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Understanding Countertransference with Patients with Borderline Personality Disorder : an Exploratory Quantitative Investigation

Michelle Saxen Hunt
Philadelphia College of Osteopathic Medicine, thmh98@comcast.net

Philadelphia College of Osteopathic Medicine

Clinical Psychology

Department of Psychology

UNDERSTANDING COUNTERTRANSFERENCE WITH PATIENTS WITH BORDERLINE PERSONALITY DISORDER: AN EXPLORATORY QUANTITATIVE INVESTIGATION

by Michelle Saxen Hunt

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Dissertation Approval

This is to certify that the dissertation presented to us by Michelle Saxen Hunt on the 17th day of March, 2003, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

Rosemary Mennuti, Ed.D., Chairperson

Robert A. DiTomasso, Ph.D., ABPP

Gina M. Fusco, Psy.D.

Arthur Freeman, Ed.D., ABPP, Chair, Department of Psychology

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Abstract

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Michelle Saxen Hunt

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Philadelphia College of Osteopathic Medicine

Rosemary B. Mennuti, Dissertation Advisor

The present study surveyed 58 psychologists regarding their countertransference (CT) behaviors, CT management ability, empathy, and working alliances when treating patients with borderline personality disorder (BPD). Common positive and negative CT behaviors were identified when treating their typical patient with BPD. As predicted, results yielded negative correlations between therapists' CT behaviors and their CT management ability, working alliance, and empathy, as well as a positive correlation between therapists' CT management and working alliance, linking CT management to positive treatment outcomes. Therapists' level of experience and theoretical orientation were also examined, finding no significant impact on CT behaviors, CT management, or working alliance. Implications for training and supervision of therapists treating patients with BPD, suggestions for future research, and limitations of the study are discussed.

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Chapter 1

Introduction

Statement of the Problem

Encountering individuals suffering with Borderline Personality Disorder (BPD) is becoming increasingly common in the clinical setting. Available data show that approximately 10% of all psychiatric outpatients and 15% to 20% of psychiatric inpatients are estimated to meet criteria for BPD (Anonymous, 2001; Widiger & Frances, 1989). Additionally, these sources show that of patients with some form of personality disorder, 33% of outpatients and 63% of inpatients appear to meet BPD criteria. The diagnosis is estimated to be present in 2% of the general population (Anonymous, 2001).

Statistics suggest that there is a high cost to patients with BPD, their families, and society. Data collected from longitudinal studies of patients with BPD cite that despite functional role attainment 10 to 15 years following admission to psychiatric facilities, only about one-half of the patients will have stable, full-time employment or stable marriages (Anonymous, 2001). Many of BPD patients will attempt suicide. Completed suicide occurs in 8% to 10% of borderline individuals, a rate of 50 times higher than in the general population (Anonymous, 2001). Additionally, patients with BPD tend to have a greater lifetime utilization of a variety of medications and types of psychotherapy in comparison to patients with schizotypal, avoidant, obsessive-compulsive personality disorder patients, or those with major depression (Bender, et al., 2001). Consequently,

clinicians are often left feeling frustrated trying to find effective treatments to manage these patients in their clinical setting.

Patients with a diagnosis of BPD have come to be known in the psychiatric community as difficult to treat. They are known to elicit negative reactions from staff, resulting in poor therapeutic alliance, high therapy dropout rates, and negative treatment outcomes (Book, Sadavoy, & Silver, 1978; Marziali, Munroe-Blum, & McCleary, 1999; Gunderson, Najavits, Leonhard, Sullivan, & Sabo, 1997; Fraser & Gallop, 1993). A qualitative investigation of psychiatrists' views of the "difficult to treat patient," revealed that the diagnosis of BPD was mentioned four times more frequently than the next most commonly mentioned category (Bongar, Markey, & Peterson, 1991). However, this difficulty may be a function of the impaired interaction between the patient and treatment provider, labeled as countertransference (CT). These doctors reported setting too many limits, denying anger, being overly cautious, discharging prematurely, and rejection of their patients (Bongar; et al., 1991).

Book et al. (1978) outline common CT constellations noted from the experiences of the treatment teams on an inpatient psychiatric unit working with patients with BPD. They posit that four predominating types of CT reactions are elicited in staff when working with this patient population. These include: (1) Pejorative treatment toward patients; (2) viewing treatment outcome either overly optimistically or too hopelessly; (3) staff disagreements over treatment strategies, leading to severe breakdown of the treatment team; and (4) problems setting limits with patients. Another author outlines common CT reactions by therapists toward patients with BPD, including feelings of guilt, rescue fantasies, crossing of professional boundaries, rage and hatred, helplessness and

worthlessness, anxiety, and terror (Gabbard, 1993). A review of the existing literature on CT indicates a link between therapists' management of CT reactions and psychotherapy outcomes (Gelso & Hayes, 2002; more in depth discussion to follow).

Considering the high prevalence rate of BPD in the clinical setting, the difficulties in treating these patients, and their intense need for risk management during treatment, it is important to more fully understand the frequency of the CT reactions of therapists toward their BPD patients. Further, it is important to understand how this CT impacts on the effective delivery of treatment, in relation to what is known about positive treatment outcomes from the psychotherapy literature.

Purpose of the Study

The general aim of this study was to examine the frequency of positive and negative CT reactions of psychologists who work with patients with BPD. The purpose of the examination was to gain a better understanding of the CT reactions of psychologists that are elicited by BPD patients, their CT management skills, and the relationship of CT behavior to therapists' self-reported ratings of working alliance and empathy with borderline patients, in terms of the potential impact on therapeutic outcome. Additionally, the relationship between CT behaviors and several demographic variables was examined, such as theoretical orientation and number of years of clinical experience.

The method used to obtain this information involved a survey, which included measurements designed to assess psychologists' self-reported frequency of CT reactions, CT management skills, the typical working alliance, and typical ability to express

empathy when working with patients with BPD. The surveys were mailed to a representative sample of psychologists throughout the United States. The information collected represents a summary of the frequency of the positive and negative CT reactions of psychologists throughout the United States when working with borderline patients. Further, it highlights the relationship between psychologists' reported CT behavior with their reports of working alliance, empathy, and CT management ability in their practice with patients with BPD. Understanding CT reactions that may create barriers to treatment with this high risk patient population could be used to better prepare psychologists to work with patients with BPD. This information could be incorporated into doctoral training programs, supervision, consultation, continuing education, and manualized treatment protocols. Additionally, data obtained from this survey serves to contribute to the current body of literature that exists on CT, that has not paid particular attention to specific patient populations (Gelso & Hayes, 2002), as well as to existing literature on the pejorative nature of the label of BPD (Bongar, et al., 1991). Further, this study attempts to tie these findings to the psychotherapy outcome literature, which has only begun to examine the role of CT (Gelso & Hayes, 2002). The study utilized an existing and valid measurement of supervisors' ratings of the extent to which their supervisees display CT behaviors (Inventory of Countertransference Behavior, ICB; Friedman & Gelso, 2000), which was adapted to measure psychologists' self-report of frequency of CT behaviors. Self-report was used in this study to collect data on the personal experiences of psychologists who vary in terms of level of experience, as opposed to supervisors' ratings of supervisees, who tend to be less experienced.

In summary, this study attempted to answer the following research questions:

1) Are there particular patterns of the self-reported frequency of positive and negative CT responses common to psychologists who treat patients with BPD, as measured by an adapted version of the ICB?
2) Are psychologists' self-reported expression of CT behaviors, as measured by scores on the adapted version of the ICB, inversely related to psychologists' self-reported ability to manage CT, as measured by scores on the adapted version of the Countertransference Factors Inventory-Revised (CFI-R; Latts, 1996), when working with their typical patients with BPD?
3) Are psychologists' self-reported ability to empathize, according to the empathy subscale scores on the adapted CFI-R, and form a working alliance, according to scores on the adapted Working Alliance Inventory-Short (Therapist Version; WAI-Short; Tracey & Kokotovic, 1989), inversely related to the self-reported frequency of CT behavior, as measured by scores on the adapted version of the ICB, when working with their typical BPD patients?
4) Do psychologists' level of experience and theoretical orientation have an impact on their self-reported frequency of CT behaviors, as indicated by scores on the adapted version of the ICB, working alliance, as reported on the WAI-Short (Therapist Version), and CT management, as measured by self-reported scores on the adapted version of the CFI-R, when working with their typical BPD patients?

Understanding the development and presence of the frequency of psychologists' CT with patients with BPD first requires a discussion of the development of the term and the operational definition used in this study.

Operationally Defining CT

Classical view. It was Freud who first termed the constructs of transference and CT in 1910 (as cited in Gelso & Hayes, 2002). Transference was defined as the patient's distortion of the therapeutic relationship, resulting from the perception of the therapist as possessing personal characteristics similar to someone in the patient's past. He viewed CT to be problematic in therapy, resulting from the therapist's unconscious feelings stirred up from the patient's session material. Essentially, Freud viewed CT as the therapist's transference reactions to the patient's transference (as cited in Gelso & Hayes, 2002), which should be overcome and avoided in the future. It was believed that a good analyst would be capable of keeping his own personal conflicts out of the therapeutic relationship. This became known as the *classical* conception (Epstein & Feiner, 1988). Those who hold this view of CT do not believe there is any positive value to it.

Totalist view. Just as classic Freudian psychoanalysis evolved, so did the ideas about CT. The *totalist* school of thought emerged in the 1950's (Kernberg, 1965), defining CT as all of the therapist's emotional reactions to the patient, including realistic and unrealistic, positive and negative. This definition led to a view of CT as something worthwhile of therapist attention and as potentially valuable information for understanding patients. This broadened definition of CT was appealing to therapists at a time when work was beginning to be done with more severely disturbed and personality disordered patients (Gelso & Hayes, 2002). Perhaps it was comforting to therapists to see the process and experience of CT normalized.

