of diagnostic group. Significant differences were found in therapists' wish for their patients (WSO), with therapists most commonly reporting that they wanted to support (Cluster B) the patient with MDD and assist the patient with borderline personality disorder to be independent (Cluster D). Therapists most frequently perceived patients with borderline personality disorder to respond to them in a disharmonious manner while patients with MDD were reported to frequently display harmonious responses.

More specifically, significant in session patient differences were found with the borderline personality disorder group perceived as withdrawing (Cluster M), while the MDD group were frequently perceived as attending (Cluster A). Both BPD and MDD groups were reported to display overly dependent responses (Cluster G). No statistically significant differences were found in therapists' reports of therapeutically supporting their patients (RSO). However, therapists' expressed feeling more confident (Cluster D; RSS) in providing support to patients with MDD and more frequently withdrew (Cluster M) from patients in the BPD group. Common example statements by therapists in

relation to their responses to each diagnostic group are coded into CCRT responses patterns in Figure 1.

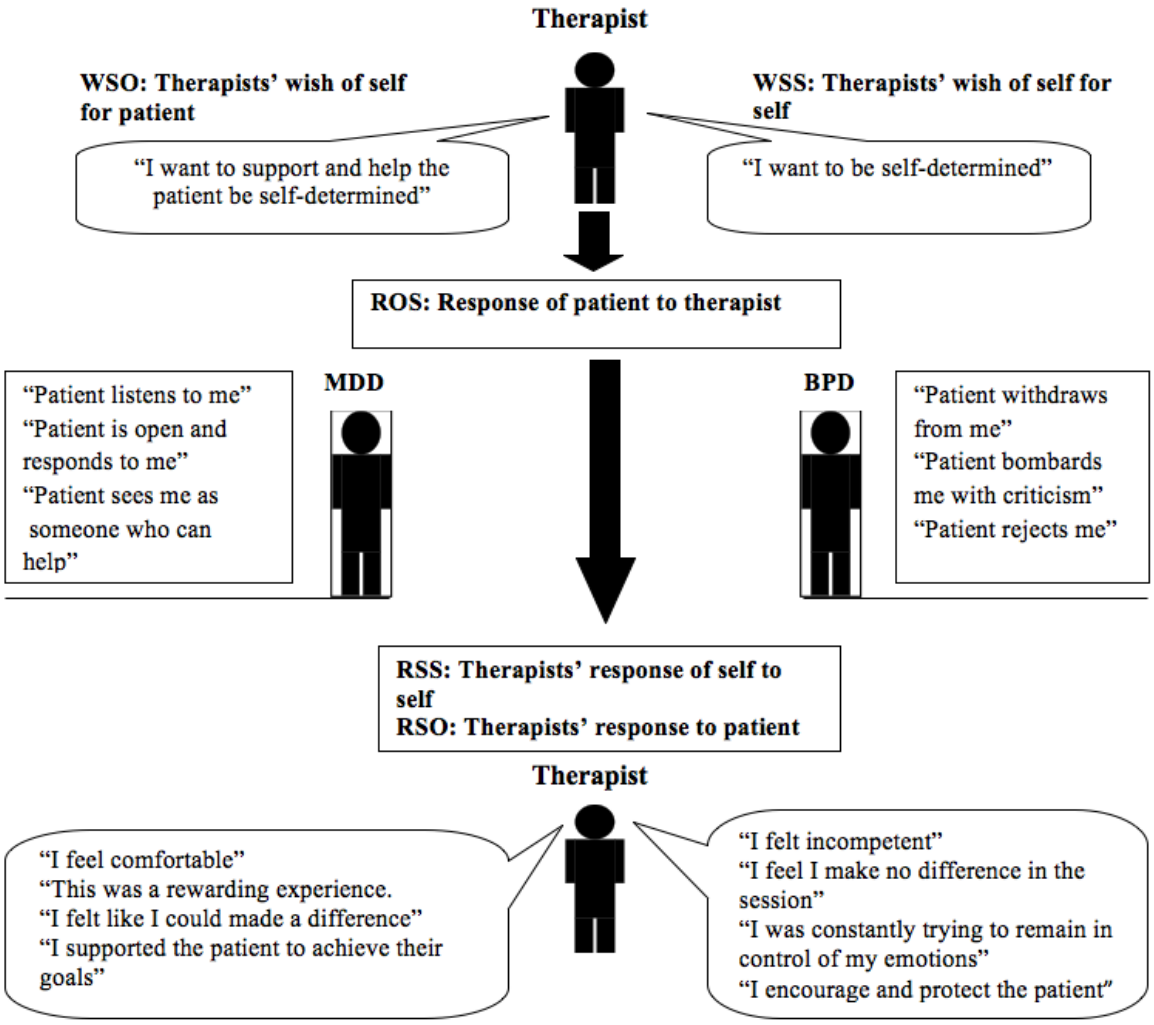

Figure 1. Therapists' CCRT response patterns in relation to patients with Borderline Personality Disorder and patients with Major Depressive Disorder; Wish of Self for Other (WSO), Response of Self to Other (RSO) and Response of Self to Self (RSS)

Next, multilevel modelling was used to examine the extent to which the valence of therapist's responses differed as a result of variance due to the individual differences of the patient at level 1 and the therapist at level 2 of the model. This first intercept-only model was statistically significant ($p < .05$) indicating significant differences at both

level 1 and 2. The following are the goodness of fit indices for CCRT components of this model: ROS Deviance = 235.62; RSO Deviance = 222.69; RSS Deviance = 247.07. We then conducted a second model to test the extent to which the valence of responses differed as a result of variance due to the patient diagnosis. The effect of patient diagnosis was significant ($p < .05$) with coefficient, standard error (*SE*) and model fit as follows: ROS = -1.29, *SE* = .19, Deviance = 202.54; RSO = -1.04, *SE* = .19, Deviance = 198.70; RSS = -1.41, *SE* = .21, Deviance = 212.17. A coefficient twice the size of the *SE* indicates a significant ratio. These results indicated that lower valence scores (negative valence) on all CCRT components are significantly related to patients with borderline personality disorder. Finally, patient pre-treatment GAF scores, therapist years of experience and theoretical orientation were added to the model. No significant main effects were found for patient pre-treatment, GAF, years of experience or theoretical orientation. The final model containing the within and between-subject predictors accounted for only a small amount of additional variance when compared to the model with patient diagnosis as a single predictor (ROS Deviance = 199.18; RSO Deviance = 194.24; RSS Deviance = 209.90). The minimal decrease in the deviance indices from model two to model three indicated that the model fit improved only marginally. Statistically significant group differences in therapist's valence of ROS, RSO and RSS are presented in Figure 2.

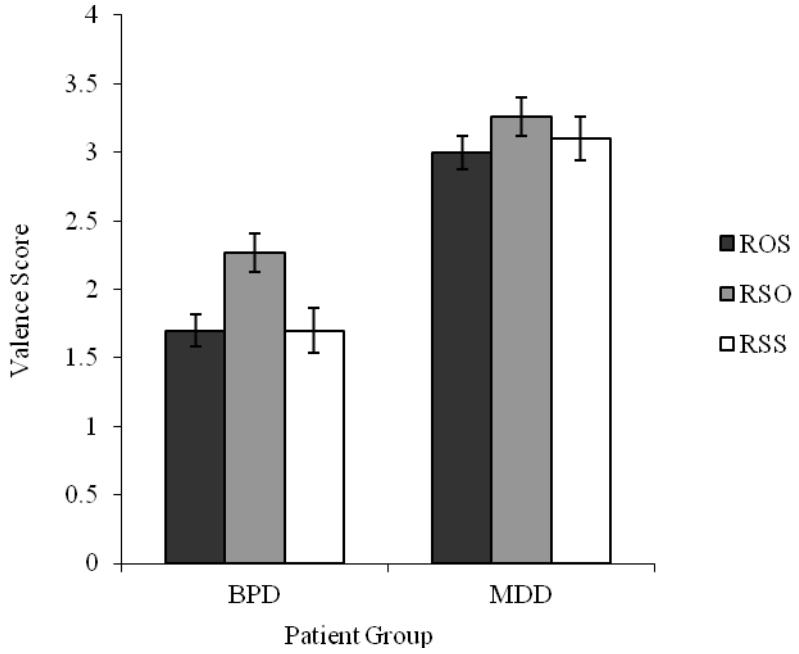

Figure 2. Therapists' mean and standard error valence scores in relation to patients with BPD (n = 40) and patients with MDD (n = 38) for CCRT components Response of Other to Self (ROS), Response of Self to Other (RSO) and Response of Self to Self (RSS)

Response of Other to Self. Therapists reported that patients diagnosed with borderline personality disorder predominately responded to them (ROS) in a very negative manner (47.50%) compared to patients diagnosed with major depressive disorder (7.90%). Furthermore, therapists reported a small percentage of very positive responses (2.50%) from patients diagnosed with borderline personality disorder compared to 39.50% being very positive responses from patients diagnosed with major depressive disorder.

Response of Self to Other. The therapist's responses towards patients (RSO) in the BPD group were predominately positive (55%) however, 32.50% of responses were very negative; there were no responses with a very positive valence. This contrasted with therapists' responses to patients in the major MDD group with 44.70% having a very positive valence and a small 5.30% having a very negative valence.

Response of Self to Self. Therapist's responses towards themselves (RSS) were largely very negative (55%) and negative (25%) in relation to their experience of treating patients from the BPD group. In comparison, 50% of self-responses were very positive, 15.80% were positive and 28.90% were negative in relation to the MDD group.

Table 1. Percentage Distribution of Therapists' Core Conflictual Relationship Theme (CCRT) Components Towards Patients with Borderline Personality Disorder and Major Depressive Disorder

	WSO		WSS		ROS		RSO		RSS	
Harmonious Cluster Category	BPD	MDD	BPD	MDD	BPD	MDD	BPD	MDD	BPD	MDD
A Attending to	17.50	7.90	15.00		10.00	34.20*	5.00	15.80	2.50	2.60
B Supporting	37.50	63.20*	5.00	13.20		5.30	32.50	47.40	2.50	
C Loving/Feeling well	5.00	7.90	2.50	5.30	2.50	21.10*	2.50	15.80*		18.40
D Being self-determined	40.00	21.10*	77.50	81.60	5.00	7.90	17.50	7.90	17.50	42.10*
Total Harmonious (%)	100.00	100.00	100.00	100.00	17.50	68.50*	57.50	86.90	22.50	63.10*
Disharmonious Cluster Category										
E Depressed							2.50		7.50	5.30
F Being dissatisfied/scared					7.50		12.50	5.30	45.00	28.90
G Being determined by others					20.00	15.80	2.50	2.60	10.00	2.70
H Being angry/unlikable							7.50		7.50	
I Being unreliable					2.50		2.50			
J Rejecting					17.50	10.50		2.60	2.50	
K Subjugating					7.50					
L Annoying/Attacking					7.50					
M Withdrawing					20.00	5.20*	15.00	2.60*	5.00	
Total Disharmonious (%)					82.50	31.50*	42.50	13.10*	77.50	36.90*

Note. BPD = Borderline Personality Disorder (n = 40); MDD = Major Depressive Disorder (n = 38); WSO = Wish of Self for Other; WSS = Wish of Self for Self; RSO = Response of Self to Other; RSS = Response of Self to Self.

*$p < .05$.

2.4. DISCUSSION

The foremost aim of Study 1 was to operationalise therapists' response patterns using the CCRT-LU method. Similarities were found in therapists' desire to be confident in their therapeutic role. Furthermore, they expressed more frequent desires to help and support patients with depression and to facilitate independence in patients with borderline personality disorder. In general, patients with depression were perceived to respond with predominately harmonious relational patterns displaying an attentive and friendly style, while patients with borderline personality disorder were perceived to express more disharmonious responses. Therapists expressed a greater sense of feeling confident when working with patients with depression compared to patients with borderline personality disorder. The most frequent response towards all patients was one of support, suggesting that therapists engaged in an advanced empathic stance regardless of the patients' diagnosis. However, therapists reported withdrawing more from the borderline personality disorder patients compared to the depressed patients.

Statistically significant differences were found in the valence of therapists' responses. Predominately negative valence in relation to patients with borderline personality disorder may be indicative of the intensity of interpersonal interactions and contradictory responses emanating from patients of both withdrawing and being excessively dependent. This is consistent with previous findings that report patients with higher proportions of immature defenses also display more oppositional responses (de Roten et al., 2004). Defenses such as splitting (holding or oscillating between polarized views of self and others as either all good or all bad) and projective identification (projecting unrecognised troubling aspects of the self onto another) may evoke strong intrapersonal responses in the therapist (Clarkin, Yeoman & Kernberg,

1999; PDM Task Force, 2006). Therefore, ongoing internal dialogue that encourages therapist's personal awareness and insight, and clinical supervision in interpreting ones emotional responses, are important professional development skills necessary to avoid the enactment of the patient's response patterns. Contrary to the findings of Brody and Farber (1996), who reported that more experienced therapists are less likely to report experiencing negative affect, we found that the therapist's years of clinical experience or theoretical persuasion did not influence the valence of therapists' responses.