Complementary view. The classical view of CT is very limiting and negative, while the totalist view, in contrast, is very broad and non specific. A third view of CT was then developed, referred to as the *complementary* approach. Racker (1957) suggested that every patient action is countered with a similar reaction by the therapist. Every positive transference from the patient is met by a positive CT and every negative transference is met by a negative therapist CT. The "good therapist," however, refrains from acting out the actual behavior, seeking to understand his or her own responses, for the benefit of therapy. Like the classical view, this approach recommended that therapists do not act out their CT behaviors, but like the totalist view, suggested CT could yield worthwhile clinical information.

Operational definition in the present study: Schematic view. Gelso and Hayes (2002) defined CT, incorporating an integration of all three models: CT is the therapist's inability to manage or control "unresolved issues" so that these issues manifest themselves during treatment, in potentially helpful or harmful ways to the therapeutic process. Unresolved issues or conflicts, for the purpose of this study, refer to therapists' childhood, professional, and adult schema that influence their perceptions of what the patient presents in therapy (further discussion to follow). This definition incorporates the therapist's reaction to both transference and non transference patient session materials (Gelso & Hayes, 2002), including characteristics of the patient, the patient's symptoms and behaviors, and the patient's physical qualities. Similarly, Gabbard and Wilkinson (1994) posit that CT is a "joint creation" (p. 11) between the patient and therapist. Essentially, they believe that the pattern of interaction between the patient and therapist is

affected by both the therapist's past conflicts as well as the projected aspects of the patient's transference. Cognitive therapists believe that CT represents all of therapists' responses to the patient, including their automatic thoughts, beliefs or schemas, and emotions (Layden, Newman, Freeman, & Morse, 1993).

CT can be experienced by the therapist as an internal state or as a behavioral expression. According to Gelso and Hayes (2002), CT behavior is generally viewed as negative because it involves action toward the patient, whereas internal CT is generally viewed as potentially helpful. If the therapist is able to recognize and understand these CT internal reactions, it may provide important information about the patient that is useful in treatment. For the purpose of operationally defining CT in this study, a *schematic view* has been taken, expanding on the complementary view of Gelso and Hayes (2002), as well as that of Layden and colleagues (1993), by including the therapist's own personal and professional schema or beliefs, as they interact with the patient's: *CT can be experienced both internally and expressed behaviorally, having both potentially helpful and harmful effects when working with the BPD patient; it is a function of the interaction between the therapist's own personal schematic interpretation of the patient's session material, and the patient's own schema or beliefs that lead to the creation of the session material.*

Operationally Defining BPD

A personality disorder is defined as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the person's culture, is pervasive and inflexible...is stable over time, and leads to distress or impairment" (American Psychiatric Association, 2000, p. 686). Personality disorders, at the very core, involve maladaptive patterns of interpersonal behavior that can interfere with the establishment of functional relationships. These maladaptive behaviors are based on assumptions and beliefs, or schemas, about the world in general and social relationships in particular (Freeman, Pretzer, Fleming, & Simon, 1990). BPD is classified as a Cluster B personality disorder, along with antisocial, histrionic, and narcissistic personality disorders, all of which are marked by frequent dramatic, emotional, or erratic behavior (Reid & Wise, 1995). The "essential feature of Borderline Personality Disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (American Psychiatric Association, 2000, p. 706). To meet criteria, an individual must meet five or more of the following as listed in the DSM-IV-TR (APA, 2000, p. 710):

(1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.

(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

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

(7) chronic feelings of emptiness

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

(9) transient, stress-related paranoid ideation or severe dissociative symptoms

It is significant to note that 75% of those patients diagnosed with the disorder are women and that the disorder is five times more common among first-degree biological relatives with the disorder in comparison to rates in the general population (American Psychiatric Association, 2000). Risk for death by suicide is increased for individuals with BPD and co-occurring mood disorders or substance-related disorders. Additional common co-occurring Axis I disorders include eating disorders, post-traumatic stress disorder, and attention deficit/hyperactivity disorder (American Psychiatric Association, 2000).

For the purpose of this study, the survey respondents were asked to identify patients whom they have diagnosed with BPD, according to the above criteria from the DSM-IV-TR (APA, 2000). Due to the high co morbidity of Axis I disorders with BPD (APA, 2000), patients who met criteria for BPD and another Axis I disorder were

included in the study. Patients considered in the psychologists' survey responses may also have had a co-occurring Axis II disorder, however, the diagnosis of BPD must have been the disorder causing the patient the *most impairment in functioning*. A history of the development of the concept of BPD is included in the following section.

Theoretical Background

The frequency of CT reactions in psychologists can be understood through a cognitive-behavioral and information processing model. Subsequently, the historical roots of the BPD diagnosis will be discussed, followed by a presentation of the currently accepted biosocial model of the etiology of the BPD.

Cognitive model and CT. A cognitive-behavioral theoretical conceptualization will be considered as the framework for understanding the importance of psychologists' beliefs about their patients with BPD. This theoretical orientation "hypothesizes that people's emotions and behaviors are influenced by their perception of events. It is not a situation in and of itself that determines what people feel but rather the way in which they construe a situation" (Beck, 1995). The way people feel is not determined by the situation, rather, it is mediated by their interpretation of the situation. People develop beliefs, rules, and assumptions that help them to make sense of their environment. They need to organize their experience in some systematic way that enables them to function adaptively (Beck, 1995).

Our normal functioning of information processing, though bringing meaning and organization into our lives, may also serve to distort our experiences. Coined as "schemas" (Bartlett, 1932), these "meaning structures" regulate our attention, storage, and retrieval of information in a given domain. Schemas allow us to identify things quickly, cluster it into manageable units of information, and select further information for obtaining our goal (Singer, Sincoff, & Kolligian, 1989). Social interactions are heavily guided by schema, outlining the appropriate sequence of events. With the therapy sessions representing one such social context, schema for the therapist may reflect professional experiences, expectations, training experiences, and knowledge of a particular diagnostic category (Singer, et al., 1989). These schema serve as a "prototype" that assists the therapist in filling in the other attributes of the patient, even if all of the attributes may not fit the particular patient. For example, a therapist who has worked with many severely depressed and suicidal patients may presume that their present patient, who presents with depressive symptoms, has a diagnosis of major depressive disorder, overlooking the symptoms of a manic episode that the patient experienced two weeks ago. In this example, the therapist "assimilated" the patient's symptoms into his existing schema of depressed patients.

Piaget (1976) described the process of assimilation and accommodation in cognitive development. Though beyond the scope of this discussion, assimilation is the process of fitting new information into one's existing schemas, while accommodation is the process of modifications of one's schema to account for new information (Piaget, 1976).

The presence of new information is therefore subject to possible distortion and consequently may provoke CT reactions (Singer, et al., 1989). In Sternberg's (1985) theory of intelligence, he described how novel tasks and situations are much more difficult to process than familiar ones because novelty requires a modification of existing strategies. Further, Singer and colleagues (1989) cite research by Tomkins in 1978 that suggests that large amounts of novelty may extend a person's schema too far, evoking negative emotions such as anger and fear. Therefore, when a therapist is presented with much novel patient information in session, the information is subject to distortion and has the potential to elicit negative feeling states. According to this model, CT reactions result from therapists' past experiences in their personal and professional lives, which have developed into schema that shape the processing of information in therapy situations. Further, it is likely that therapists will respond negatively when their expectations of a patient are consistently disconfirmed over a period of time (i.e., does not fit their existing schema; Singer, et al.,.1989). Similarly, though not discussed by Singer et al. (1989), positive CT reactions (e.g., excessively agreeing with the client) are likely to occur when patients provide data in the session that activates the therapist's schema of a "good patient," who is likely to make positive treatment gains.

This information processing and cognitive-behavioral conceptualization of the development of therapists' dysfunctional schema, suggests that dysfunctional schema associated with BPD patients can be unlearned and replaced with new schema, leading to more effective therapy. New or adapted schema can be learned through training and supervision.

Historical roots of the BPD diagnosis. The diagnosis of BPD, in the form we know it today, has only formally existed since the publication of the DSM-III in 1980. As Stone (1992) points out, unlike other personality disorders such as dependent, avoidant, histrionic, and so forth, the term "borderline" does not depict the characteristics of the disorder. The label "borderline" has historical roots dating back to the 1930s when psychoanalysis was prominent. Psychopathology was viewed at that time as existing on a continuum, based on psychoanalytic theory of ego defenses and libidinal development (Kroll, 1988). All mental illnesses were seen as either regressions or fixations at more primitive developmental stages (Kroll, 1988). All people could be seen as falling somewhere on a continuum with normal on one end, neurotic in the middle, and psychotic at the other end. The term "borderline" originally was used to define those patients who fell somewhere between neurotic and psychotic (Stern, 1938; Kernberg, 1975). Stern (1938) originally described borderlines as a group of patients who did not benefit from traditional outpatient psychoanalysis and whose symptoms did not seem to fit clearly as either neurotic or psychotic. Knight (1953) used "borderline" to describe patients who were too severe to be considered neurotic, yet whose reality testing and functioning were at too high a level to be considered psychotic. Thereafter, the term became a reference for patients who were difficult to treat (Linehan, 1993).

Gunderson (1984) viewed the borderline population as those patients who appeared to be good candidates for psychoanalysis, yet did not respond to treatment, often doing worse than when not in treatment. In 1984, Reiser and Levenson wrote about various ways that they believe the borderline diagnosis has been abused and used as a justification for the expression of therapists' hate toward clients, for rationalizing

treatment failure, and for use with patients who are difficult to diagnose, among other abuses. There are some who believe that borderline pathology may not even represent a personality disorder at all, but rather reflecting symptoms, as does pathology represented in an Axis I disorder (Stone, 1992). More specifically, Stone (1992) argued that unlike other personality disorders in the DSM-III-R, where criteria represent features of one's personality, the criteria for borderline represent "symptoms." He stated that because of the mixture of symptoms and traits in the criteria, that borderline pathology does not clearly fit on Axis I or Axis II.

Stone (1992) reported that the conceptualization of borderline as a personality disorder in the DSM-III resulted from early definitions of the term that used the word "personality" in their description (Kernberg, 1967; Gunderson & Singer, 1975). Stone (1992) raises the point that within the DSM-III and DSM-III-R criteria for BPD, there is so much variability that there are "ninety-three ways to be borderline." Further, he criticizes the diagnostic criteria in stating that someone could meet the five necessary items to be labeled with a BPD diagnosis but not manifest impulsivity, identity disturbance, or affect instability, contrary to all of the historical definitions of the borderline patient. Stone (1980) has proposed that perhaps there are subtypes of borderlines; those related to schizophrenia, those related to affective disorders, and those related to organic brain syndromes, in milder forms.

Others have conceptualized BPD in terms of a biosocial learning theory (Millon, 1981). Millon (1981) has used the term "cycloid personality" to describe the behavioral and mood fluctuation that are central to the disorder, in his view. Similarly, Linehan (1993) has devised a reorganization of the diagnostic criteria for BPD, by way of

outlining behavioral patterns commonly associated with many BPD patients, particularly those who engage in self-injurious or suicidal behaviors. These are labeled as patterns of "emotional vulnerability," "self-invalidation," "unrelenting crisis," "inhibited grieving," "active passivity," and "apparent competence" (Linehan, 1993). *Emotional vulnerability* addresses the high sensitivity to negative emotional stimuli, accompanied with high levels of emotional arousal, with a slow return to baseline that is frequently apparent with BPD patients. *Self-invalidation* refers to the unrealistically high standards and expectations that BPD patients place on themselves. *Unrelenting crises* reflect the common patterns of dysfunction present in the BPD patients' lifestyle and/or environment. Inhibited grieving refers to the BPD patient's tendency to inhibit or overcontrol negative emotions associated with grief and loss. *Active passivity* defines the tendency for BPD patients to actively seek out others to solve their problems as opposed to engaging in active problem-solving. Lastly, *apparent competence* is the tendency for the BPD patient to appear skillful and "well," despite a lack of skill or intense feelings of emotional distress (Linehan, 1993). Linehan's reorganization of the diagnostic criteria into behavioral patterns has led to the development of an efficacious cognitive-behavioral treatment program to address these problem areas for the patient.

At present, during a time where diagnostic criteria and a system of classification dominate our current understanding of psychopathology, the DSM-IV-TR (APA, 2000) structures our thinking about the borderline patient. Further, understanding the etiology of BPD through a biosocial model helps to better understand the symptom presentation of BPD patients that appear in the treatment setting.

Biosocial model of the etiology of BPD. There are various explanations for the etiology of BPD, ranging from insecure attachment (Sack, Sperling, Fagan, & Foelsch, 1996; Sperling, Sharp, & Fishler, 1991; West, Keller, Links, & Patrick, 1993) to parental loss (Akiskal, Chen, & Davis, 1985; Soloff & Millward, 1983) or disturbance (Walsh, 1977; Frank & Paris, 1981; Goldberg, Mann, Wise, & Segall, 1985) to early childhood abuse (Zanarini, 1997), all of which have been supported in the literature as associated with those patients diagnosed with BPD. Other research has examined the role of organic disturbance (e.g., epilepsy, head trauma, or encephalitis) in the etiology of BPD, with some contradictory results (Andrulonis & Vogel, 1984; Soloff & Millward, 1983). Marsha Linehan (1993) has developed a comprehensive biosocial model to explain the etiology of BPD. She postulates that BPD pathology represents a disruption of the patient's emotion regulation system. According to Wagner and Linehan (1997), "emotion dysregulation in individuals with BPD consists of two factors: emotional vulnerability and deficits in the ability to regulate emotions." Borderline individuals, according to this model, are highly sensitive to emotional stimuli and experience intense or extreme reactions to emotional events. These individuals often then have a slow return to baseline. Emotion dysregulation is thought to be due to the transaction of biological and social factors.

The biosocial theory proposes that patients with BPD have biologically based difficulties in the processing of emotion (perception of, reaction to, and modulation of emotions; Wagner & Linehan, 1997). Biological factors may be genetic or due to harmful intrauterine events, such as poor nutrition or substance abuse during pregnancy. In addition, there is evidence to suggest that childhood environmental events can affect

the development of the brain and nervous system (Wagner & Linehan, 1997). A study by Teicher and colleagues (1997), has shown that childhood sexual abuse or trauma could affect the development of the cerebral cortex and limbic system, areas of the brain associated with emotion. Other evidence has been found for a low threshold of activation of limbic structures and increased EEG dysrhythmias in BPD patients (Wagner & Linehan, 1997).

The biological predisposition to emotional vulnerability discussed above becomes problematic when the child grows up in an environment that does not take the vulnerability into account. Linehan (1993) calls this an *invalidating environment*. An invalidating environment is one that consistently communicates to a child that his or her cognitive and emotional actions and reactions are not appropriate or valid responses. The child's communication of thoughts and feelings to a caregiver are responded to with erratic, inappropriate, and extreme responses. The private experience of the child is disregarded, trivialized, or punished, rather than validated by the caregiver. This type of environment does not teach the child how to label emotions, regulate emotions, or to solve problems. Extreme emotional displays by the child often become necessary to evoke a helpful response from the environment. The child consequently learns to distrust his or her personal experience and relies on the environment for information on how to feel, think, and act (Linehan, 1993; Wagner & Linehan, 1997). A child who is emotionally sensitive due to biological factors may be at an increased risk to evoke invalidating responses from his or her environment. It is in this way that a transactional process takes place.

Understanding the biosocial model of BPD is relevant for understanding the impact that treating these patients may have for both the patient and therapist. BPD patients tend to elicit emotionally charged and invalidating responses (labeled CT) from their therapists, which consequently serve to perpetuate the patients' feelings of invalidation, counter productive to a positive therapeutic outcome.

Rationale for the Present Study

A review of the literature reveals the presence of therapists' negative reactions to patients with BPD in therapy (Bongar, et al., 1991; Book, et al., 1978; Gabbard & Wilkenson, 1994). Clearly, borderline patients are not going away; in fact, BPD is the most common personality disorder seen in clinical settings (Anonymous, 2001) and poses serious challenges to therapists in treatment (Gabbard & Wilkinson, 1994; Linehan, 1993). One such challenge is managing CT. Therapists' expression of CT was found to be significantly related to lower ratings of the working alliance between patient and therapist in two recent studies (Ligiero & Gelso, 2002; Rosenberger & Hayes, 2001). The working alliance has been repeatedly found to be a robust predictor of positive treatment outcome (Horvath & Symonds, 1991). This link between CT behaviors to working alliance suggests that CT may likely have an impact on psychotherapy outcomes (Gelso & Hayes, 2002). Marziali, Munroe-Blum, & McCleary (1997) emphasize the specific importance of establishing the therapeutic alliance with patients with BPD, as they are particularly prone to tumultuous interpersonal relationships. Therefore, the

study of the CT reactions of therapists who treat BPD patients is of particular relevance for learning how to enhance positive treatment outcomes.

Similarly, therapists' knowledge of a BPD diagnosis alone, in the absence of further clinical information, is associated with negative ratings of patients (Gallop, Lancee & Garfinkel, 1989). Considering the link between positive treatment outcome and therapists' ratings of the "likeability" and positive treatment prognosis of their patients, along with their ability to empathize and self-disclose with their patients (Beutler, Machado, & Neufeldt, 1994), therapists' CT reactions (both internal and overt) are of legitimate concern for further study. If variables linked to psychotherapy outcomes, such as working alliance and empathy, are found to be correlated to CT behavior in this study, it will further strengthen the support for CT as a potential outcome variable, paving the way for further empirical investigation.

Moreover, therapists' own schema shape their expectations and behavior toward their patients (Singer, et al., 1989). According to the cognitive-behavioral model, negative interpretations of a BPD diagnosis may lead to therapists' negative emotional responses and behaviors (Beck, 1995), which are likely to impact negatively on treatment (in the form of negative CT behavior). On the contrary, patients with BPD may present in therapy with a sense of neediness or dependency that has the potential, at times, to foster over involvement by the therapist, in the form of positive CT behavior (Gutheil, 1989). Positive CT may be expressed subtly as overly agreeing with the patient in session or as serious as a major boundary violation. Therapists can benefit through the study of CT (both positive and negative) that identifies common patterns of the frequency of CT reactions with BPD patients. This awareness has the potential to help therapists

avoid serious negative outcomes resulting from errors in treatment, such as trauma to the patient or malpractice litigation (Gutheil, 1989).

Awareness of CT has been found to be an important factor in the management of CT behaviors (Van Wagoner, Gelso, Hayes, & Diemer, 1991). Van Wagoner and colleagues (1991) surveyed 122 experienced therapists and asked a third of them to rate male therapists that they believed to be "excellent" on various qualities, while another third rated female therapists that they believed to be "excellent," and the last third rated their concept of the typical therapist on these same qualities. The results indicated that therapists seen as "excellent" by the participants (both male and female) differed from therapists in general with regard to the five areas theorized to be associated with managing CT; self-insight, self-integration, empathy, anxiety management, and conceptualizing ability. Rather than asking supervisors to rate counselors-in-training on such qualities, this study asked participants to rate themselves on these qualities, as an assessment of their self-reported CT management ability. Of the five factors hypothesized by previous researchers (Van Wagoner, et al., 1991; Hayes, Gelso, Van Wagoner, & Deimer, 1991), self-integration and self-insight were shown to play the most important role in CT management, however, all five areas of CT management skills overlap. Factor analysis of the CFI-R revealed that the instrument appears to be measuring one construct, hypothesized as CT management, as opposed to five separate or clearly defined areas.

A study by Friedman and Gelso (2000) has shown that therapists' ability to self-manage CT reactions was associated with less overt expressions of positive and negative CT behaviors, according to supervisors' ratings of their supervisees.

Presumably, these therapists are more likely to establish a positive working alliance with their patients and to have more positive treatment outcomes than therapists who overtly express greater CT reactions. Despite its importance, the current body of literature has not examined the CT reactions of therapists working with patients with BPD through a quantitative analysis. The present study attempted to add to the current literature by providing data on the frequency of psychologists' CT reactions to BPD patients, as measured by an adapted version of the validated Inventory of Countertransference Behavior (Friedman & Gelso, 2000). These findings have important implications for the incorporation of additional training on attention to CT in doctoral programs, continuing education courses, and supervision.