Although this study did not analyse the narrative episodes using the Connected Central Relationship Patterns (CCRP) methodology proposed by Dahlbender and colleagues (1998), an interpretation of the interconnected nature of the current findings is suggested. It would appear that the individual CCRT-LU components do not emerge in isolation but represent important interactive relations between the therapist and patient. Repetitive interpersonal themes in which the therapists' desire to be confident in supporting and facilitating change in the patient comes into conflict or is denied to a larger extent by patients with borderline personality disorder. Therapists typically described the behavioural tendencies of borderline personality disorder as withdrawing, and rejecting of others, while showing excessively dependent tendencies. For example, one therapist reported: "…she's quite antagonistic at times and then quite child-like at other times, she sort of flicks between the two. She would be pleading and trying to elicit a nurturing [and] mothering thing from me, and then at other times, she would be bombarding me with criticism that I'm a hopeless therapist". Another therapist offered this description of their patient: "She vacillated a lot between a response of anger and frustration and then she would also respond in a highly sort of dependent way trying to treat me, or put me on a pedestal". Likewise, another therapist reported: "This person attended therapy but at the same time resisted therapy or resisted participating in a

therapeutic relationship. [They] wouldn't disclose any information, [they were] defensive but at the same time wanted me to provide her with a magic wand, 'I've come here, you should be able to help me – where is it?'". Similarities in the therapists' responses to such behavioural tendencies are captured in the following: " So I feel like I'm constantly giving much less than what she is asking for, so there's this real kind of sense of almost feeling sorry for not being able to fulfil what she needs, I found that hard". Here the push-pull response of the patient to withdraw and to be dependent on the therapist for help, interplays with the therapist's wish to be confident and helpful, which results in the therapist experiencing a range of disharmonious self-responses.

These findings are consistent with clinical observations that patients with borderline personality disorder have behavioural tendencies that create various anxious and overwhelmed responses in therapists (Aviram et al., 2006; McHenry, 1994; McWilliams, 1994). Findings from Study 1 are also consistent with a number of previous empirical studies reporting an association between therapists' negative intrapersonal states towards stimuli representing borderline personality disorder psychopathology (Brody & Farber, 1996; McIntyre & Schwartz, 1998) and in relation to interactions with patients with borderline personality disorder (McCready, 1987; Rossberg et al., 2007).

An interesting comparison can be made between therapist's relational patterns found Study 1 and previous findings of CCRT patterns of patients with borderline personality disorder. Drapeau and Perry (2004) reported that patients with borderline personality disorder wished to be supported and attended to, while also wanting to withdraw from others. Notably, they perceived the responses of others as both rejecting and supporting, and expressed being dissatisfied and scared. It is possible that the borderline personality disorder patient's sensitivity to rejection, fear of establishing

relationships and negative beliefs about self and others (Boldero et al., 2009), result in interactions in which both therapist and patient express feeling receptive to wanting to provide or receive help, but then feel rejected, dissatisfied and scared. This ambivalent presentation is in marked contrast to patients with depression who do not appear to have this extreme interpersonal ambivalence or push-pull experience, but rather express their needs more simply with a wish to be happy (Chance et al., 2000; Vanheule, Desmet, Rosseel, & Meganck, 2006).

These findings suggest that the desire for interpersonal interaction is an overlapping feature of both diagnostic groups. However, the ambivalence towards intimacy is a discriminating relational feature which may reflect the splitting of object representations unique to borderline personality disorder psychopathology. Findings from Study 1 are inconsistent with the finding that borderline personality disorder traits were associated with therapists' feelings of helpfulness (Thylstrup & Hesse, 2008). The divergent findings may be due to the different clinical comparisons of antisocial personality disorder that was used in that study, highlighting the additional complexity of antisocial personality disorder in comparison to borderline personality disorder. Another possible explanation is that participants in the Thylstrup and Hesse study may have experienced minimal or casual patient contact, in contrast to intense individual therapeutic engagement in the present investigation. Thus participants may not have been strongly invested in a helping relationship or had not experienced inconsistent patient response patterns, and therefore were not as vulnerable to experiencing negative emotional and cognitive reactions. Further research is needed to establish whether therapists in long-term and intense therapeutic engagements experience different relational patterns compared to those that involve casual contact.

2.5. LIMITATIONS AND CONCLUSIONS

Study 1 is not without limitations. First, we used a snowball sampling technique to recruit participants. Therefore, results should be interpreted with caution, as it is difficult to ascertain whether the sample is representative of the wider population. The focus on the primary DSM-IV diagnosis of borderline personality disorder or major depressive disorder in this study did not include patient comorbidity. Given that patients with borderline personality disorder and depression frequently present with comorbid conditions, it is possible that comorbidity information would provide a broader picture of the patients' diagnostic characteristics. A common criticism levelled at all empirical investigations that rely on self-report data is the possibility of response bias motivated by social conformity. This is a significant confounding factor which needs to be considered. Therapists may have attempted to avoid judgment regarding their therapeutic ability. If this were the case we could assume that the results are a conservative approximation of the therapists' emotional and cognitive responses and would not be contributing to spurious "significant" results.

It is also possible that because therapists were not blind to the diagnostic status of the patient, the therapists' preconceived or patient stereotypes may have influenced results. Therapist's may have been inclined to mentally stress between-group differences, forget or minimize the common feature shared by these patients or report on particularly interesting and memorable cases. Likewise, they may have been inclined to choose patients that best fit the borderline personality disorder and depression typologies, increasing the likelihood to find between-group differences in the CCRT configurations. The use of one long narrative (RE) per patient may have also contributed to such bias as the RE reported may not have accurately reflected their entire relational experience but rather a stereotypical example. However, the results

presented here make sense in relation to clinical experience and show a consistent trend with analogue studies (e.g., Brody & Farber, 1996; McIntyre & Schwartz, 1998). Importantly, in the above studies, therapists were not aware which diagnostic group the emotion evoking stimulus represented. This suggests that stereotypes may not have contributed significantly to these results. Most importantly it must be recognised that Study 1 investigated therapist's retrospective accounts of their experiences of patients and their own emotional and cognitive reactions. As such, it should be kept in mind that the CCRT is a measure of the subjective experience, which does not equate to a direct measurement of actual patient-therapist interpersonal interactions.

Further research of a more in-depth nature, as gained by case studies, may be necessary to thoroughly investigate the many possible variables that contribute to therapists' cognitive and emotional responses in each patient-therapist dyad, such as therapist and patient attachment styles and perceptions of the working alliance (Botella et al., 2008; Martin, Buchheim, Berger, & Strauss, 2007). A broader picture of the therapist-patient interpersonal dynamics would be provided by future research employing an objective observer rated measure to code in-session transcripts.

To our knowledge this study is the first to code and score therapist's narratives using the CCRT-LU method. As such it provides support for the utility of clinical quantitative methodology to investigate the cognitive and emotional experiences of therapists. Therapists may utilize the CCRT-LU method to further their conceptualization, self-understanding and awareness of their countertransference response in their clinical work. Formulating interpersonal conflictual relationship themes from the therapist's perspective may be of value in understanding the relational pressures and enhance insight into the common themes and manifestations of their own emotional reactions. This may in turn better equip the therapist to remain disentangled from the patient's

pathology, and thus give guidance in training, self-care and supervision, as well as indirectly enhance the patient's therapeutic experience.

The results of study 1, using the CCRT-LU method, accord with theoretical and clinical literature that document the emotionally challenging and demanding nature of therapeutic engagement with patients with borderline personality disorder (Bateman & Fonagy, 2004; Clarkin et al., 1999; Gunderson, 2009b; Kernberg, 1968a; Linehan, 1993a; Young et al., 2003). From these findings Study 2 goes on to identify further detail in the therapist's response patterns using computer-assisted content analysis Leximancer (Smith & Humphreys, 2006) to classify prominent concepts and themes. Furthermore, using the same sample, Study 2 investigated patients' relational patterns using a quantitative self-report questionnaire (Psychotherapy Relationship Questionnaire; Bradley, Heim, & Westen, 2005). Thus, Study 2 employed both quantitative and qualitative methodologies in its design.

CHAPTER THREE

STUDY TWO: THERAPIST'S ACCOUNTS OF PSYCHOTHERAPY PROCESS WITH PATIENTS WITH BORDERLINE PERSONALITY DISORDER[2]

3.1. INTRODUCTION

It is often reported that mental health professionals view patients with borderline personality disorder as challenging (Shanks, Pfohl, Blum, & Black, 2011) and difficult to work with (Tyrer & Mulder, 2006). Study 1 indicated that the therapist is an active participator in the therapeutic relationship therefore at risk of being emotionally drained by the challenging nature of therapeutic work with patients with borderline personality disorder.

A small but growing body of evidence supports the investigation of therapist responses to psychotherapy with patients with borderline personality disorder (Brody & Farber, 1996; Holmqvist & Armelius, 1996; McIntyre & Schwartz, 1998; Rossberg et al., 2007; Thylstrup & Hesse, 2008). Holmqvist (2000b) showed how patients with borderline personality disorder were more likely to illicit angry and hostile emotional responses among therapists, compared to patients with psychotic disorders. Another study reported that clinicians experienced, to differing degrees, antagonistic judgments towards patients with borderline personality disorder experiencing suicidal tendencies (Bodner, Cohen-Fridel, & Iancu, 2011).

There is an understanding that the complex nature of treating patients with personality disorders lies not only with patient's behaviour but also in the therapist's response (Kernberg, 1968b; Linehan, 1993a; McWilliams, 1994). A number of

[2] This study is in press Journal of Personality Disorders.

overlapping constructs conceptualize the therapeutic process as an interactional process between therapist and patient, including alliance rupture and repair (Safran et al., 2001), pathways of emotional communication (Bucci, 2001), and transference-countertransference (Guy & Brady, 2001b; E. E. Jones, 2000; Kiesler, 2001; McWilliams, 1994; Meares, 2005). Findings from Study 1 suggests that therapists are consistent in their wish to help these patients, but that the way that wish is experienced by the patient can fluctuate and cycle between positive to negative, confirming the approach-avoidance interpersonal pattern of the patient in treatment (Bourke & Grenyer, 2010). It is possible that the responses of the therapist are evoked by the patient and thus are common experience shared by all who interact with the patient. The therapist's responses may therefore provide important clinical information about the patient's interpersonal problems (Anchin & Kiesler, 1982).

The Psychotherapy Relationship Questionnaire (PRQ; Westen, 2000) has been used to operationalize the construct of transference and investigate the structure of relational patterns in the therapeutic relationship. This clinician-report measure of patients' relational patterns is consistent with the therapeutic practice which relies on gathering data from clinical observation and judgment. Clinician-report data is considered a valid and reliable source of psychometric information, with strong correlations between independent observers (Western & Muderrisoglu, 2003).

The natural language used by the therapist to describe their experience also provides rich descriptive data. A variety of manual and computerised content analysis strategies are available to quantify such narrative data. Leximancer concept mapping software (Smith & Humphreys, 2006) is a popular alternative to hand coding, as it provides a graphical overview of the conceptual structure of large bodies of text. Three recent examples of how Leximancer has previously been used in clinical research

include to identify pathways to help-seeking in Bulimia Nervosa and Binge eating problems (Hepworth & Paxton, 2007), to examine conversations between carers and people with schizophrenia (Cretchley, Gallois, Chenery, & Smith, 2010) and recently to survey students' and programme directors' perspectives of postgraduate clinical programmes across Australia (Scott, Pachana, & Sofronoff, 2011) . There are a number of advantages of applying this system to the investigation of therapists' interview narratives. First, it enables an unrestricted, exploratory approach to text-mining. Second, an interview method can be used to generate flexible responses from participants as opposed to forced responses generated from simple word checklists. This preserves the original contextual quality of the responses and generates data that is directly linked to the narrative. Lastly, as Smith and Humphreys emphasize, this system is designed to expose the " context and significance of concepts and to help avoid fixation on particular anecdotal evidence, which may be atypical or erroneous" (2006, p. 262).

Research into therapists' response patterns is limited, in that analogue and field studies have frequently used simple affect checklists to study therapists' responses. The approach taken in Study 2 differs from previous approaches, being the first to use both qualitative and quantitative methodologies to investigate relational patterns within psychotherapy with patients with borderline personality disorder. The qualitative analysis of therapists' narratives may have the advantage of generating rich descriptive data suitable for concept mapping and thus the identification of prominent themes and concepts. In addition the use of an established instrument, the PRQ, may further elucidate the structure of relational patterns and thus allow deeper understanding of these issues (Bradley et al., 2005).