The ICB was developed to assess supervisors' ratings of counselor trainees' CT reactions during individual therapy sessions (Friedman & Gelso, 2000). Participants were asked to think about their most recent supervision session and rate their supervisee on the behaviors in the questionnaire. The investigators believed that supervisors' ratings reflected "an effective blend of objectivity and involvement" in the therapy case since supervisors are not as "embroiled in the issues" as the therapist. For the present study, the investigator was not interested in the behaviors of therapists in training; rather, the behaviors of currently practicing psychologists. Therefore the ICB, as well as the CFI-R, were adapted for use as self-report measures.

Self-report inventories are the most commonly used type of measures in clinical research (Kazdin, 1998, p. 280). This popularity is attributed to the ability of self-report measures to directly assess peoples' feelings, thoughts, perceptions, attitudes, and/or behaviors. People themselves are able to best report the most accurate assessment of

their present state, past behaviors, and so forth. The supervisors' ratings used in the studies thus far with the ICB and CFI-R reflected the supervisors' interpretations of the trainees' report of their in-session behavior, not the supervisors' direct observation of the sessions. Therefore, the supervisor was in a position of making second-hand reports on the trainees' behavior. Though supervisor ratings may be more objective, they are limited by the quality and detail of the supervision sessions conducted, as well as the supervisors' suppositions of material for which they were not actually present to observe first-hand. Other studies, prior to the development of the ICB and CFI-R, have examined therapists' self-report of their CT reactions (Peabody & Gelso, 1982; Hayes, et al., 1998), supporting it as an acceptable procedure for obtaining data on therapists' CT reactions.

As with all research methods, there are limitations to self-report ratings. The main limitation is bias and distortion on the part of the participant. Though this remains a limitation in this study, self-report is the only method to directly assess psychologists' personal experiences in working with BPD patients. The anonymity of the study attempted to reduce the social desirability factor (discussed further in Method section). Further, a validity check was incorporated to exclude participants' ratings who reported that the questionnaire did not accurately represent their experiences in working with BPD patients. With these features incorporated into the design, self-report on the ICB and CFI-R yielded valuable information.

The ICB is the only existing valid measure of CT behavior. The items were slightly adapted for use as a self-report inventory and the rating scale was changed to reflect frequency of CT behavior as opposed to extent of CT behavior displayed. The adapted version of the ICB is not yet validated, serving as a limitation; however, the

potential benefits to be gained from the psychologists' self-report of their CT reactions with their BPD patients, deemed this a worthwhile investigation.

Further, it was not clear whether therapist variables, such as years of experience, theoretical orientation, and experience in treating BPD patients were related to their expression of CT behavior, though these variables have been examined in other CT literature (Little & Hamby, 1996). A study by Williams, Judge, Hill, and Hoffman (1997) suggests that therapists' level of experience does relate to the amount of CT behavior displayed, with less experienced therapists exhibiting greater CT reactions. In the psychotherapy outcome research, studies have found that a greater length of therapists' experience was associated with positive outcomes in therapy that was shorter than 12 sessions and when the patients were more severely disturbed. Additionally, therapists' level of experience has been found to be positively correlated with the quality of the therapeutic alliance (Beutler, et al., 1994). If more clinical experience were also found to be correlated with lower ratings of psychologists' CT behavior and greater ratings of their working alliance with BPD patients in this study, in comparison to less experienced psychologists, this would provide additional support for CT as a possible psychotherapy outcome variable itself. It may even be possible that this reduction in CT behavior levels off at a particular point in one's career or perhaps may even increase again as one begins to burn out in their clinical practice. Studying this variable opens up a whole new area for future research. This is a piece that has been missing in the previous research that has studied only the CT of trainees.

Psychologists' theoretical orientation may also play a role in the attention given to CT in their practice. Presumably, as the construct of CT emerged from psychoanalytic

writings, psychologists who have been trained in this orientation may be more likely to have been taught to identify CT and to suppress or manage such reactions, while other disciplines are traditionally less focused on teaching psychologists about CT. A study by Little and Hamby (1996) examined theoretical orientation as one of several variables in clinicians who treat adults with issues of childhood sexual abuse. The researchers found some significant differences across disciplines in diagnostic formulations and the self-report of certain feelings and behaviors toward patients. Specifically, with analysts and feminists differing most significantly with each other. With consideration of the potential negative impact of the overt expression of CT on patients with BPD, it was important in this study to explore whether the training of psychologists in particular disciplines enhances or inhibits attention to CT in clinical practice and its effect on their self-report of actual CT behavior. Important information for training programs, continuing education, and supervision may be derived if differences were found.

A recent study by Miller and Davenport (1996) examined the effects of a self-instructional program on nurses' attitudes toward BPD. The nurses' attitudes were examined in pre- and post-testing on knowledge and attitude scales according to the Questionnaire on Borderline Personality Disorder. The results suggested that information and training can lead to improved care of patients with BPD. Shearin and Linehan (1992) also suggest that clinicians must learn to reframe their views of BPD patients in less pejorative terms to foster a sense of acceptance, balanced with encouraging change in patients' behavior throughout therapy. Examination of therapists' non pejorative conceptualizations of BPD patients was even found to be associated with reductions in patients suicidal behavior (Shearin & Linehan, 1992), illustrating the necessity that

therapists' are aware of CT, understand their own CT, and learn to manage it with BPD patients.

In summary, an investigational quantitative analysis of psychologists' CT in working with borderline patients provides data that outlines the self-reported patterns of the frequency of positive and negative CT, as well as self-reported CT management skills, contributing to the current literature and opening up a new avenue for the study of CT and BPD. Further, this study used an adaptation of the ICB and CFI-R to measure psychologists' self-report of CT, as opposed to supervisors' ratings of supervisees in its original form. This study reveals whether the ICB and CFI-R will be useful for self-report in future research, potentially expanding its utility as a measurement tool and providing researchers with additional methods for gauging CT, a construct historically difficult to define and measure (Gelso & Hayes, 2002).

An investigation of the relationship between CT and other psychotherapy outcome variables, such as working alliance and expression of empathy, could also support and strengthen the idea of CT as a psychotherapy outcome variable and encourage other researchers to engage in direct empirical research. Further, since the management of CT behaviors has already been linked to positive psychotherapy outcomes (Latts, 1996; Gelso & Hayes, 2002), data obtained from this study can be used to facilitate the development of improved training and supervision for psychologists, designed to improve effective treatment delivery that reduces harm to the patient and therapist and leads to improvement in the quality of life of BPD patients.

Related Research

Conceptualizing the psychotherapy relationship. Examination of the therapist-patient relationship on the outcome of psychotherapy has been a theme as early as the writings of Freud in 1913 (Horvath & Symonds, 1991). As cited by Horvath and Symonds (1991), "Freud explored the difference between the neurotic aspects of the patient's attachment to the analyst (transference) and the friendly and positive feelings that the analysand has toward the therapist (alliance)." Freud later expanded this to include the possibility of a beneficial patient-therapist attachment that was based on reality. Further, Freud believed that although the interpretations of the patient's unresolved experiences are central to therapy, it is also important for the reality-based portion of the self to develop a relationship with the therapist for successful therapy (Horvath & Luborsky, 1993). Zetzel (1956) also wrote about this topic, defining the working alliance as the non-neurotic component of the patient-therapist relationship. Zetzel (1956) described successful therapy as switching between periods when the relationship is dominated by transference and periods when it is dominated by the working alliance.

Object-relation theorists believed that the patient develops the capacity to form positive, need-gratifying relationships with the therapist across the process of treatment. Further, they saw the task of the therapist as one to maintain a positive and reality-based position with the patient, allowing the patient to distinguish between distorted and reality-based aspects of the relationship (Horvath & Luborsky, 1993). The key issue that has been debated among researchers is the extent to which the patient's past relationships

influence the working alliance. The consensus among psychodynamic theorists appears to be that the alliance accounts for the influence of past experiences and concurrently as an aspect of the current relationship with the therapist (Horvath & Luborsky, 1993).

Carl Rogers (1957) theorized that it was the therapist's capacity to be empathic and unconditionally accepting that was the key ingredient for therapeutic success. The construct of empathy is different from that of the working alliance, with empathy being one component of the alliance. Research on Rogers's "therapist offered conditions" has shown that the patient's perception of the therapist as empathic is highly correlated with positive therapeutic outcome (Horvath & Luborsky, 1993). Others have compared empathy to the alliance, showing the alliance to be more predictive of outcome (Horvath, 1989). Further, it is believed that empathy may be a precursor to alliance development (Horvath & Luborsky, 1993).

Next, throughout the 1970s and thereafter, there was a trend in psychotherapy research to test whether different modalities of therapies yielded better outcomes over another. Despite the criticisms for the methodological limitations (Horvath & Luborsky, 1993), studies have found that different therapies produced similar amounts of therapeutic gain (Stiles, Shapiro, & Elliot, 1986). These results led researchers to then focus on the working alliance as a "pantheoretical factor" that may be responsible for a significant proportion of the common variance across therapies (Horvath & Luborsky, 1993). One such researcher, Edward S. Bordin (1979), described the working alliance as the patient's positive collaboration with the therapist. He identified three components of the alliance, which consisted of *agreement on goals*, *agreement on an assignment of tasks*, and *development of bonds*.

Bordin (1979) described the formation of goals as a process that begins prior to treatment. The therapist must then carefully search with the patient for the goal of change that is most fully related to their current difficulties. The process of negotiation is the key part to the building of a strong therapeutic alliance (Bordin, 1994). Once the goals for change have been identified, the therapist selects the therapeutic tasks; however, the patient must be taught the relevance of each task as it relates to change. This understanding and agreement is essential in order for the patient to take an active role in following through with the tasks (Bordin, 1994). The bond between the patient and therapist, according to Bordin (1994), "grows out of their experience of association in the shared activity. Partner compatibility (bonding) is likely to be expressed and felt in terms of liking, trusting, respect for each other, and a sense of common commitment and shared understanding in the activity. Thus, the specific nature of the bonds will vary as a function of the shared activity." Bordin (1994) believes that when commitment to change and understanding of the tasks are a function of the mutual bond, the therapeutic relationship can provide leverage to deal with any transference reactions that may take place throughout therapy.

Research to examine Bordin's conceptualization of the working alliance has assessed the cognitions of patients during therapy (Horvath, Marx, & Kamann, 1990). The results supported the idea that patients' expectations of therapy outcome were based on collaboration with the therapist, rather than a response to therapist factors or interpersonal factors alone. To develop a strong alliance, it appears that the therapist has to communicate to the patient the link between specific tasks in therapy with the accomplishment of the overall treatment goal. Additionally, the therapist must remain

aware of the patient's level of commitment to the tasks and intervene if resistance is present (Horvath & Luborsky, 1993).

At present, the pantheoretical definition of the working alliance is commonly accepted. Though the definitions may vary slightly, all modern conceptualizations of the working alliance involve the sense of patient-therapist collaboration, as well as a mutually agreed upon plan related to carrying out the therapy (Horvath & Symonds, 1991).

Gelso and Carter (1994) further theorized about the psychotherapy relationship. Based on the early work of Freud (as cited in Gelso & Carter, 1994) and Greenson (1965), Gelso & Carter (1985) wrote about the three components that they believe exist in all patient-therapist relationships, regardless of the type of therapy being practiced. In addition to the working alliance, which has received considerable empirical attention (Horvath & Symonds, 1991), they also believed all therapy relationships included a "transference configuration" and a "real relationship."

They described the transference configuration as consisting of the patient's transference reactions in therapy *and* the therapist's CT (Gelso & Carter, 1994). Patient transference may occur as a result of patient's past experiences that have shaped their present schema, which in turn shapes their expectations, behaviors, and feelings in therapy. It has been suggested that pre formed transference may even occur prior to the patient entering therapy, based on their expectations of therapy (Gelso & Carter, 1994). Similarly, CT occurs in all therapy situations, as the therapist enters the relationship with his or her own set of schema, formed by childhood and adult experience, as well as professional knowledge and experience. Gelso & Carter (1994) suggest that transference

and CT begin from the moment of initial contact (and before). Both have the potential to be beneficial, neutral, or destructive to therapy. The outcome depends upon the nature of the transference and CT reactions, their intensities, and how they are handled in therapy (more in depth discussion to follow). In a qualitative study by Gelso and Hayes (1998), therapists interviewed were able to identify CT in 80% of their sessions, supporting its universality as a component of the psychotherapy relationship.

The third component of the psychotherapy relationship proposed by Gelso and Carter (1994) is the "real relationship." The real relationship is defined as being made up of genuineness (authenticity, openness, honesty) and realistic perceptions (accurate and non defensive). This is the component of the whole relationship that is non transferential and undistorted. Gelso & Carter (1994) propose that all patient-therapist relationships contain some element of a real relationship. Additionally, they believed that all three components of the therapy relationship interact in important ways that have the potential to impact psychotherapy outcomes as follows:

- Positive transference and CT at times serve to strengthen the working alliance and negative transference and CT serve to weaken it.
- The strong working alliance can buffer against the effects of negative transference and CT.
- A positive real relationship between the therapist and patient will strengthen the working alliance, however, too much positive feelings toward one another may interfere with therapy and the alliance.

- The stronger the working alliance, the more expression of genuine and realistic appreciation for the qualities of the therapist and patient toward each other.
- As transference and CT increase, the real relationship decreases (and vice versa).

Further discussion of the research on the working alliance and CT are relevant to this study, considering the research questions. It has been shown empirically that CT impacts negatively on ratings of the working alliance (Ligiero & Gelso, 2002; Rosenberger & Hayes, 2001). Because only one study on CT has directly investigated its relation to psychotherapy outcome (Hayes, Riker, & Ingram, 1997), it is important to discuss the research on the working alliance, which has been found to be a robust predictor of outcome (Horvath & Symonds, 1991). Additionally, the studies on working alliance and BPD will be reviewed.

Research on the working alliance. Horvath and Symonds (1991) conducted a meta-analysis of 24 studies related to the working alliance. The investigators sought to examine the strength of the relation between working alliance and success of therapy, as well as the relationship between measurement variables or specific therapy variables to the strength of the alliance across the existing literature. Studies included in the meta-analysis were those that reported quantifiable associations between the alliance and some other outcome measure, included five or more subjects, and involved individual therapy modalities (Horvath & Symonds, 1991).

The meta-analysis revealed that the working alliance is an important variable to successful therapy outcome. Specifically, it yielded an average effect size of $r = .26$, which may even be a conservative estimate (Horvath & Symonds, 1991). This magnitude does not seem large, however, "when the impact of the alliance is compared with other relationship factors whose relation to outcome has been estimated, the alliance appears to be a robust variable" (Horvath & Greenberg, 1994). There is evidence to suggest that the link between early alliance and therapy success might be as high as $r = .32$ (Horvath & Symonds, 1991; Horvath & Greenberg, 1994).

The meta-analysis also examined the relation between alliance and outcome according to who assessed the alliance relationship (i.e. through patient, therapist, or observer report). Analysis revealed that the patient-rated outcome is a better predictor than therapist-reported outcome, which is superior to observer-rated outcome. One possible explanation for the less predictive value of therapists' alliance ratings offered by the researchers, is that therapists who overestimate the strength of their alliance are likely to have poor outcomes. Therapists may mistake their patients' over compliant behavior for genuine collaboration (Horvath & Symonds, 1991). Therapists may also mistake their own attitudes of hope, healing, and confidence in the treatment method as equally shared by their patients when they are not (Hatcher, 1999). It appears that therapists base their judgments of the alliance on their sense of patients' active and confident involvement in treatment, features viewed by therapists as signs related to treatment progress (Hatcher, 1999). Regardless of the reason for their misjudgment of the alliance, therapists will then fail to see the need for action to maintain or improve the relationship (Hatcher, 1999), which may serve to be detrimental to the therapy.

Horvath and Symonds (1991) also examined the relation between alliance and therapy outcome based on measures taken at various points in the therapy relationship. Early alliance ratings were defined as first to fifth session, while late alliance ratings were at or near the end of therapy. Averaged alliance ratings were also examined, where ratings were summed across multiple sessions. It was found that early and late alliance ratings were similar in terms of relationship with therapy outcome (r = .31, r = .30, respectively), while average alliance ratings across sessions yielding much lower value in predicting therapy outcome (r = .21). The authors report that this is due to the "large between-session fluctuations of the alliance that are typical of the middle phase of therapy" (Horvath & Symonds, 1991). Other researchers confirm this mid stage fluctuation by results that have shown improvements in therapeutic alliance ratings in the session following a sudden therapeutic gain (Luborsky, 2000).

Follow-up to this meta-analysis reported that alliance ratings taken early in treatment are most strongly related to outcome (Horvath & Greenberg, 1994). These authors and others have stated that failure to engage with the therapist, develop trust, and agree on the therapeutic tasks by the first three to five sessions will likely lead the client to disengage from therapy (Horvath & Greenberg, 1994; Saltzman, Leutgert, Roth, Creaser, & Howard, 1976). More research is needed on the midstage of the alliance to achieve clarification both clinically and conceptually (Horvath & Greenberg, 1994). Similarly, a lack of research exists on the late stage of therapy, which may have implications for the long-term effectiveness of the therapy (Horvath & Greenberg, 1994).

Lastly, the meta-analysis found no differences in alliance ratings on therapy outcomes as a function of the length of treatment (studies examined ranged from

approximately 10 to 50 sessions) or modality of treatment received. The studies examined consisted of psychodynamic, eclectic, cognitive, and Gestalt interventions. Other research, however, has found cognitive-behavior therapy to yield superior ratings of working alliance over other treatment modalities (Raue, Castonguay, & Goldfried, 1993; Raue, Goldfried, & Barkham, 1997).

Overall, the existing research on the working alliance consistently reveals that a good working alliance is related to positive therapeutic outcome. The working alliance is presently considered to be the "best model of the in-therapy pantheoretical process variable" (Horvath & Greenberg, 1994).

Because both patients with BPD and their treatment providers are known to have difficulty engaging collaboratively in treatment and in the therapeutic relationship, some research has examined the concept of the therapeutic alliance with this population (Marziali, et al., 1997, 1999; Gunderson, et al., 1997; Yeomans, et al., 1994). Marziali and colleagues (1999) suggest that patients with BPD are more likely to closely monitor their therapists' responses, due to their difficulty in developing and maintaining trusting and positive relationships with others. Thus, it is an important objective in therapy, particularly with the BPD patient, to develop a stable therapeutic alliance. If the therapeutic alliance fails, these patients are likely to drop out of therapy, which serves to reinforce the cycle of rejection and negative interpersonal experiences (Marziali, et al., 1999).

Because studies have consistently shown that the quality of the therapeutic alliance is associated with overall therapeutic success, symptom reduction, and improved interpersonal relations with standard patient populations (Beutler, et al., 1994; Bordin,

1979), a recent experiment by Marziali and colleagues (1999) specifically tested the therapeutic alliance on measures of treatment effects with patients with BPD. Their sample of 79 subjects, who met criteria for BPD, was randomly assigned to an individual therapy treatment condition and a group therapy treatment condition. Subjects rated themselves on measure of social adjustment, clinical symptoms, and were interviewed to determine level of behavioral dysfunction. Therapeutic alliance was measured for patients by self-report questionnaires at various intervals over the course of individual and group sessions. It was found that patients with BPD who had a severe symptom profile scored lower in their ratings of the therapeutic alliance supporting clinical observations.