3.1.1. *Aims*

Study 1 highlighted the emotionally challenging nature of the therapeutic work with patients with borderline personality disorder. The broad aim of Study 2 was to extend these findings by identifying specific relational patterns expressed by the patient and prominent linguistic patterns expressed by the therapist. The first aim was to investigate consistent relational patterns expressed by patients, with either borderline personality disorder or major depressive disorder, towards the therapist. Secondly, Study 2 aimed to analyse concepts and themes discussed by therapists and furthermore investigate the interconnectedness of lexical terms in these narratives. Consistent with the broad trends found in Study 1of greater negative valance of therapists' perceptions of the response of the patient towards them (ROS), it was hypothesised that therapists would perceive patients to respond with greater hostile and narcissistic patterns as measured by the PRQ. It was also hypothesized that concepts and themes in therapists' responses when working with patients with borderline personality disorder compared to patients with depressive disorder, would be indicative of emotional distress.

3.2. METHOD

3.2.1. Participants

The therapist and patient sample was the same described in study 1 at 2.2.1.

3.2.2. Measures

The Psychotherapy Relationship Questionnaire (PRQ; Westen, 2000). The PRQ is a clinician-report questionnaire designed to measure a wide range of relational patterns consistently expressed by the patient towards the therapist. This 90-item instrument has both clinical and research utility for the purpose of operationalising patient's

interpersonal response patterns. Items such as “repeatedly tests or fails to respect the boundaries of the therapeutic relationship” are rated on a likert scale from 1 (not true) to 5 (very true). The factor structure consists of loadings onto six factors: (1) Hostile (2) Narcissistic, (3) Compliant/Anxious, (4) Positive working alliance, (5) Avoidant/Dismissing (6) Sexualized; with alpha coefficient ranges of 0.84-0.94 (Bradley et al., 2005).

Computer-assisted content analysis. 'Leximancer' is the term referring to a concept mapping approach that identifies prominent concepts and themes in textual data (Smith & Humphreys, 2006). This system goes beyond keyword searching by creating a thesaurus classifier specific to the lexical data being analysed. That is, identified lexical terms form the basis of a bootstrapping thesaurus build and the importance of the terms are ranked and weighted relative to how indicative they are of the target concept. When weighted terms within sentence blocks accumulate and reach the required threshold, a concept is tagged (Smith & Humphries, 2006). Clusters of three sentences were adopted here as recommended for long narrative. This facilitates an exploratory approach with minimal manual intervention, and allows existing concepts to emerge from the text.

The strength of association between concepts is indexed by the relative co-occurrence frequency (see Smith & Humphreys, 2006, for the statistical process underpinning the software). The interconnectedness of the concept matrices can then be graphically represented in a two-dimensional concept map using cluster analysis (Smith & Humphreys, 2006). Themes are labelled (when appropriate, themes can be renamed by the researcher) and displayed as circles. Related concepts are labelled and positioned within the theme. The size and location of the themes indicate patterns of association and centrality in the overall narrative. Therefore, themes and concepts that cluster together or overlap are closely related within the narrative, whereas those that appear

distant in the matrix are unrelated in the text. For example, a large circle labelled ‘sadness’ in the centre of the matrix enclosing words ‘distress’ and ‘depression’ would translate as a broad theme of ‘sadness’ appearing frequently throughout the text with related more specific concepts referring to ‘distress’ and ‘depression’.

3.2.3. Procedure

The procedure was the same as Study 1 described at *2.2.3*.

3.2.4. Statistical Analyses

Multilevel modelling (MLM) was utilized to account for the hierarchical structure of factor scores on the PRQ. Using a restricted maximum likelihood method in MLwiN version 2.13 (Browne, 2009), patient was modelled as Level 1 nested within therapist, modelled at Level 2, accounting for sample sizes differences at each level. Level 2 between-subjects effects of therapist years of experience and theoretical orientation (cognitive behaviour vs. interpersonal/psychodynamic) were also modelled. Next, we performed content analysis on therapist’s interview narratives to examine patterns in therapists’ natural language.

3.3. RESULTS

Patients’ Response Patterns

Multilevel modelling was used to examine the extent to which therapists’ perceptions of patient relational patterns differed as a result of variance due to the individual differences of the patient at level 1 and the therapist at level 2 of the model. This first intercept-only model was statistically significant ($p < .05$) indicating significant differences at both level 1 and 2. We then conducted a second model to test the extent to which factor scores differed as a result of variance due to the patient diagnosis. The effect of patient diagnosis was significant ($p < .05$) with coefficient, standard error (*SE*)

and model fit presented in Table 2. A coefficient twice the size of the *SE* indicates a significant ratio.

These results indicated that high scores on PRQ factors Hostile, Narcissistic, Compliant/Anxious, Avoidant/Dismissive, and Sexualized were significantly related to the diagnosis of BPD. High scores on Positive Working Alliance were associated with a diagnosis of MDD. Therapist's years of clinical experience and theoretical orientation was not a significant independent variable when included in the model, with only a minimal decrease in the deviance indices from model two to model three indicating that the model fit improved only marginally.

Table 2. Parameter estimates (and standard error) for multilevel modelling of Psychotherapy Relationship Questionnaire factor scores

Variable	Patient Diagnosis		Therapist		Deviance
PRQ Factors					
Hostility	0.75	(0.17)*			181.76
	0.76	(0.17)	-0.03	(0.23)	181.74
Narcissistic	1.07	(0.16)*			177.83
	1.08	(0.16)	-0.2	(0.21)	176.96
Compliance/Anxious	0.74	(0.16)*			178.15
	0.74	(0.16)	0.01	(0.23)	178.15
Positive working alliance	-0.34	(0.14)*			148.91
	-0.34	(0.14)	0.14	(0.16)	148.18
Avoidant/Dismissive	0.50	(0.15)*			168.64
	0.50	(0.15)	-0.02	(2.10)	168.67
Sexualised	0.33	(0.17)*			178.16
	0.37	(0.17)	-0.16	(0.20)	177.50

Note. *$p < .05$; PRQ = Psychotherapy Relationship Questionnaire; Therapist = Therapist variables years of experience and theoretical orientation

Themes and concepts portraying therapists' experiences in relation to patients with Borderline Personality Disorder

Four main themes within the matrix: 'destructive', 'felt' (given the interpretive label 'therapist response'), 'trust', and 'extreme'. As seen in Figure 3 the themes large size and central position indicate their importance in therapists' narratives. Four main themes emerged from the Leximancer analysis. 'Supervision' was a distal theme, with related concepts 'support' and 'empathic'. This theme partially overlapped with the theme 'therapist response', while the themes 'defensive' and 'engage' were positioned independently to the other themes in the matrix, indicating their unique nature. Related concepts to each theme can be seen in Table 3, together with concept frequency and thesaurus related words.

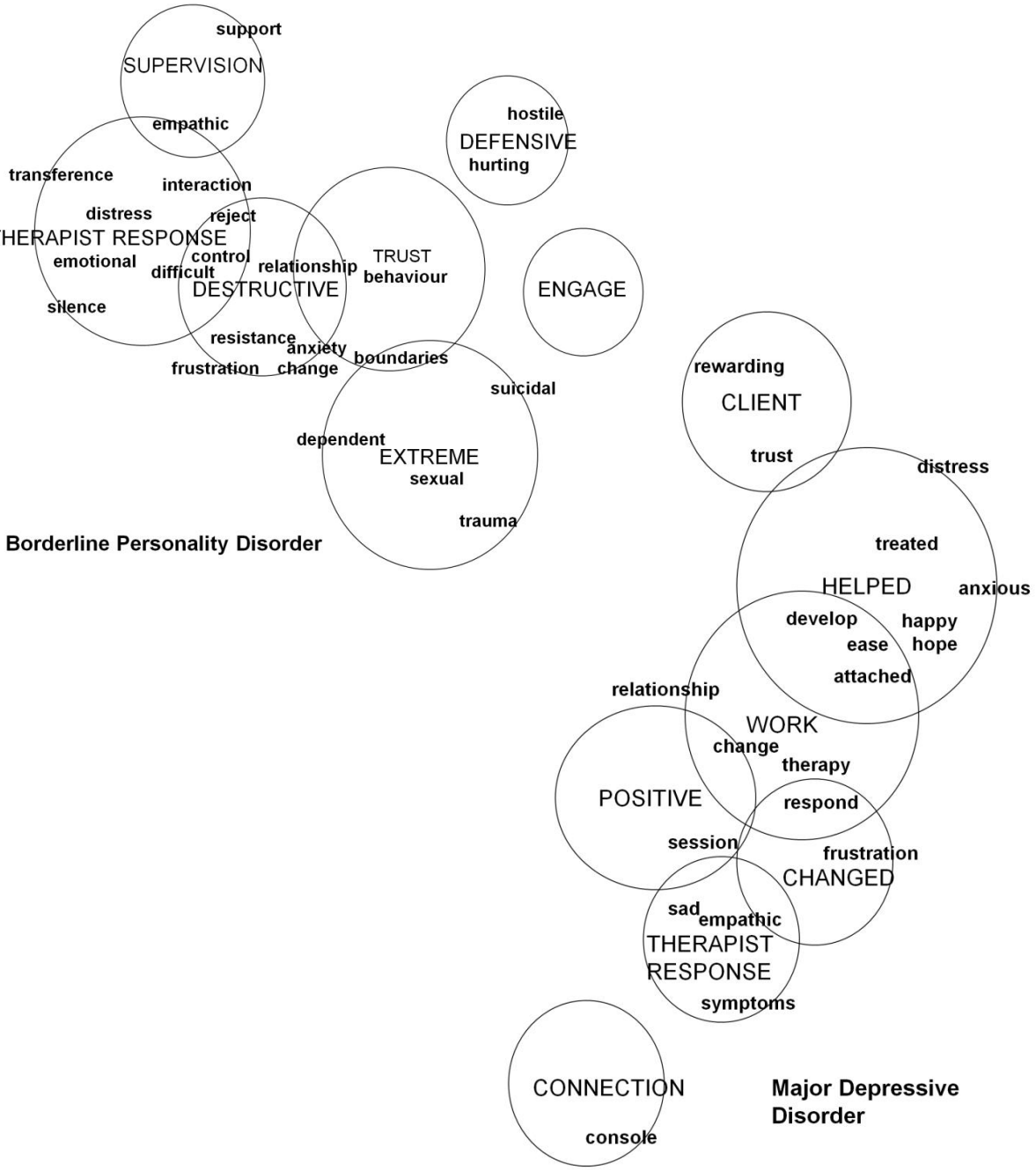

Figure 3. Concept maps produced by Leximancer highlighting prominent themes and concepts associated with therapists' response patterns in relation to patients with Borderline Personality Disorder and to patients with Major Depressive Disorder

Table 3. Prominent themes, concepts, and thesaurus words associated with therapists' perceptions of treating patients with Borderline Personality Disorder

Theme	Concept (%)	Thesaurus Identified Words
Destructive	Frustration (73)	Frustration, frustrate, frustrated, upset, irritate, irritated
	Resistance (59)	Resistance, resistant, deny
	Anxiety (54)	Anxiety, anxious, worried, angst
	Depression (32)	Depression, depressed, low mood, sad
	Change (23)	Change, changing, movement
	Reject (17)	Reject, rejection, push
	Relationship (15)	Relationship, rapport, connection
	Control (8)	Control, controlling, manipulate
	Difficult (12)	Difficult, hard, complex
	Empathic (4)	Empathic, empathy, protective, defend
Therapist response	Emotional (100)	Emotional, emotions, feel, feeling, felt
	Distress (75)	Distress, suffering, suffer, pain
	Interaction (59)	Interaction, interactions, interpersonal
	Silence (37)	Silence, still, slow
	Reject (17)	Reject, rejection, push
	Control (8)	Control, controlling, manipulate
	Difficult (12)	Difficult, hard, complex
	Transference (9)	Transference
	Empathic (4)	Empathic, empathy, protective, defend
Trust	Behavior (37)	Behavior, physical, complaining, acting-out
	Boundaries (25)	Boundaries, limits, restrict
	Relationship (15)	Relationship, rapport, connection
Extreme	Trauma (30)	Trauma, grief, loss, abuse
	Suicidal (35)	Suicidal, crisis, risk
	Dependent (25)	Dependent, depend, attention, rely
	Boundaries (25)	Boundaries, limits, restrict
	Sexual (21)	Sexual, sexualized
Supervision	Support (31)	Support, reassure, reassurance, comforting, confidence
	Empathic (4)	Empathic, empathy, protective, defend
Defensive	Hostile (41)	Hostile, hostility, antagonistic, argue, argumentative
	Hurting (39)	Hurting, hurt, pain, painful
Engage	Engage (3)	Engage, engaging, committed, commitment

Note. Percentage (%) refers to the percentage of times the concept occurs in the text compared to the most frequently occurring concept

Themes and concepts portraying therapists' experiences in relation to patients with Major Depressive Disorder

Central and prominent themes in therapists' descriptions of working with patients with MDD were 'work' and 'helped'. 'Therapist response' (identified as 'feel' by Leximancer) was part of an overlapping cluster of themes which also included, 'work', 'positive' and 'changed'. In total, six overlapping themes can be identified in the concept map, indicating a strong interconnectedness in the themes throughout the matrix. Table 4 presents associated concepts and their frequency in the text.