Patients with BPD are twice as likely to drop out of therapy than those patients with other personality disorders and neuroticism, and are four times more likely to drop out than patients with schizophrenia. Failure to form a therapeutic alliance has also been associated with dropout and treatment non compliance (Gunderson, et al., 1997). An investigation by Gunderson and his colleagues (1997) examined the therapeutic alliance in patients with BPD involved in long-term therapy. This prospective study compared therapists' and their patients' ratings, changes in the alliance throughout the course of therapy, and whether early ratings of alliance were related to treatment outcomes. Ratings of the alliance were completed at 6 months, 1 year, and each year up to 5 years. Results showed a significant correlation between patients' and therapists' alliance ratings up until 2 years, with therapists' ratings being generally higher. Therapists' baseline ratings of alliance could distinguish the patients who would eventually drop out of therapy from those who would remain. The patients' ratings did not have this same level

of predictability. These results strengthened the idea that patients with BPD, who fail to develop a therapeutic alliance by 6 weeks, are at high risk for dropout. Alliance ratings at 6 weeks were not, however, correlated highly with 3-year outcomes (Gunderson, et al., 1997).

A study by Yeomans et al. (1994) examined characteristics of the early therapeutic alliance that were related to the BPD patient staying in treatment. Similar to the Gunderson, et al. (1997) study, they found that most of the patients who dropped out of treatment did so during the first 3 months, confirming that this may be a critical period for forming a strong alliance. Not surprisingly, the BPD patient variable most strongly associated with dropout was a high level of impulsivity.

In summary, a strong working alliance is an essential component of all psychotherapy relationships. This variable is a robust predictor of treatment outcome and has particular relevance when working with BPD patients, whose problem areas typically include difficulty in interpersonal relationships.

Research on countertransference. As stated previously, it is the position of this investigator that the manifestation of CT results from therapists' schematic interpretation of the patient and the events in therapy. It is important to note that others who have written extensively on this topic similarly believe that the origins of CT are developmental in nature and that the roots of CT can usually be traced back to childhood (Hayes & Gelso, 2001). However, a difference in theoretical orientation leads some researchers and theorists to view the origins of CT as "derivatives of earlier conflicts" (Hayes & Gelso, 2001). For example, Hayes and Gelso (2001) describe a therapist who

has CT related to termination with patients in therapy. They trace this therapist's CT back to earlier experiences of loss, abandonment, or rejection in the therapist's own life. The investigator of this study is in agreement with this interpretation, however, makes one fundamental distinction: the therapist's CT in the above example is the result of the therapist's *schema* (i.e., set of beliefs) related to earlier experiences of loss, abandonment, or rejection in his or her life.

In 1951, Reich first wrote about acute and chronic CT. This has become a useful distinction in the current literature (Gelso & Hayes, 2002; Hayes & Gelso, 2001). The essential difference is that acute CT refers to situation-specific CT reactions, while chronic CT reflects a particular pattern of response typical for an individual therapist. Reich saw acute CT as an identification with the patient, occurring sporadically, while chronic CT is related to more pervasive unresolved needs of the therapist, occurring as common responses from a particular patient. The useful implication from this distinction is that the triggers of CT will vary according to the individual therapist and that chronic CT is likely to occur irrespective of particular client or session variables.

Early CT research sought out to explore triggers of therapists' CT. An early study by Yulis & Kiesler (1968) examined therapists' CT in response to hostile, seductive, and neutral patients, hypothesizing that more hostile and seductive patients would elicit more CT behaviors from the therapists than the neutral patient. The results indicated that the therapists responded similarly to all three types of patients, despite patient characteristics that would seemingly trigger CT reactions. Other investigators have attempted to repeat this study in the laboratory with therapist trainees (Hayes et al., 1991; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987). In these studies, therapists were presented with audio

taped hostile, seductive, and neutral patients and were given the chance to respond at various points in the tape. Therapists could choose to address the patients' behavior (considered the appropriate response) or could avoid it (CT response). All three studies also failed to show significant differences among the patient characteristics. Other studies of CT have examined therapists' responses to gay and lesbian patients, which indicated that client sexual orientation did not affect CT (Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993). Overall, the empirical literature does not support the notion that patient factors alone stimulate CT. These studies failed to account for therapists' CT origins and therefore could not accurately predict patient factors that would trigger CT (Hayes & Gelso, 2001).

Other studies examined therapist variables associated with the origins of CT reactions. The two studies noted above also examined therapists' responses to gay and lesbian patients while accounting for therapists' ratings of homophobia. It was then that the expected results emerged. More homophobic therapists displayed greater CT behaviors (Gelso, et al., 1995; Hayes & Gelso, 1993). Another study has found that patient appearance has also been found to elicit CT in some therapists, particularly if the patient reminds them of someone significant in their lives, such as a former client, family member, or him or herself (Hayes, et al., 1998). It appears to be the therapists' personal associations with the patient features, as opposed to the features themselves, which elicit the CT response. These results illustrate the interaction between patient and therapist variables, emphasizing that neither should be examined in isolation (Hayes & Gelso, 2001).

One older study examined the interaction of patient material presented in session with therapists' unresolved issues (Cutler, 1958). The therapists in the study were rated to be less effective with patients when their own areas of conflict were approached as topics in session. Similarly, a study by Little and Hamby (1996) examined the impact of the therapists' sexual abuse history when treating patients for issues related to childhood sexual abuse. As predicted, therapists who had histories of childhood sexual abuse, displayed greater CT behaviors, such as crying with their clients, making boundary mistakes, and sharing details of their own sexual abuse, in comparison to other therapists without such histories.

Among other conclusions drawn in Singer and Luborsky's (1977) chapter on the status of CT, they state that therapists with a higher level of experience and overall competence tend to possess a greater understanding CT and have less of a tendency to display CT behavior. Williams, et al. (1997) decided to test this using therapist trainees. Utilizing various measures, patients, trainees and their supervisors rated reactions to each session, while trainees rated their sense of self-efficacy and state-trait anxiety. Supervisors rated the trainees' therapeutic skills and ability to manage CT. It was found that over the course of 9 to 11 sessions, trainees became less anxious, developed greater therapeutic skills, and were able to better manage CT reactions. Trainees often questioned their competence as a therapist and reported difficulty in defining their role, likely contributing to their CT reactions. Information processing would suggest that more experienced therapists have developed a multitude of more complex schema surrounding therapy. Therefore, when presented with information in session are able to more easily

and accurately fit material into existing schema, leading to appropriate therapist responses and minimizing CT reactions (Singer, et al., 1989).

All CT behavior appears to be preceded by thoughts and feelings of the therapist (Hayes & Gelso, 2001). When internal reactions of CT are not managed or well attended to, they are likely to result in CT behavior. A qualitative study conducted by Hayes et al. (1998) found that the majority of the eight therapists interviewed felt angry, bored, sad, nurturing, and inadequate in half of their sessions. A survey of 285 therapists indicated that 80% of the therapists tended to experience fear, anger, and sexual feelings in the context of their work (Pope & Tabachnick, 1993). In terms of cognitive distortions, McClure and Hodge (1987) sought to empirically establish a relationship between CT and therapists' beliefs about their patients. They found that the greater their liking of a patient, the more similar to themselves they perceived the client to be, while the more they did not like the client, the more they perceived the client as dissimilar from themselves in comparison to actual measures of their personality traits. Further, the researchers found that positive CT was observed in 80% of the cases where positive attitudes were displayed and negative CT in 79% of the cases where negative attitudes were displayed. When there was an absence of strong feelings, there was not distortion of the patients' personalities. Therapists' ratings of positive prognosis were greater for those patients they liked versus those they disliked (McClure & Hodge, 1987). Further, positive prognosis has been found to be a predictor of positive psychotherapy outcome (Beutler, et al., 1994). This suggests that when CT can be managed appropriately, positive feelings toward a patient may lead to greater feelings of hope, resulting in

therapist behaviors that promote positive therapy outcomes (i.e. a strong working alliance, use of empirically supported interventions, etc.).

In contrast, Hayes et al. (1998) found that therapists may even choose to end treatment prematurely when CT issues are aroused. In the survey of therapists by Pope and Tabachnick (1993), 97.2% of the therapists feared that a patient would commit suicide, 90.9% feared a patient would get worse, 89.8% felt angered at a client for being uncooperative, and 89.1% feared that a client would attack someone. These feelings impacted negatively on the therapists, with 53.3% of them indicating that their fears about a client affected their eating, sleeping, or concentration. These percentages are not surprising when one considers that 18% of therapists reported having been physically attacked by a patient in the past, 58% reported working with male patients who have formerly attacked a third party, 44.6% reported working with female patients who have formerly attacked a third party, and 28.8% of therapists reported that they experienced at least one patient suicide. Exposure to these traumatic events is likely to impact and shape the schemas of therapists, ultimately affecting therapists' CT behavior.

In addition to therapists' thoughts and feelings related to CT, CT behavior has also been examined in the literature. Most often the focus has been on negative forms of CT. Two studies have found that therapists' lack of empathy toward patients is related to therapists' avoidant behavior. A common pattern also emerged among several of the therapists interviewed in Hayes et al. (1998) qualitative study. Therapists described a tendency to respond to patients as either empathic or avoidant when CT issues were raised in session. Peabody and Gelso (1982) found that empathy was negatively related to avoidant behavior. It was also found in this study that therapists with greater empathic

ability were less likely to act out on their CT feelings, suggesting the importance of empathy in CT management (Hayes, et al., 1991).

CT behavior can also take the form of over involvement with patients (Friedman & Gelso, 2000; Hayes, et al., 1998; Williams, et al., 1997). Several of the trainees followed in the study by Williams et al. (1997) became too attached to their patient, took on a peer advisement role, and lost objectivity in dealing with their patients. Over involvement has the potential to result in boundary crossing if therapists' fail to recognize their CT behaviors. Smith and Fitzpatrick (1995) discussed common patient-therapist boundary issues. They identified the potential for dual relationships to form when therapists become a friend to the patient or engage in seemingly harmless non sexual physical contact that is misinterpreted by the patient as a sexual advance or indication of a less than professional relationship. Inappropriate and detailed self-disclosure may also cross the line and become a boundary issue. Smith and Fitzpatrick (1995) note that sources identify inappropriate self-disclosure as the boundary violation that most frequently precedes therapist-client sex. Highlighting this problem, 8% of psychologists surveyed by Lamb and Catanzaro (1998) indicated that they have engaged in at least one serious boundary violation.