Table 4. Prominent themes, concepts, and thesaurus words associated with therapists' perceptions of treating patients with Major Depressive Disorder

Theme	Concept	Thesaurus Identified Words
Work	Relationship (100)	Relationship, rapport, connection
	Doing (43)	Doing, responsible, serious
	Change (53)	Change, adjust, regulate, evolved
	Respond (31)	Respond, responds, reply, improvement
	Therapy (28)	Therapy, treatment, therapeutic
	Attached (23)	Attached, attachment, bond, together
	Ease (21)	Ease, simple, enjoyment
	Develop (15)	Develop, development, progress
Therapist response	Empathic (89)	Empathic, empathy, empathize, understand
	Symptom (87)	Symptom, sign, medical, withdrawn
	Sad (45)	Sad, sadness, grief, loss, losses
Helped	Anxious (79)	Anxious, anxiety, stress,
	Distress (56)	Distress, distressed, suffering
	Angry (40)	Angry, anger, distancing
	Develop (35)	Develop, development, progress
	Issues (30)	Issues, core, abandonment, struggling
	Treated (32)	Treated, treatment, achieving, management
	Hope (35)	Hope, hoping, hopeful, wish, expect
	Happy (37)	Happy, pleased, glad, laugh
	Attached (23)	Attached, involved, friendly
	Ease (21)	Ease, simple, enjoyment
Client	Rewarding (89)	Rewarding, reward, achieve
	Trust (79)	Trust, confident, satisfying
Changed	Responsibility (60)	Responsibility, responsible, independence
	Frustration (32)	Frustration, frustrated, inability, barriers
	Respond (31)	Respond, responds, reply, improvement
	Therapy (28)	Therapy, treatment, therapeutic
Positive	Session (25)	Session, sessions, therapy, therapeutic
	Depressed (18)	Depressed, depression, despair
Connection	Console (30)	Console, mothering, regulate

Note. Percentage (%) refers to the percentage of times the concept occurs in the text compared to the most frequently occurring concept

3.4. DISCUSSION

Linguistic analysis identified the theme ‘therapist response’ in both the borderline personality disorder and depressive disorder matrix, yet the words frequently found in each matrix relating to this theme are in striking contrast. For example, ‘reject’, ‘control’, difficult’, ‘empathic’, ‘emotional’ and ‘distress’ related to patients with borderline personality disorder and ‘empathic’, ‘sad’ and ‘symptoms’ related to patients with depression. This finding is consistent with our hypothesis suggesting that therapists experienced greater emotional distress when working with patients with borderline personality disorder compared to patients with depression. Furthermore, therapists described the behavioural tendencies of patients with borderline personality disorder as self-destructive and resistant, in contrast to patients with depression who were described with words ‘respond’, ‘ease’, ‘develop’ and ‘attached’. Overall the themes and concepts in the matrix for the depressed group had a positive emotional valence to the descriptive tone. The concept of ‘relationship’ was also present in both matrixes. However in the borderline personality disorder matrix it occurred with the themes ‘trust’, and ‘destructive’ in contrast to the themes therapeutic ‘work’ and ‘change’, in the depressive disorder matrix.

Results suggest that therapists experience a more harmonious alliance and working relationship with patients with depression, where as they experience a push-pull interpersonal dynamic and are under greater pressure to forge a successful therapeutic relationship when working with patients in the borderline personality disorder group. Factor scores on the PRQ are consistent with identified themes and concepts. Therapists perceived patients with borderline personality disorder to use hostile, narcissistic, compliant and anxious, and sexualised responses with greater

frequency compared to depressed patients. That is, patients with borderline personality disorder appeared to therapists to be conflicted between anxious and compliant tendencies, fearing rejection and criticism, in conjunction with dismissive, angry, and seductive behaviour. These results suggest that therapists perceived the borderline group to display greater variety of attitudes and affects in their interpersonal interactions compared to patients from the depression group. Results from Study 2 did not find evidence that therapist years of experience and theoretical orientation accounted for significant variance in their assessment of patient transference patterns. It is probable that relationship skill in managing such patients is particularly important and that mere age or experience confers only a weak relationship to this skill development, compared to differences in attitude and capacity for empathy towards patients.

Taken together these results suggest that the extremes in the relational style of the patient with borderline personality disorder places demands on the therapist not only in managing the patient's relational patterns, but also in managing their own emotional and cognitive responses. Therapists frequently referred to an awareness of their own anxiety and emotional distress and made reference to the need to maintain therapeutic 'boundaries' in the relationship with patients with borderline personality disorder. This may be indicative of intense negative interactions and the contradictory affect associated with patient maladaptive interpersonal interactions. Furthermore, speech analysis identified that the theme 'supervision' was a feature only in the borderline personality disorder matrix. Supervision appeared to play a greater role in therapeutic practice to help therapists maintain a positive therapeutic frame towards patients with borderline personality disorder, while an empathic connection seemed to develop with greater ease towards patients with depression who were reported to make greater positive therapeutic contributions and engage in a cohesive working alliance. This is an

interesting finding especially when taken together with the findings from Holmqvist (2000a) who reported that negative staff feelings that shift to positive feeling over time were associated with positive therapeutic outcomes for patients with borderline personality disorder. Thus, supervision in assisting therapists in managing their emotional responses may have a direct influence on patient treatment outcomes.

Increasing therapists' understanding and awareness of these interactional entanglements may be a protective factor that enhances their skill set in a way that allows them to work more effectively with patients that are highly dependent on therapeutic help yet, respond with reactive and resistant attachment. Gabbard and Wilkinson (1994) emphasize that therapists' awareness and understanding of their emotional responses is only one aspect of the psychotherapy process. Supervision to support the therapists' capacity for meta-cognitive monitoring (Bateman & Fonagy, 2004), and thus become less reactive, may further allow the therapist to integrate and translate emotional responses with greater therapeutic effect. The results further support the impact of work with patients with borderline personality disorder on the therapist. Findings from Study 2 validate therapist's difficulties in managing the therapeutic relationship. Major themes of attachment and emotional dyscontrol reinforce that therapists need to keeping their interventions simple, safe and in the here-and-now, to mitigate further tensions in the relationship.

3.5. LIMITATIONS AND CONCLUSIONS

There are several limitations that must be considered when interpreting the results of Study 2. First, the sample recruitment involved a snowball methodology therefore this convenience sample may not be representative of a broad cross section of therapists.

Further research that involves a broader recruitment approach would be beneficial in extending the current findings. Second, therapists reported on their experiences retrospectively and in so doing may have experienced recall bias. For instance, therapists may filter their recall of the actual event with a degree of hindsight bias with regards to how they felt, or what they and their patients said. It is difficult to determine the extent of this as a confounding factor since it would be very difficult to design a study of this type that did not involve recall by therapists. Thirdly, responses may be motivated by social conformity and the desire to avoid negative judgments regarding their professional ability. In considering this confounding factor, it is suggested that such an influence would be across the entire data set and would be less likely to increase group differences. Furthermore, therapists' preconceived beliefs about patient stereotypes may have contributed to between-group differences. However, due to the consistency of our results with analogue studies (e.g., Brody & Farber, 1996; McIntyre & Schwartz, 1998), in which participants were blind to the diagnostic status of the stimulus material, we propose that stereotype bias is unlikely to have contributed to spurious results.

In summary, therapists perceived patients with borderline personality disorder as more resistant and defensive, and reported greater emotional distress and an increased need for supportive supervision. While these findings are not counterintuitive, they underscore common themes experienced by therapists in their clinical work with patients with resistant and defensive interpersonal patterns. Study 3, goes on to understand the therapist's emotional world through their language. Therefore, this forthcoming study focuses on the therapist and how emotional engagements in the therapeutic milieu influence linguistic, affective and cognitive processes.

CHAPTER FOUR

STUDY THREE: THERAPIST'S LINGUISTIC, AFFECTIVE AND COGNITIVE PROCESSES IN THE TREATMENT OF BORDERLINE PERSONALITY DISORDER[3]

4.1. INTRODUCTION

We are well informed from clinical and theoretical reports of the 'difficult' and emotionally charged nature of therapeutic work with patients with borderline personality disorder (Bourke & Grenyer, 2010; Linehan et al., 2000). We are less conversant with how these emotionally charged engagements influence therapists' capacity to mentalise. The words that people use in natural language have been found to be psychologically revealing, particularly when the person is describing emotion laden experiences (Pennebaker, Mehl, & Niederhoffer, 2003). This is not a new or novel phenomenon with Freud (1901) first pointing to the revealing nature of a person's slips of the tongue, betraying implicit desires, motives and fears. More recently, it has been suggested that a person's linguistic style is marked by pronouns, emotion-related words, and cognitive or thinking words (Pennebaker et al., 2003), revealing psychological processes. More specifically, words representing insight (e.g., think, understand, realize) and causality (e.g., cause, because, effect) have been found to have a positive correlation with higher levels of student health and academic achievement (K. Klein & Boals, 2001) while suicidal poets have been found to use more first person pronouns in their poetry than nonsuicidal poets (Stirman & Pennebaker, 2001).

[3] A manuscript from this study is in review in the Bulletin of the Menninger Clinic.

4.1.1. *Aims*

The aim of Study 3 was to examine therapists' natural language when recalling and mentalising on their experiences of the therapeutic process with patients with borderline personality disorder and patients with major depression. It is possible that therapists' natural word use will reveal clinically important information, and provide a window into the therapist's psychological processes. The use of content analysis to identify the linguistic style of therapists when discussing their actual patients has the advantage of external validity and clinical application, thus furthering our understanding of the therapeutic process with patients with borderline personality disorder. To our knowledge this is the first study to investigate the linguistic style of therapists. While we expected that therapists would use higher negative emotion words when talking about their patients with borderline personality disorder compared to their patients with depression, we did not hold any prior predictions about the detail of the therapists' linguistic patterns. Without prior findings on which to make aprior predictions, we conducted this study from a predominately exploratory approach.

4.2. METHOD

4.2.1. Participants

The therapist and patient sample was the same described in study 1 at 2.2.1.

4.2.2. Measure

Linguistic Inquiry and Word Count (LIWC). The LIWC is a text analysis application designed to investigate cognitive, emotional and structural components in verbal and written speech samples (Pennebaker et al., 2007). The most recent version, LIWC2007, analyses over 86% of words used in natural languages, matching text words with words

in a default dictionary file with 66 thematic word categories (e.g., positive emotion words). Approximately, 80 output variables are expressed as percentages of total word use in any given speech/text sample. For the purpose of this study variables that are classified into the following broad dimensions were utilised: standard linguistic processes (e.g., percentage of words that are pronouns, verbs etc.), psychological constructs (e.g., affect, cognition), and paralinguistic dimensions (e.g., fillers and nonfluencies). LIWC scales highly correlate with independent judges' ratings. For details on external validity, and external and internal reliability of each variable consult the LIWC2007 Manual (Pennebaker et al., 2007).

4.2.3. Procedure

The procedure was the same as Study 1 described at *2.2.3*.

4.2.4. Statistical Analyses

Discriminate function analysis was used to examine the extent to which the lexical complexity of therapists' speech samples differed as a function of the diagnostic category of the patient being discussed.

4.3. RESULTS

Analysis of Lexical Complexity

A discriminate analysis was used to determine if patients from diagnostic groups, (borderline and depressed), were discussed by therapists using differential linguistic, cognitive and spoken categories. Predictor variables of linguistic processes were: total function words, pronouns (i.e., personal, 1st person singular, 1st person plural, 2nd person, 3rd person singular, 3rd person plural, impersonal), articles, common verbs, auxiliary verbs, past tense, present tense, future tense, adverbs, prepositions,

conjunctions, negations, quantifiers, numbers, and swear words. Predictor variables of psychological processes were: affective processes, positive emotion, negative emotion, anxiety, anger, sadness, cognitive processes, insight, causation, discrepancy, tentative, certainty, inhibition, inclusive, and exclusive. Predictor variables of spoken categories were: assent, nonfluencies, and fillers. The discriminate function revealed a significant association between diagnostic groups and 20 predictors accounting for 84.64% of the variance (Wilks $\lambda = .16$, Chi-square = 120.53, df = 20, Canonical correlation = .92, $p <$ .000). A closer analysis of the structure matrix using a cutoff of +/- .30 identified 12 significant predictors. Higher use of words associated with fillers, anger, negative emotions, anxiety, sadness, tentative, 1st person singular pronouns and adverbs were associated with the borderline group compared to the depressed group. Lower word use portraying positive emotions, cognitive processes, causation, and insight were associated with the borderline group compared to the depressed group. Table 5 presents, standardized conical coefficients and structure weights of lexical variables that contributed to the multivariate effect. The linear combination of predictor variables accurately classified 100% of patient group membership.

Table 5. Lexical variables, mean, standard deviation *(SD)*, standardized conical coefficients and structure weights form the discriminate model

	Grand Mean (*SD*)					
	BPD Group (*N* = 40)		MDD Group (*N* = 38)		Canonical Coefficients	Structure Weights
Linguistic Processes						
1st person singular pronoun (*I, me, mine*)	4.86	(1.25)	3.62	(1.62)	0.52	-.32
Adverbs (*very, really, quickly*)	5.56	(1.28)	4.79	(1.46)	-0.04	-.42
Psychological Processes						
Positive emotion (*love, nice, sweet*)	1.77	(0.56)	9.33	(0.56)	1.12	.53
Negative emotion (*hurt, ugly, nasty*)	11.11	(3.14)	1.56	(0.72)	0.17	-.62
Anxiety (*worried, fearful, nervous*)	3.88	(1.23)	0.40	(0.38)	0.11	-.56
Anger (*annoy, disgust, defensive*)	4.79	(1.41)	0.35	(0.30)	- 0.91	-.64
Sadness (*cry, grief, sad*)	2.06	(0.61)	0.46	(0.26)	0.38	-.50
Cognitive processes (*cause, know, ought*)	20.05	(1.93)	34.35	(6.02)	0.84	.48
Insight (*think, know, consider*)	2.93	(0.63)	4.89	(0.91)	0.17	.37
Causation (*because, effect, hence*)	1.62	(0.58)	15.75	(6.34)	- 0.64	.47
Tentative (*maybe, perhaps, guess*)	4.71	(1.43)	3.22	(1.17)	-0.33	-.37
Spoken categories						
Fillers (*blah, I mean, you know*)	8.91	(1.92)	1.77	(1.33)	- 0.60	-.64

4.4. DISCUSSION

Using an explorative approach, Study 3 aimed to identify specific linguistic markers of therapists' mentalisation when discussing patients with BPD compared to patients with depression. Results indicate that therapists used different linguistic styles when discussing patients from each diagnostic group. Consistent with reports that therapists experience various anxious and overwhelmed responses towards patients with borderline personality disorder (Aviram et al., 2006; Shanks et al., 2011), therapists in this study also expressed more negative affect, using more words describing anxious, angry and sad emotions in when discussing their work with patients with borderline personality disorder. They were also less likely to use words related to cognitive processes (understood, thought, consider), insight (accept, believe, means), and causation (change, because, solution). Furthermore, therapists provided a more tentative (usually, guess, seem), descriptive account of psychotherapy process and used more first person singular pronouns. High use of first person pronouns has been found to relate to an increase in self-focus (Ickes, Reihead, & Patterson, 1986).

One possible explanation for the linguistic patterns in Study 3 is that heightened emotional processing overloads cognitive processing, effectively impairing the therapists' metalizing ability. Other differences in therapists linguistic features were the higher use of intensive adverbs (very, really, quickly), when discussing patients with borderline personality disorder compared to patients with depression. It is possible that the therapists' word choice is influenced by their affective processes, expressing the extremes in their emotional tone (e.g., "it was *very* frustrating to..." "I felt *really* nervous..."), and thus use more adverbs in their narratives. Therapists also differed in

their spoken categories using more linguistic fillers (e.g., I mean, you know, blah), when they spoke about patients with BPD compared to patients with depression. It has been found that linguistic fillers serve as a pause in the speakers narrative and are a cue to the speaker's metacognitive states (Brennan & Williams, 1995). A speaker is more likely to use fillers when they are unsure of the answer demonstrating greater cognitive load, uncertainty and difficulty in answering.

Another explanation is that deficits in the patient's executive functioning such as social cognitions, reflective functioning, are reflected in suicidal behaviour, risky decision making, cognitive distortions, reduced empathic awareness, and poor treatment adherence (Mak & Lam, 2013), interfere or strain therapists' neurocognitive processing. The clinical implications of these findings concur with previous clinical observations that therapists treating patients with maladaptive interpersonal relationship patterns, such as those with borderline personality disorder psychopathology, may be at greater vulnerability of being drawn into a cyclical-relational pattern (McWilliams, 1994).

Contemporary views of the analytic situation demonstrate that the therapist is not a blank screen, moreover therapists' responses may differ in relation to the patients relational patterns (Hölzer, Mergenthaler, Pokorny, Kächele, & Luborsky, 1996; Lenzenweger et al., 2008) . Furthermore, Bourke and Grenyer (2010) suggest that therapists perceive patients with BPD to have more disharmonious interpersonal patterns, while therapists themselves experience more negative feelings and are less confident in their therapeutic ability when working with this patient group. From a Core Conflictual Relational Theme (CCRT; Luborsky, 1998a) perspective, a therapist may be triggered to react to the patients' response (RO) in a rejecting or angry way, which in turn reinforces the patients' expectations of others as hostile and rejecting (Drapeau & Perry, 2004). It is suggested that therapists who work with patients with borderline

personality disorder play special attention to their own mentalising processes. An awareness of speech patterns, that is: heightened negative emotionality; frequent use of first person pronouns, adverbs, linguistic fillers and tentative words, as well as, less frequent use of words indicating insight and causation, may inform both the therapist and the supervisor that the therapist is experiencing heightened self-focus and may be limited in their mentalising ability.

4.5. LIMITATIONS AND CONCLUSIONS

The limitations of Study 3 must be considered when interpreting these results. As with Studies 1 and 2, findings are based on a sample recruited using a snowball methodology, therefore therapists in this study may not be representative of the general population. Further research would benefit if a randomised recruitment procedure were implemented.

To conclude, despite inherent limitations, Study 3 has been an important preliminary examination of therapists' linguistic styles when mentalising on their work with patients with borderline personality disorder. Furthermore, the results point to the potential value of computer-based analysis in a clinical paradigm. Taken together these findings offer preliminary empirical evidence of specific markers of therapists' differential psychological processes in mentalising on their patients. These results probably parallel and reflect the challenges therapists face when thinking and working in the psychotherapy session. They thereby contribute to our understanding and awareness of therapists' cognitive and affective processes when working with patients with borderline pathology, which can assist in preparing therapists for work with this patient group. Furthermore these results may be informative about processes likely to be present when therapists consult with senior colleagues for supervision and guidance with regards

to their clinical work. The proceeding investigation, Study 4, involves a detailed analysis of therapist/patient interactions during psychotherapy.

CHAPTER FIVE

STUDY FOUR: THE INTERIOR OF PSYCHOTHERAPY WITH PATIENTS WITH BORDERLINE PERSONALITY DISORDER

5.1 INTRODUCTION

A number of review articles have emphasised the centrality of therapists' cognitive and emotional response to the therapeutic process and have highlighted the need for further empirically research (Fauth, 2006; Harris, 1999; Hayes, 2004; Najavits, 2000; Rosenberger & Hayes, 2002; Schwartz & Welding, 2003). A detailed analysis that identifies clinically important moments in therapeutic interactions between therapists and patients with borderline personality disorder is yet to be conducted. Given the extensive clinical and theoretical support of therapist's reporting 'difficult' therapeutic engagements with patients with borderline personality disorder (Linehan, et al., 2000), there is considerable value in studying therapist-patient interactions. Moreover, research into patient and therapist response patterns may deepen our understanding of the therapeutic process.

Erhard Mergenthaler (1996) has developed a model of psychotherapy process that describes temporal variations in patient and therapist emotional, cognitive and behavioural variables known as the therapeutic cycles model (TCM). Using computerised statistical analysis these patterns can be tracked in a cyclical manner within sessions and across complete treatments (Mergenthaler, 2008). Furthermore, session characteristics of critical moments of therapeutic change and ruptures in psychotherapeutic processes can be identified and analysed in detail. Using the TCM McCarthy and colleagues (2011) identified patterns of therapist interventions and key moments of therapeutic change for the patient. A number of other studies have identified the utility of the TCM, identifying clinically significant events and cyclical

patterns in therapist-patient dialogue (Lepper & Mergenthaler, 2007, 2008). The TCM conceptualises the narrative styles of both the therapist and the patient as composed of emotional language or tone and conceptual language or abstraction. Figure 4 depicts a prototypical therapeutic cycle which is thought to represent heightened therapist-patient engagement. Therapeutic process can be differentiated into four emotion-abstraction patterns that vary in the amount of emotional and conceptual language above and below the mean. A sequence of relaxing, experiencing, connecting and returning to a relaxing phase completes a therapeutic cycle and is representative of significant change moments (Lepper & Mergenthaler, 2005).

In the relaxing phase emotional tone and abstraction are equal to or below the mean. You can see this in the first three bars of Figure 4. Here the patient is describing what they are talking about. During the experiencing phase there is much emotional tone and little abstraction. This is evident when conflictual themes are being experienced emotionally with either positive or negative valence to the emotion. The connecting phase is when emotional tone and abstraction are both high. Here the patient has found emotional access to conflictual themes and they can reflect on them. The connecting phases often coincide with moments of insight or change. And finally the reflecting stage, emotional tone is low and abstraction is high. Here the patient discusses topics without intervening emotions, often seen when intellectualising.

Therapist interventions may assist and support the patient to move through each stage by helping to regulate and connect emotional tone and abstraction. When the patient is having difficulty accessing emotions the therapist may initiate deepening, for example by asking questions to trigger feelings or emphasise emotions, for example "You are alone and feel abandoned". When the patient is stuck in the experiencing phase, or unable to reflect on their feelings the therapist may encourage a connecting

phase by increasing conceptual language, for example by asking, "What does this mean to you"? (Fontao & Mergenthaler, 2008). Therapeutic change is observable after steady repetition of therapeutic cycles in the clinical discourse (Lepper & Mergenthaler, 2008).

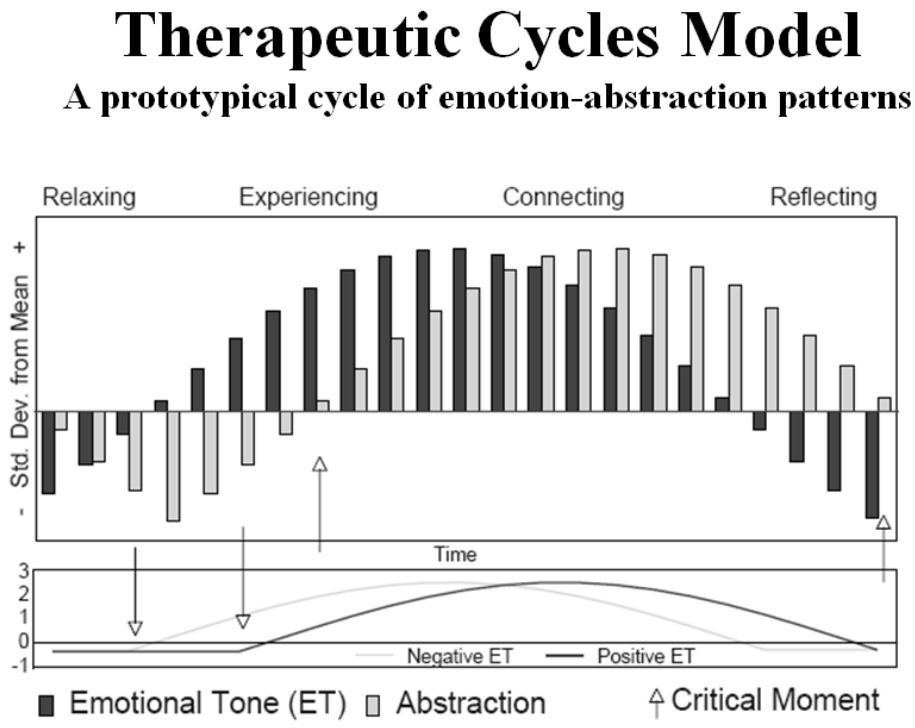

Figure 4. Prototypical therapeutic cycle: linguistic patterns above and below the mean of abstraction and emotional tone (Mergenthaler, 1996, p. 1308).