In the development of the Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000), both positive and negative CT factors emerged through statistical factor analysis. The purpose of the development of this measure was to capture the full spectrum of CT behavior, as opposed to previous studies that have defined and measured CT as avoidance or withdrawal behaviors (Peabody & Gelso, 1982). The ICB sought to measure over involvement as well as under involvement of therapists

conducting therapy and the items were developed to reflect such behaviors. Through expert ratings and factor analysis, two factors did emerge in the measure and were labeled as "positive" and "negative" CT. Friedman and Gelso (2000) noted that all behavioral manifestations of CT feelings are a form of therapist avoidance, however, the expression may be in the positive or negative form. Through positive and approach-based behaviors, therapists are avoiding dealing with other issues emerging in therapy. Depending upon the individual issues of therapists, CT may have a "positive or negative valence" (Friedman & Gelso, 2000). This is presumably related to the therapists' own beliefs about the patient, themselves, or other similar patients. This study is the first in the literature to conceptualize positive CT as potentially damaging to therapy. Other work has discussed positive CT as facilitating the therapeutic relationship (McClure & Hodge, 1987).

The items reflected in the positive CT subscale reflect ways of approaching patients that are inappropriate and conflict based. Items on the negative subscale reflect therapist behavior that is avoidant or hurtful (more in depth discussion of the ICB is included in the Measurement section). Friedman and Gelso (2000) suggested that therapists' inexperience may be an important variable in expression of CT. They cite the example of the therapist who has unresolved feelings of inadequacy or a desire to please. Befriending a patient, talking too much, or providing too much structure in the session may reflect these underlying needs to be liked or perceived as competent. It is likely that patient session material activates therapists' schemas related to certain relationship factors from their own lives and are displayed as CT within session. It is likely that

therapists who treat BPD patients develop a "BPD schema" over time, which becomes activated simply by knowledge of the diagnosis.

Following the development of the ICB, Ligiero and Gelso (2002) had supervisors of doctoral psychology students rate their CT behavior and working alliance in mid treatment. Results indicated that negative CT behavior was significantly and negatively related to supervisor and therapist ratings of each of the components of the working alliance. It is interesting to note that positive CT behaviors were found to be significantly and negatively related to supervisors' ratings of the therapeutic bond (one of the three components of the working alliance). These results are important in providing empirical support that negative CT, and typically positive CT as well, are correlated with weaker working alliances. Further, Rosenberger and Hayes (2001) engaged in a 13-session case study examining CT behavior and working alliance. Specifically, results indicated that the expression of CT behavior in sessions was related to poorer ratings of working alliance. Negative CT was associated with a weakened working alliance bond. As stated earlier, working alliance is a strong predictor of psychotherapy outcome (Horvath & Symonds, 1991) and CT is likely also an important variable for psychotherapy outcome.

One study by Hayes et al. (1997) attempted to directly measure CT's relationship to psychotherapy outcome. Supervisors rated CT in therapy sessions of trainees. Psychotherapy outcome was then rated by therapists, supervisors, and clients at the end of the brief therapy. Results indicated that expression of CT behavior was found to be greater in less successful cases, in comparison to more successful cases.

Data from qualitative studies also suggest preliminary support that expression of CT behavior negatively effects psychotherapy outcome. One such study extensively

interviewed 12 therapists about disagreements between patient and therapist that ceased with the premature ending of treatment. CT was a significant factor mentioned in such treatment impasses (Hill, Williams, Heaton, Thompson, & Rhodes, 1996). The therapists interviewed reported difficulty in handling session material when it touched on issues related to their personal histories. In a similar vein, a survey of therapists by Little and Hamby (1996) revealed that therapists with histories of childhood sexual abuse who work with sexually abused patients reported greater amounts of CT behaviors, in comparison to the non abused therapists. Specifically, they tended to over empathize with their patients, to make boundary mistakes, and to feel angry with the perpetrator of the abuse, illustrating the point that therapists' schema and unresolved issues can impact on their responses to patients in treatment.

On the other hand, the therapists' ability to manage their CT is likely to impact on their ability to use CT in a therapy-enhancing manner. It is also likely that therapists' ability to manage their CT is related to whether or not the CT is expressed behaviorally or experienced internally. As suggested earlier, CT that is processed internally provides the therapist with useful clinical information, while acting out behaviorally in response to CT may result in harm to the patient or the therapeutic process. Several studies have examined CT management. Because CT is inevitably experienced in all therapeutic relationships (Gelso & Carter, 1994), a point made previously, when its overt expression is managed by some therapists the harmful effects of CT are minimized. Peabody and Gelso (1982) attempted to understand what factors were related to those who could manage their reactions and those who could not. They examined the early work of Reich (1951, 1960; as cited by Peabody and Gelso, 1982), who hypothesized that therapists'

empathy, awareness of CT feelings, and ability to make sense of the feelings were the important factors in CT management. Peabody and Gelso (1982) examined 20 therapists in training and found that empathy appeared in inhibit CT behavior when threatening session material was presented. Empathy and openness to CT were also found to be related.

Similarly, Robbins and Jolkovski (1987) examined CT behavior and CT awareness in 58 therapists in training. Their results indicated that the greater the therapists' awareness of CT, the lower the expression of CT behavior. Also noteworthy, is that those therapists who had a theory to rely on and had high CT awareness, expressed the least amount of CT behavior. Using a theory without having CT awareness was not associated with management of CT and was, in fact, associated with the greatest CT behavior. Latts and Gelso (1995) found these same results many years later.

The concept of CT management was further expanded on by Van Wagoner, and colleagues (1991), who proposed a five-factor model. They theorized that self-insight, self-integration, empathy, anxiety management, and conceptualizing ability were an interrelated set of skills associated with CT management ability. They explained that *self-insight* refers to the therapists' awareness of their own feelings, including the roots of their CT, while *self-integration* refers to therapists' intact character structure and recognition of boundaries between themselves and others. *Anxiety management* refers to therapists' ability to experience anxiety while possessing internal skills to control and understand the anxiety, avoiding over expression in session. *Empathy* allows therapists to identify with patients and to remain focused on the patients' needs and to resist

attending to their own needs, while *conceptualizing ability* refers to therapists' ability to draw upon a theory in their therapeutic work (Gelso & Hayes, 2002).

Van Wagoner et al. (1991) created an instrument to measure the five factors of CT management, called the Countertransference Factors Inventory. Using the instrument, it was found that therapists who were viewed to be "excellent" were rated favorably on all five factors of the CFI, suggesting that excellent therapists have good CT management skills. The CFI was revised in 1996 by Latts, who aimed to improve its psychometric properties (becoming the CFI-R). The CFI-R was used in Friedman and Gelso's (2000) study mentioned previously, where it was found that therapists' expression of CT behaviors was inversely related to therapists' CT management ability, as rated by the therapists' supervisors. Additionally, the study of cases by Rosenberger & Hayes (2001) found that stronger ratings of the working alliance were related to the management of CT. The one study that directly measured CT management with therapy outcome also found that therapists better managed their CT in cases with more successful outcomes (Gelso, Latts, Gomez, and Fassinger, 2002).

Overall, it would appear from the most recent research on CT that the construct is linked with psychotherapy outcomes. No research to date has investigated how these patterns of CT behavior and management manifest when working with specific patient populations, such as BPD, as was the intent of the present study.

Other psychotherapy outcome and related research. Another body of research has examined therapist and patient variables associated with treatment outcome. One study by Rosenkrantz and Morrison (1992) examined therapist characteristics that may be associated with negative perceptions of their patients with BPD. They found that therapists who scored higher on measures of analytic depression, including themes of dependency, neediness, loneliness, and fear of abandonment, tended to view their patients with BPD more negatively than therapists without these traits. In addition, therapists scoring high on interpersonal boundaries, tended to view BPD patients more positively than therapists scoring low on this dimension. Having a high boundary style, with a preference for highly differentiated interpersonal relationships, may provide the therapist with some protection from distress or CT reactions to patients with BPD (Rosenkrantz & Morrison, 1992).

Beutler et al. (1994) reviewed the body of psychotherapy literature on therapist characteristics that affect therapeutic outcome. Many of these studies have led to inconsistent or mixed results, presumably because therapist characteristics interact in complex ways with patient characteristics, the situation, the type of therapy practiced, and the research method used (Beutler, et al., 1994). Studies on therapists' age, sex, and ethnicity have yielded inconclusive results, suggesting that these variables alone are weak predictors of therapy outcome (Beutler, et al., 1994). Review of the studies examining therapist and patient locus of perceived control and conceptual level (cognitive style), indicate that effective therapeutic process and outcome may be enhanced by client and therapist similarity on these variables. Similarity of cognitive style and level may facilitate retention in therapy and early therapy gains (Beutler, et al., 1994).

Numerous studies that have examined therapists' emotional well-being have consistently concluded that therapists' level of positive adjustment is related to positive therapy outcomes (Beutler, et al., 1994). Some studies have suggested that inconsistent or disrupted skills occur in therapy when the therapists' own conflicts are activated during the therapeutic process (Beutler, et al., 1994). This implies that if a BPD patient exhibits symptoms or behaviors that activate distress or conflict in the therapist, there is a significant chance that the therapeutic process and outcome will be impacted negatively. Consider the study discussed previously where therapists' CT was greater with sexually abused clients if the therapists themselves have a history of sexual abuse (Little & Hamby, 1996).

The values and attitudes of therapists have also been studied in the therapy outcome literature. A study by Lafferty, Beutler, and Crago (1989) found that therapists who value intellectual pursuits and hard work tend to be more effective than therapists who place higher value on social and economic status. A review of the literature indicates that during the course of successful therapy, patients tended to adopt the personal values of their therapists. Further, several of those studies noted that initial differences in values were associated with later similarity between therapist and patient values and beliefs (Beutler, et al., 1994). Evidence suggests that the therapists' ability to communicate with their patients within the patients' value framework may provide a greater contribution to patient improvement than the particular values held by the therapist (Beutler, et al., 1994). Clearly, if psychologists hold negative attitudes toward their patients with BPD, this is likely to impair their ability to communicate effectively with them in terms of the patients' own value system.