5.1.1. Aim

The foremost aim of this pilot study was to discover in-session linguistic interactions between a therapists and a patient with borderline personality disorder in comparison to a patients with depression. This study further aimed to identify key moments in therapeutic process that differ as a function of the patient's diagnosis. It was hypothesised that change moments or shift events identified by the TCM in the session with the patient with borderline personality disorder will be characterised by

high levels of experiencing. In contrast we expected that shift events identified in the session with the patient with depression will be characterised by high levels of connecting. In addition we hypothesised that therapists would intervene in attempts to bring about shift event more frequently in the session with the patient with borderline personality disorder compared to the session with the patient with depression. Such information, will in turn, inform treatment guidelines for therapists aiming to work with this clinical population. Furthermore, this clinically important information has utility in providing additional guidance for therapists in training and supervision (Hayes & Gelso, 2001; Reiser & Levenson, 1984). To the best of our knowledge, a microanalysis of in-session processes with patients with borderline personality disorder has not previously been performed therefore, this was an original study.

5.2 METHOD

5.2.1. Data source

Archival in vivo transcripts of two psychotherapy sessions were compared.

All participants gave written informed consent following Institutional Review Board approval for this study. The treating clinician in both sessions was a doctoral-level clinical psychologist who had 14 years post-internship experience. She was 44 years of age and identified with an interpersonal-dynamic theoretical orientation. The data studied were single sessions of a patient with a DSM-IV diagnosis of Borderline Personality Disorder and a patient with DSM-IV diagnosis of Major Depressive Disorder. Both in-session transcripts were session seven of the patient's treatment.

The first transcript was a 30 year-old unmarried female with the following DSM diagnosis:

Axis II	301.83 Borderline Personality Disorder
Axis IV	Psychosocial stressors
	Isolation/ few friends
	Employment stress
Axis V	GAF 60

The second transcript was a 42-year-old married man with two children with the following DSM diagnosis:

Axis I	296.30 Major Depressive Disorder, Recurrent, Unspecified
	304.30 Cannabis Dependence (28 yrs)
Axis IV	Psychosocial stressors
Axis V	GAF 65

5.2.3. Measures

Psychotherapy Process Q-set (PQS)

The PQS is an observer rated coding system comprising of 100 items. Session transcripts are coded on a wide range of patient and therapist attitudes and behaviours and as well as therapist-patient interactions. This allows for a systematic investigation and comparative analysis using a standard language for describing psychotherapy process. The PQS is commonly used to identify processes that predict positive outcome (Ablon & Jones, 2002), and to determine specific processes that distinguish models of psychotherapy (Ablon, Levy, & Katzenstein, 2006; Sirigatti, 2004). To date, this is the first study to use the PQS in a comparative analysis of disorder specific psychotherapy processes.

Computer-assisted content analysis

The TCM (Mergenthaler, 1996) was used to explore process factors in the treatment of a patients with borderline personality disorder compared to a patient with depression. The TCM uses pre-set lexical dictionaries to identify words related to emotional tone, abstraction, and narrative style, and has been demonstrated to reliably identify key moments of change within psychotherapy sessions (Mergenthaler, 2008). For each word block of 150 words an emotion-abstraction pattern of either, relaxing, experiencing, connecting or reflecting was identified. Significant change events are conceptualised as a cycle containing at least one connecting phase that is proceeded and followed by a relaxing phase (Mergenthaler, 2008).

5.2.4. Data Analysis

Using methodology described by Jones (2000) session transcripts were analysed and coded to identify most and least characteristic Q-sort items. Two transcripts from the same therapist, one with a patient with borderline personality disorder and one with a patient with major depressive disorder were coded and scored by two independent judges. Judges had undergone extensive training to establish reliability and reached an inter-rater reliability of $r = .80$.

The TCM (Mergenthaler, 2008) was used to compare therapist and patient emotional tone, abstraction (conceptual language), and narrative style. Microanalysis of the in-session transcripts were performed using the University of Ulm Cycles Model software.

Patient and patient/therapist linguistic patterns

The proportion of emotional and abstraction patterns within each transcript were analysed using only the patient data and again using both the patient and the therapist.

Thus, the relative percentages that the patient spent in each of emotion-abstraction pattern (relaxing, experiencing, connection, reflecting) was calculated as a proportion of the total number of word blocks. For example, if the patient was in a relaxing phase for 14 word blocks out of the entire 46 word blocks for the session, this was reported as the patient spending 30.43% of the session in the relaxing phase. The breakdown of the emotion-abstraction patterns for the combined patient and therapist language patterns were calculated in the same manner.

Change in linguistic patterns influenced by therapist

The overall change in emotion/abstraction patterns attributable to the therapist's interventions were calculated by the sum of percentage difference in emotion/abstraction patterns of the patient alone and patient/therapist combined. For example, if there was a difference in the patient and patient/therapist emotion/abstraction patterns of 2% relaxing, 5% reflecting, 3.30% connecting, and 5% experiencing, the total overall therapeutic change attributable to the therapist's interventions would be 15.3%, being the sum of these differences. The number of times the therapist's interventions resulted in a change in the emotion-abstraction pattern were counted. Additionally, the number of therapist interventions that resulted in pattern changes was calculated as a proportion of overall changes in the emotion-abstraction patterns.

5.3. RESULTS

Psychotherapy Process Q-set

Session 7 with the patient with borderline personality disorder, as presented in Table 6, was strongly characterised by the patient's expressions of self-accusatory, shame and

guilt, well as, experiencing emotional discomfort (Q-sort item 26), high tension and anxiety (Q-sort item 9), feelings of inadequacy and inferiority (Q-sort item 59). The patient discusses their experiences as if distance from their feelings (Q-sort item 56). The therapist was tactful (Q-sort item 77) and refrained from making condescending or patronizing remarks (Q-sort item 51). The patient's treatment goals (Q-sort item 24) and the meaning of other's behaviour (Q-sort item 4) were not topics of discussion in that session, rather the therapist made remarks aimed at facilitating the patients' speech (Q-sort item 3).

Table 6**.** Rank ordering of Q-Items for patients with Borderline Personality Disorder

	PQS item and no.	*M*
	5 Most Characteristic items	
71	P is self-accusatory; expresses shame and guilt	9.0
9	P is anxious or tense	9.0 [a]
3	T's remarks are aimed at facilitating patient speech	8.5
26	P experiences discomforting or troublesome affect	8.0
59	P feels inadequate and inferior (vs. effective and superior)	8.0
	5 Least Characteristic items	
51	T condescends to or patronises the patient	1.0 [a]
77	T's own emotional conflicts intrude into the relationship	1.5
24	T discusses patient's treatment goals	2.0
4	T suggests the meaning of other's behaviour	2.0
56	P discusses experiences as if distance from his or her feelings	2.5

Note. Means for session 7; PQS = Psychotherapy Process Q-set; T = Therapist; P = Patient.
[a] Indicates those items that were also among the most or least characteristic items for therapist or patient with major depressive disorder.

Session 7 with the patient with major depressive disorder, as presented in Table 7, was strongly characterised by discussions about the patient's interpersonal relationships (Q-sort item 63), more specifically the patient's love and romantic relationships (Q-sort item 64). The patient was able to explore their own inner thoughts

and feelings (Q-sort item 97). Furthermore, the therapist encouraged the patient's introspection by emphasizing the patient's feelings, asking for greater elaboration (Q-sort item 31) and thus promoted the emotional experience at a deep level (Q-sort item 81). The patient presented in a relaxed (Q-sort item 9) and cooperative manner (Q-sort item 58). The therapist worked with the patient in a respectful and thoughtful manner (Q-sort item 77 and Q-sort item51).

Table 7**.** Rank ordering of Q-Items for patients with Major Depressive Disorder

PQS items and item numbers		
	5 Most Characteristic items	*M*
63	P's interpersonal relationships are a major theme	9.0
97	P is introspective, readily explores inner thoughts and feelings	8.5
81	T emphasises patient's feelings in order to help him/her experience them more deeply	8.0
64	P's love and romantic relationships are a topic of discussion	8.0
31	T asks for more information or elaboration	8.0
	5 Least Characteristic items	
9	P is anxious or tense	1.0 [a]
15	P does not initiate topics; is passive	1.0
58	P resists examining thoughts, reactions, or motivations related to problems	1.0
77	T is tactless	1.0
51	T condescends to or patronises the patient	1.5 [a]

Note. Means for session 7; PQS = Psychotherapy Process Q-set; T = Therapist; P = Patient.
[a] Indicates those items that were also among the most or least characteristic items for therapist or patient with borderline personality disorder.

Therapeutic cycles

The results from the TCM analysis of Session 7 with the patient with borderline personality disorder are presented in Figure 5. Based on the therapist/patient linguistic patterns (bottom graph), three therapeutic cycles can be identified (represented as circles on the graph) and appear across 20 of the 50 session word blocks. That is, the patient

spent 40% of the session in a therapeutic cycle. Working from left to right on the graph, the first therapeutic cycle is marked by a rather high emotional tone relative to abstraction, leading to a connecting block in word block 12. The second therapeutic cycle reveals a strong connecting profile with four connecting blocks in word blocks 27, 28, 29, and 30. The third therapeutic cycle is spread over two parts with the first part being characterized by high abstraction and one connecting block in word block 37. The second part of this cycle is high in emotional tone and has a solitary connecting block in word block 43. Missing data were recorded in four of the word blocks. Of the remaining 46 word blocks the patient linguistic patterns comprised of 30.43% relaxing, 19.56% reflecting, 19.56% connecting, and 30.43% experiencing. When the patient and therapist language patterns were combined the relaxing phase decreased to 28%, reflecting increased to 20%, connecting remained stable at 20%, and experiencing increased to 32%. The therapists made 12 interventions that resulted in emotion/abstraction pattern changes (represented by arrows on the graph). That is, 44.40% of changes in linguistic patterns were influenced by the therapist. These interventions resulted in 4.02% change in emotion-abstraction pattern change across the entire session.

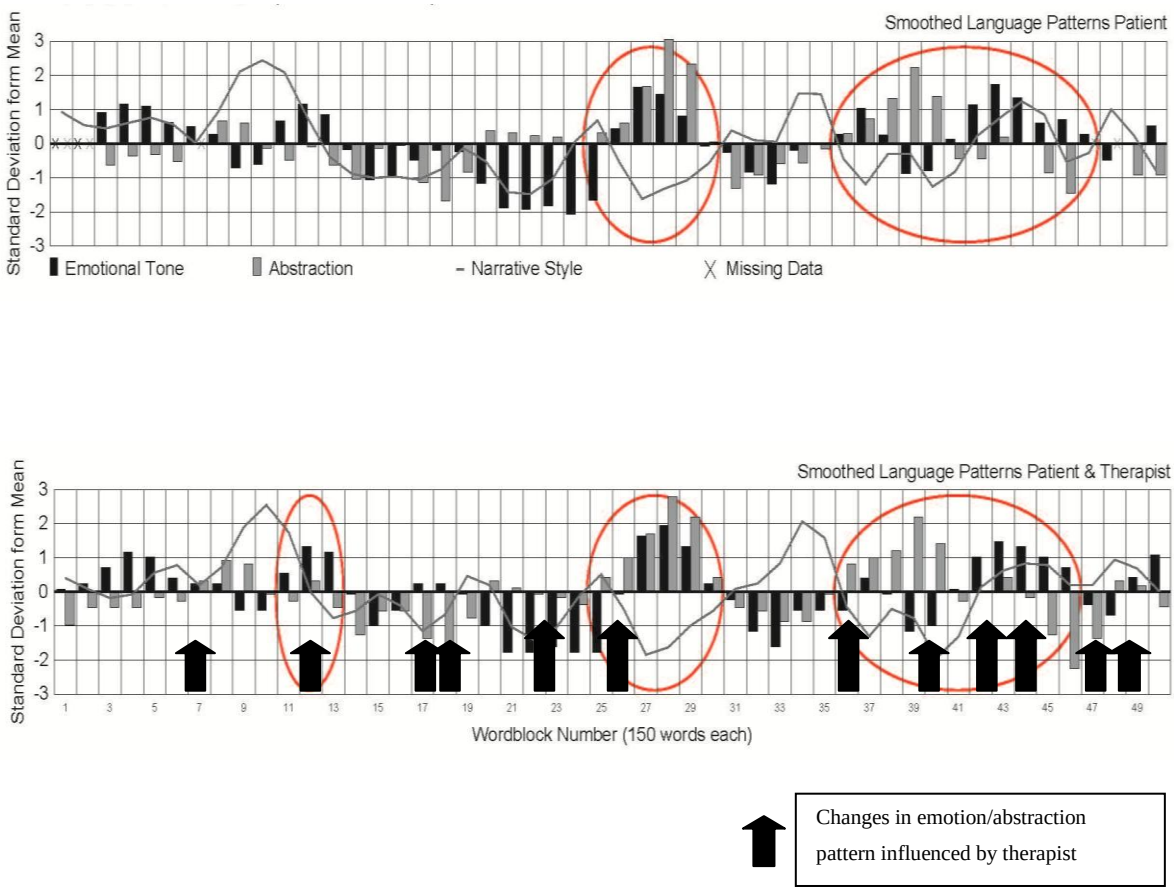

Figure 5. Graphic output provided by the cycles model software for Session 7 emotion-abstraction patterns and narrative style for patient only with borderline personality disorder (top) and combined patient and therapist (bottom) segmented into word blocks

Note. Left to right represents time in the session across number of word blocks. The circle marks a therapeutic cycles.

The results from the TCM analysis for Session 7 with the patient with major depressive disorder are presented in Figure 6. Two cycles can be identified in the patient and therapist linguistic patterns, and appear across 14 of the 42 session word blocks. Therefore 33 % of this session the patient experienced a therapeutic cycle. The first therapeutic cycle is marked by a high abstraction relative to emotional tone and leads to three connecting block in word block 4, 7, and 8. The second therapeutic cycle is high in emotional tone and low in abstraction and has two connecting blocks in word blocks 41 and 42. Four of the patient's word blocks were not complete and thus were recorded

as missing data. The remaining word blocks comprised of 40.50% relaxing, 24.30% reflecting, 16.20% connecting, and 16% experiencing. When the patient and the therapist language patterns were combined the relaxing phase decreased by to 30.90%, reflecting increased to 26.20%, connecting remained stable at 16.67%, and experiencing increased to 26.20%. The therapists made four interventions (represented by arrows on the graph), which resulted in emotion/abstraction pattern changes. That is, 23.60% of changes in linguistic patterns were influenced by the therapist. These interventions resulted in 18.84% change in emotion-abstraction pattern change across the entire session.

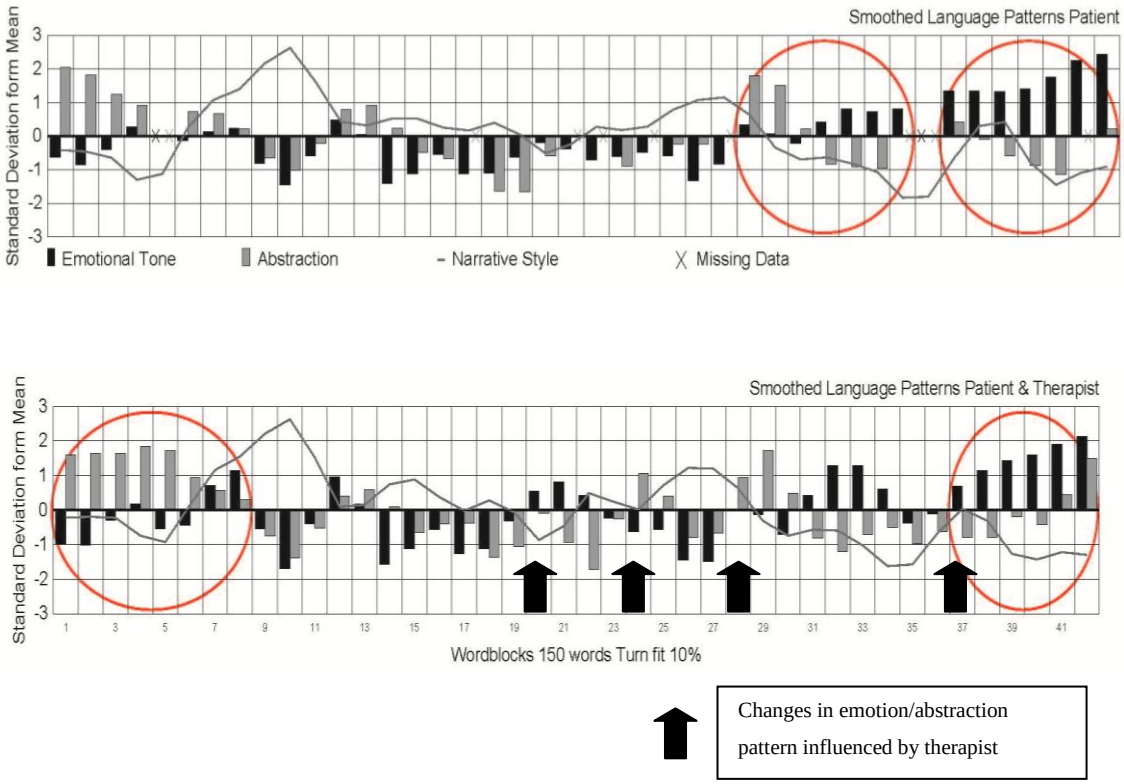

Figure 6. Graphic output provided by the cycles model software for Session 7 emotion-abstraction patterns and narrative style for patient only with major depressive disorder (top) and combined patient and therapist (bottom) segmented into word blocks

Note. Left to right represents time in the session across number of word blocks. The circle marks a therapeutic cycles.

5.4. DISCUSSION

This preliminary investigation systematically examined and identified specific process variables that characterise borderline and depressed treatment profiles, through the analysis of the underlying structural features of in-session therapist/patient communication patterns. The description of psychotherapy using the PQS and the linguistic analysis using the TCM revealed a number of qualitative and quantitative differences.

First, the therapist intervened more frequently when working with the patient with borderline personality disorder compared to the patient with depression. 44.40% of changes in linguistic patterns were influenced by the therapist in the session with the patient with borderline personality disorder compared to 23.60% of changes in the session with the patient with depression. This pattern suggests that the therapist is working harder to trigger or encourage change in emotion/abstraction patterns in the session with the patient with borderline personality disorder than the patient with depression. Furthermore, the results from Study 4 suggest that the cognitive and emotional responses of the patient with borderline personality disorder are more resilient to the therapist's interventions. That is, the therapist's attempts to contain and steer the therapy session has minimal sustained results with the patient frequently resuming their original emotion-abstraction pattern after the therapist's intervention. The therapist's efforts result in 4.02% change in emotion-abstraction pattern change across the entire session with the patient with borderline personality disorder compared to 18.84% with the patient with depression. Therefore, the therapists is working more than twice as hard as when they are working with the patient with borderline personality

disorder and are gaining less than a quarter of the amount of change in emotion-abstraction patterns. These results are consistent with our aprior hypotheses.

Second, the borderline personality and depressed profiles had a similar amount of connecting blocks, being 20% and 16.67% respectively, which are representative of insight or therapeutic change. Yet, in the profile with the patient with borderline personality disorder the connecting blocks were more diffuse and spread from the beginning, middle and end of the session. In comparison, the profile of the patient with depressive disorder revealed significant therapeutic moments at the beginning and end of the session. While the overall therapeutic change appears to be quantitatively similar, the two profiles have interesting qualitative differences. A trend in the emotion-abstraction patterns show a trend that supports our hypotheses that the session with the patient with borderline personality disorder would be characterised by high levels of experiencing. However results do not support the hypothesis that the session with the patient with depression would be characterised by high levels of connecting. It is unclear if this pattern would be present in other sessions or across different patients meeting the same diagnostic criteria.

Psychotherapy process coded with the PQS revealed a similar and consistent pattern of patient involvement and therapist response. The dyad with the patient with borderline personality disorder was strongly characterised by the patient's high negative emotionality expressed as anxious tension, guilt, shame and feelings of inadequacy. The patient appears to be distanced from their feelings and thus could be seen to invite the therapist interventions aimed at facilitating their psychological and emotional processing. This is consistent with the TCM analysis were it appears that the therapist is working hard at regulating the patients emotion-abstraction patterns to promote a connecting phase where the patient experiences their emotions in conjunction with high

levels of insight or understanding (abstraction). In contrast, the dyad with the depressed patient is characterised by the patient's ability to explore their own inner thoughts and feelings. Here the patient is encouraged by the therapist to introspect and experience their emotions at a deeper level. In this session the therapeutic relationship appeared harmonious with the patient presenting in a relaxed and cooperative manner.

5.5 LIMITATIONS AND CONCLUSIONS

This was a pilot analysis of only two in-session transcripts. Therefore, the findings only apply to the sample studied. Nevertheless, the preliminary findings are promising and support the application in future research of cycle model and the PQS to individual psychotherapy with a larger sample of patients with borderline personality disorder. Replication studies will greatly improve the empirical examination of psychotherapy process with patients with borderline personality disorder.

These results suggest that the nature of the work with patients with borderline personality disorder places high demands on the therapist to provide frequent interventions to assist the patients in regulating and processing their emotions. This in turn may place greater emotional and cognitive load on the therapists who may work harder to see psychological gain and positive outcome in the patient with borderline personality disorder compared to the patient with depression. This therefore helps us understand the findings from Study 1, 2, and 3.

CHAPTER SIX

OVERALL SUMMARY AND FUTURE DIRECTIONS

The aims of this thesis were eightfold:

1. To identify therapists' Core Conflictual Relationship Themes when recalling psychotherapy with actual patients (Study 1).
2. To identify the valance of the emotional tone of therapists' responses (Study 1).
3. To investigate relational patterns expressed by patients towards their therapist (Study 2).
4. To analyse prominent concepts and themes discussed by therapists towards their patients (Study 2).
5. To investigate the interconnectedness of lexical terms in therapists' narratives (Study 2).
6. To identify linguistic, affective and cognitive processes in therapists' natural language when recalling their experiences of the therapeutic process (Study 3).
7. To describe a range of patient and therapist attitudes, behaviours and therapist-patient interactions identifiable during a psychotherapy session (Study 4).
8. To identify patient and therapist emotion-abstraction patterns in therapeutic process that differs as a function of the patient's diagnosis (Study 4).

A growing body to clinical and theoretical evidence suggests that therapists often experience negative emotional response when working with patients with borderline personality disorder and are at risk of enacting their patients interpersonal response patterns (Linehan et al., 2000; McWilliams, 1994). This thesis represents a program of research cognisant of these observations.

6.1 INTEGRATION OF FINDINGS

Taken together, these four studies have led to a number of discoveries in relation to the treatment of borderline personality disorder. Although major depressive disorder was used as a comparison, we can now more confidently state some of the therapist's emotional, cognitive, and linguistic responses to borderline personality disorder in psychotherapy:

1. Therapists all shared the same desire to help patients. In Study 1 therapists expressed a CCRT wish component to be confident in their therapeutic role and to help their patients, regardless of diagnostic group.
2. Patients with borderline personality disorder were reported to be more negative and conflictual towards therapists. Therapists perceived interpersonal response patterns of patients with borderline personality disorder as typically withdrawing, and patients with major depressive disorder as attending within sessions. Therapists reported that patients diagnosed with borderline personality disorder predominately responded to them in a very negative manner (47.50%) compared to patients diagnosed with depression (7.90%). Furthermore, therapists reported a small percentage of very positive responses (2.50%) from patients diagnosed with borderline personality disorder compared to 39.50% being very positive responses from patients diagnosed with depression.
3. Therapists' responses towards patients in the borderline personality disorder group were predominately positive (55%). However, 32.50% of responses were very negative and there were no responses with a very positive valence. This contrasted with therapists' responses to patients in the depressed group with 44.70% having a very positive valence and a small 5.30% having a very negative valence.

4. Therapists expressed feeling more confident in providing support to patients with depression and more frequently withdrew from their patients with borderline personality disorder. Indeed, these findings suggest that the emotional demands in treating patients with borderline personality disorder impact on the therapist's emotional and cognitive response patterns both interpersonally or towards the patients, and intrapersonally, that is, towards themselves.
5. Therapists perceived patients to respond to them with hostile, narcissistic, compliant/anxious, avoidant/dismissive, and sexualized relational patterns.
6. Positive working alliance was associated with a diagnosis of depression.
7. Therapist's years of clinical experience and theoretical orientation were not a significant factor in predicting therapists' responses.
8. Therapists expressed greater emotional distress and an increased need for supportive supervision when working with patients with borderline personality disorder.
9. Four central and frequently used themes were identified in the Leximancer borderline matrix: 'destructive', 'therapist response', 'trust', and 'extreme'. In comparison therapists' descriptions of working with patients with depression centred on prominent themes of 'work' and 'helped'.
10. In their linguistic style therapists used more words denoting negative emotions, anxiety, anger and sadness, when discussing their patients with borderline personality disorder compared to more positive emotion words when referring to their patients with depression.
11. Therapists frequently used first person singular pronouns and adverbs, together with less words suggestive of cognitive processes, insight (think, understand,

realize) and causation (cause, because, effect) when discussing patients with borderline personality disorder. This linguistic pattern suggests that therapists may have a self-focused emotionally intensive linguistic style when discussing patients with borderline personality disorder and that their reflective functioning and metacognitive processes may to some degree be impaired.

12. Therapists intervened more frequently to facilitate psychological change with patients with borderline personality disorder compared to patients with depression. Yet they gained less than a quarter of the change in emotion-abstraction patterns. These results, while preliminary in nature, deepen our understanding of the therapeutic process with patients with borderline personality disorder. They have utility in understanding some of the demands that therapists experience in working with this patient group.

Findings highlight a general trend where by therapists differentially expressed relational patterns as a function of patient diagnosis. This established the rationale for a closer investigation to identify specific relational details. Findings from this thesis may serve to normalize the challenging nature of therapeutic engagement when treating patients with borderline personality disorder. In doing so, this information reminds us that the emotional demands, interpersonal challenges and emotional rewards that therapists experience may frequently be driven by the nature of pathology. As Book (1997) suggested treating personality-disordered patients is problematic, complicated and emotionally demanding for two reasons—the patient's behaviour and the therapist's response. When therapists are armed with an awareness of their intrapersonal responses, they are in a position to manage and therapeutically integrate their reactions that may otherwise have been reactive enactments to patient's maladaptive interpersonal patterns.

In sum the series of studies in this thesis have:

- Identified therapists' differential response patterns when recalling psychotherapy process with patients with borderline personality disorder compared to major depressive disorder using CCRT method. (Study 1).
- Identified themes in therapist's perceptions of patient's relational tendencies and patterns in therapist's responses using content analysis Leximancer.
- Demonstrated content analytic methods to elaborate and validate the interpersonal challenges and clinical stress experienced by therapists working with patients with borderline personality disorder.
- Identified specific markers of therapists' linguistic styles differed as a function of the patient's diagnostic group using content analysis method LIWC.
- Explored process factors in the in-session treatment of patients with borderline personality disorder which may be influential in therapist's emotional and cognitive responses.

6.1.1. Limitations and Future Directions

As with all studies that rely on the voluntary disclosure of internal processes, self-report responses may be tempered by concerns of appearing towards the researcher as incompetent or by the fear of being negatively judged. While all attempts were made to ensure that therapists felt at ease and understood that the protection of their confidentiality was paramount, self-presentation bias cannot be ruled out. Participants in this series of studies were a convenience sample and were not randomly selected. Likewise, the selection of patients in this study was at the discretion of the therapist,

once complying with inclusion criteria. Therefore, caution is required in generalising findings to the target population.

Findings from this series of studies highlight the considerable worth in further investigations into therapist response patterns in the treatment process. Given the clinical importance of this information to the therapeutic process further research of greater methodological vigour is needed. Ideally, this would constitute a sample of randomly recruited participants for both therapist and patients. Notwithstanding the promising results obtained thus far, future research directed at understanding therapists' experiences and patterns of patient interpersonal interactions in-vivo, such as in Study 4, will have great merit in advancing our understanding of psychotherapy process with patients with borderline personality disorder.

In sum, these results suggest that the nature of the work with patients with borderline personality disorder places high demands on the therapist to provide frequent interventions to assist the patients in regulating and processing their emotions. This in turn may place greater emotional and cognitive load on the therapists who may have to work harder to see psychological gain and positive outcome in the patient with borderline personality disorder compared to the patient with depression. Taken together, findings from Study 4 may help us to understand the findings from Studies1, 2 and 3, that is, why therapists struggle.

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APPENDIX A
The CCRT-LU System[4]

CLUSTERS	CATEGORIES	SUB-CATEGORIES	
I. harmonious	*A. Attending to*	**A1. exploring, admiring**	A11 being curious, being interested, exploring, being active, being motivated, being open A12 sorting oneself out, searching, standing up for something A13 considering capable A14 admiring, being impressed A15 being enthusiastic, being fascinated A16 identifying oneself, being like the other
		A2. accepting, understanding	A21 accepting, respecting, taking seriously A22 giving independence, being attentive, leaving in peace A23 approaching, noticing, showing interest, listening, excusing A24 perceiving feelings, accepting feelings, being sensitive A25 pitying, being touched, being stirred A26 understanding A27 forgiving, reconciling
	B. Supporting	**B1. explaining, confirming**	B11 explaining, communicating, stating, expressing, convincing B12 standing by someone, praising, agreeing, inspiring, encouraging
		B2. helping, giving independence	B21 protecting B22 being generous, spoiling, preferring B23 helping, standing up for someone
	C. Loving, Feeling Well	**C1. being close**	C11 being close, accepting, being intimate, providing for, being good, being loving C12 consoling, comforting C13 liking, being liked, being likeable, having friends, getting along
		C2. loving, having relationship	C21 falling in love, being attractive C22 loving C23 having children, having a relationship
		C3. being confident, satisfied, experiencing pleasure	C31 trusting, being certain, believing, being confident, being secure C32 being relieved C33 letting oneself go, being spontaneous, having scope to develop, being happy, feeling well, enjoying, having fun C34 being glad, being (happily) surprised, being satisfied
		C4. being sexually active,interested	C41 being romantic C42 making a pass, flirting C43 touching, kissing, cuddling, being affectionate C44 desiring, being aroused, wanting, being sexually attractive C45 having sex, being instinctual, being potent, being passionate, being sexually experienced
		C5. being healthy, living	C51 being healthy C52 living
	D. Being Self-Determined	**D1. being moderate (out of strength), trustworthy**	D11 being thankful D12 being tolerant, being willing to compromise D13 being considerate, being polite, being moderate, being modest D14 being calm, being patient D15 bearing, enduring, standing, coping D16 being trustworthy, being honest, being reliable, being faithful, treating fairly, being correct D17 being sensible, being constructive D18 having responsibility
		D2. being proud, being autonomous	D21 being strong, being superior, being important, being courageous, deciding D22 being capable, being experienced, being successful, being proud D23 being ambitious, being conscientious D24 being a role-model, being perfect D25 being independent, being self-sufficient D26 being sure of oneself, having trust in oneself, being self-confident D27 having self control, being thoughtful, being skeptical, being self-critical D28 changing, developing, improving

1.1 [4] Version March 2001 © C. Albani, D. Pokorny, G. Blaser, S. Grueninger, Leipzig – Ulm 2001; English translation R. Deighton, U. Jacobs, C. Fischer, Ulm – Berkeley – Leipzig 2001

CLUSTERS	CATEGORIES	SUB-CATEGORIES	
II. disharmonious	E. Being Depressed, Resigning to sth.	E1. being disappointed	E11 being unhappy, being depressed, being disappointed E12 despairing, suffering, grieving
		E2. resigning oneself to something	E21 giving up, resigning E22 being indifferent, being bored, being apathetic, being sluggish
	F. Being Dissatisfied, Being Scared	F1. feeling guilty, ashamed, being dissatisfied	F11 feeling guilty, regretting F12 shaming oneself F13 feeling unwell, feeling dissatisfied F14 feeling frustrated
		F2. being scared, anxious	F21 being anxious, being scared, being worried, avoiding, being cowardly F22 being unsure, being confused, being indecisive F23 being nervous, being hysterical, being tense, being unrestrained F24 being shocked, being outraged, feeling caught in the act
	G. Being Determined by Others	G1. being dependent	G11 being alone, missing someone, being lonely G12 being dependent, clinging G13 not being self-sufficient, being self-insecure G14 being passive, doubting, persisting, stagnating, worsening
		G2. being weak	G21 being weak, being helpless, being without rights, being exposed, being unprotected, being inferior, being injured G22 being incapable, being inexperienced G23 disappointing someone, being overstrained, failing G24 being low, being unimportant, being restrained, being ugly G25 being moderate (out of weakness)
	H. Being Angry, Unlikable	H1. feeling disgust, being angry	H11 feeling disgust H12 feeling contempt H13 being jealous, being envious H14 being hurt, being offended H15 not liking H16 being angry, being enraged, being frustrated by something H17 hating
		H2. being disliked	H21 being resentful, being impatient H22 being stingy H23 being unlikable, being disliked, being uninteresting H24 being unfriendly, being unthankful, being impolite
	I. Being Unreliable	I1. neglecting	I11 being insensitive, having no understanding, being destructive, being foolish, being uncontrolled I12 neglecting, abandoning, being superficial, being irresponsible, being heartless, being lazy
		I2. being selfish	I21 being self-satisfied, being uncritical I22 being dishonest, being unfair I23 being egoistical, being selfish, being greedy
	J. Rejecting	J1. ignoring, reproaching	J11 unnerving, disheartening, undermining, being disinterested, ignoring J12 blaming, reproaching, accusing
		J2. opposing, criticizing	J21 opposing, competing, being stubborn, disputing J22 declining, excluding, criticizing, admonishing, rejecting, judging, rebuke
	K. Subjugating	K1. being bad	K11 being bad, exploiting, cheating, betraying, denying, stealing K12 ingratiating, intriguing, deceiving
		K2. dominating	K21 committing, prescribing, influencing, pressurizing, demanding, forcing to do something K22 dominating, asserting, repressing, debasing, subjugating, disadvantaging, controlling, test someone, being strict
	L. Annoying, Attacking	L1. annoying someone	L11 hurting, offending, embarrassing, making ridiculous, humiliating L12 being malicious, being cynical, laughing at someone L13 annoying, harassing, inhibiting, bothering someone L14 disturbing, distracting
		L2. attacking	L21 scaring, threatening, attacking, provoking L22 tormenting, injuring, hostile, breaking L23 punishing, taking revenge, destroying, being violent L24 abusing, raping
	M. Withdrawing	M1. retreating, being reserved	M11 leaving, distancing, demarcating M12 keeping one's distance, retreating, withdrawing M13 being distrustful M14 avoiding conflict, being conforming, being complaisant, giving in, being submissive M15 being withdrawn, keeping quiet M16 being reserved, being shy M17 being compulsive M18 having no children, not having a relationship
		M2. being sexually inactive	M21 being disinclined, being acquiescent M22 being inhibited, not being aroused, being impotent M23 being sexually inexperienced
		M3. being ill	M31 being exhausted, being tired M32 having symptoms M33 being physically ill, being mentally ill M34 dying, killing oneself

APPENDIX B

Core Conflictual Relationship Theme Score Sheet

CCRT SCORE SHEET

Patient: _ _ **Participant ID: _ _ _- _ _**

Coder: _ _

Thought Unit/Tailor-made Method

W =
RO =
RS =

CCRT FORMULATION: -

_____

_____

_____

_____

Valance Category	**SCORE**
Very Positive	4
Positive	3
Negative	2
Very Negative	1

CCRT-LU Category	**CCRT-LU Code**	**Thought Unit**	**CCRT-LU Category**	**CCRT-LU Code**	**Thought Unit**	**Valance Score**
WOO			ROO			
WOS			ROS			
WSO			RSO			
WSS			RSS			

W				R			
WO "The other should (…)."		WS "I want to (…)."		RO "The other does (…)."		RS "I do (…)."	
WOO	**WOS**	**WSO**	**WSS**	**ROO**	**ROS**	**RSO**	**RSS**
"The client should (…) to him/herself or other."	"The patient should (…) to me."	"I want to do (…) to the patient."	"I want to do (…) to me."	"The patient does (…) to him/herself or other."	"The patient does (…) to me."	"I do (…) to the patient."	"I do (…) to me."

APPENDIX C

Therapist Demographics Questionnaire

Participant ID: _ _ _ - _ _

Therapist Demographics Questionnaire

Sex (circle): Male / Female

Age: …….

Preferred theoretical orientation: ……

In what year did you see your first patient? ……

Approximately how many patients have you seen? .....

What is your highest qualification as a psychologist?

……

APPENDIX D

Patient Demographics Questionnaire

Participant ID: _ _ _ - _ _

Patient 1:

Initials_____

Gender: (circle) Male / Female

Age:____

Diagnosis: **MDD**

Length of treatment:_____ (mths)

Treatment terminated (circle) Y N

If yes,

months since termination: ___

Patient 2:

Initials_____

Gender: (circle) Male / Female

Age:_____

Diagnosis: **MDD**

Length of treatment:____(mths)

Treatment terminated (circle) Y N

If yes,

months since termination: ____

Patient 3:

Initials____

Gender: (circle) Male / Female

Age:____

Diagnosis: **BPD**

Length of treatment:____ (mths)

Treatment terminated (circle) Y N

If yes,

months since termination: ____

Patient 4:

Initials_____

Gender: (circle) Male / Female

Age:_____

Diagnosis: **BPD**

Length of treatment:_____(mths)

Treatment terminated (circle)Y N

If yes,

months since termination: ____