Other authors discuss how general attitudes about patients with BPD develop after having difficulty managing them on an inpatient hospital unit (Rosenbluth & Silver, 1992). Unresolved staff feelings about previous BPD patients often easily trigger a rejecting and hostile response to the next patient with a similar symptom presentation. Failure of staff to recognize these CT reactions will likely impact negatively on the treatment of patients with BPD (Rosenbluth & Silver, 1992).

In Beutler et al.'s (1994) analysis of therapist variables associated with therapeutic outcome, they reviewed all the studies that have examined the social influence of therapists on their patients. Patients' ratings of therapist expertise and attractiveness were found in all studies to be associated with therapists' level of training, consistency of performance, and various non verbal (e.g., smiles, gestures, eye contact) and verbal (e.g., empathy, self-disclosure) behaviors. Responsive non verbal behavior, interpretations, and maintenance of confidentiality were found to be related to patients' perceptions of therapists' trustworthiness. Some studies indicated that non verbal therapist responses are more persuasive than verbal behaviors or therapy content. In summary, a moderate-to-strong relationship was found between perceived expertise, attractiveness, and trustworthiness with patients' satisfaction with therapy and end of therapy goal achievement (Beutler, et al., 1994). One study found that patients who dropped out of therapy viewed their therapists as less expert, less attractive, and less trustworthy than did patients who completed treatment (Beutler, et al., 1994). The researchers also found that symptom change and retention was associated with patients' positive ratings of their therapists on these variables.

Some studies reviewed by Beutler et al. (1994) attempted to examine the expectancies of therapists about their patients in treatment. One difficulty in finding conclusive results may have been a function of the changing expectancies of the therapist during the course of therapy (Heppner & Heesacker, 1983). Several studies that have tried to address this issue have found that patient improvement was related to the degree to which therapists' expectations were met. Increased improvement was found when the therapists' expectations converged with the patients' expectations over time (Beutler, et al., 1994). It can therefore be presumed that in the treatment of patients with BPD, if the therapist and patient both hold low expectations of improvement, it is likely that little improvement will occur from treatment.

Reviews of the effects of the therapists' training level indicate that the impact may vary depending on the characteristics of the patient and the type of therapy being conducted (Beutler, et al., 1994). Specifically, studies have found that a greater length of therapists' experience was associated with positive outcomes in therapy that was shorter than 12 sessions and when the patients were more severely disturbed. Additionally, therapists' level of experience was positively correlated with the quality of the therapeutic alliance (Beutler, et al., 1994). Meta-analytic review of therapists' discipline indicated a larger overall effect size for psychologists (ES [r] = .43) in comparison to psychiatrists (ES [r] = .30) for positive therapeutic outcomes (Beutler, et al., 1994).

Complementary interpersonal styles between therapists and patients have been found to be associated with positive treatment outcomes (Beutler, et al., 1994). Henry, Schacht, and Strupp (1990) found that poor therapy outcomes were associated with a

pattern of therapist hostility and patient self-criticism. The investigators referred to this as a "dominance-submission" pattern of interpersonal relations.

One way that the impact of therapists' characteristics on treatment outcome has been found to be minimized is through the use of therapy manuals (Beutler, et al., 1994). This reduces the amount of variability in the therapists' behavior. Use of manualized therapies was also associated with more consistent findings of treatment efficacy. Use of specific interventions has also been examined. It was found that when patients are prone to being resistant, they respond better to therapist interventions where directiveness is used. Alternatively, when patients are not resistant to change, interventions that were non directive proved to be more beneficial (Beutler, et al., 1994).

Therapists' use of self-disclosure has also been reviewed in the therapy outcome literature (Beutler, et al., 1994). This may foster the development of the "real relationship" component of therapy, described earlier by Gelso and Carter (1994). A summary of these studies indicates that therapist self-disclosure is more helpful when it is self-involving, rather than remote or uninvolving. Additionally, intimate disclosures are viewed more favorably by patients and are reciprocated more frequently than non-intimate therapist self-disclosures. Overall, when therapists use self-disclosure, it has been found in the literature to be associated with greater symptomatic improvement than when they did not self-disclose (Beutler, et al., 1994). Linehan (1993) suggests use of self-disclosure with borderline patients, when it serves a therapeutic purpose, with careful attention to maintenance of professional boundaries.

Several studies examined the patient traits associated with particular styles of staff responses. Specifically, one study used subjects on an inpatient psychiatric hospital unit

with personality disorder, schizophrenia, affective disorder, and other psychosis (Colson, Allen, Coyne, & Deering, et al., 1986). Hospital staff included those from backgrounds as social workers, nurses, psychiatrists, and activity therapists. They rated their affective responses to each patient in the various diagnostic groups. It was found that the staffs' anger, helplessness and fear were the emotions most highly associated with perceived treatment difficulty. Further, it was found that different types of treatment difficulty were associated with particular patterns of affective reaction by the professionals.

Characterological pathology (including behaviors perceived as demanding, manipulative, hostile, emotionally labile and likely to sabotage treatment) was most strongly associated with anger responses from the treatment team (Colson, Allen, Coyne, & Deering, et al., 1986). The personality disordered group was perceived by the treatment team as the most difficult to treat.

In a separate investigation, Colson, Allen, Coyne, and Dexter, et al. (1986) examined a group of 127 long-term psychiatric hospital patients who were perceived by the treatment team as "difficult to treat." Based on staff ratings and data in the patients' clinical records, they identified 10 profile groups of the "difficult patient." Four clusters of characteristics appear to be related to staff perceptions of difficulty: Withdrawn psychoticism, severe character pathology, suicidal-depression, and violence-agitation (Colson, Allen, Coyne, & Dexter, et al., 1986). The most difficult to treat patients were those who scored high on all four of the difficulty dimensions. These patients are seen to have a poor prognosis and as clinically complex. This study implies that because many patients with BPD tend to show behaviors in all four of the clusters of characteristics, there is a high likelihood of these patients being perceived by professionals as difficult to

treat. Another study similarly identified difficult patient behaviors as suicidal acts, violence, and substance abuse (Bongar et al., 1991).

Patients with BPD are known to have high therapy drop-out rates (Gunderson, et al., 1997). Several patient demographic variables have been found to be associated with premature termination in therapy. A review of the literature by Garfield (1994) has consistently found correlations between lower social class and lack of therapy retention beyond six sessions. Though there are many inconsistent results, it appears that there is a tendency for more Black than White patients to terminate therapy prematurely. There are no consistent findings between age or gender and therapy dropout. Patients with more serious levels of disturbance, poor ego strength, and poor personality integration, tended to have worse treatment outcomes (Garfield, 1994).

Further, patient socioeconomic status was found to be related to therapists' ratings of patient attractiveness, ease of establishing rapport, and positive prognosis; variables found to lead to continuation in therapy (Garfield, 1994). The literature suggests that therapists generally prefer patients who are of a higher social class and are more similar to themselves. It is difficult to examine therapist and patient variables in isolation, considering the interaction that is taking place in the therapeutic process. Garfield (1994) has concluded that "if the therapist regards the client as unmotivated, overly defensive, hostile, and difficult, it is conceivable that his or her attitudes may be communicated to the client and influence his or her participation and continuation in psychotherapy."

A study by Rosenzweig and Folman (1974) found three significant therapist ratings associated with continuation in therapy at the end of the second session. The ratings were the therapists' estimate of their ability to empathize with the patient,

likeability of the patient, and judgment of the patients' ability to form a therapeutic alliance. Shapiro (1974) similarly found that therapists' ratings of likeability and positive prognosis were related to therapy continuation. Further review of this literature by Garfield (1994) found that patients who continued in therapy judged their therapists to be more skilled than those patients who dropped out of treatment. Additionally, patients who demonstrate therapeutic progress are likely to be viewed more favorably by their therapists (Garfield, 1994). It appears that patient and therapist views held early on in the therapy are the most predictive of continuation or early termination of therapy.

Considering the vast literature that identifies patients with BPD as elicitors of CT, as frequent failures in the formation of a therapeutic alliance, and as difficult to treat, might simply the label of BPD shape professionals' responses to these patients? Several studies in the nursing literature have examined this question. A study by Gallop and associates (1989) examined 124 nurses' perceptions of a patient with schizophrenia or a patient with BPD. Half of the nurses were given a stimulus paragraph describing a patient diagnosed with schizophrenia, while the other half were given the same paragraph describing a patient diagnosed with BPD. The nurses were asked to respond to written statements reported to have been made by the patient. An example of an item was, "Go away – get off my case – don't you ever give up?" Nurses' responses to the patients indicated much more belittling or contradicting messages to patients with BPD, as compared to those patients who were described as having schizophrenia. This study provided some evidence that the label of BPD is pejorative, and that nurses may provide stereotypic responses and less empathic care to BPD in comparison to other patients. Patients with BPD may fail to validate nurses by rejecting help, eliciting negative

feelings, and engaging in difficult behaviors. Perhaps the nurses see the patients as deliberately choosing not to improve. One study found that nurses liked patients more if they perceived them as wanting the same things that the nurses wanted for them (Fraser & Gallop, 1993). Simmons (1992) has even suggested that BPD has become a diagnosis assigned to female patients if the clinician is experiencing negative feelings during their interaction or to patients who are difficult to treat (Beck & Freeman, 1990; Reiser & Levenson, 1984).

A study by Fraser and Gallop (1993) observed 20 patient groups on an inpatient psychiatric unit, each run by a nurse group leader. The groups were comprised of patients diagnosed with schizophrenia, BPD, affective disorders, and other additional diagnoses. A researcher blind to the study rated nurses' responses to the patients during group as either "confirming" or "disconfirming." They found the nurses responses to be significantly different by diagnostic group. Specifically, they found that patients with BPD were more likely to receive responses categorized as "impervious" and "indifferent" than patients with affective disorders. There were no difference found between patients with affective disorders and patients with schizophrenia in terms of confirming or disconfirming responses. It was found that nurses experienced much more overall negative feelings toward patients with BPD than either patients with schizophrenia or patients with affective disorders (Fraser & Gallop, 1993). The nurses' negative feelings toward the BPD patients appeared to decrease their ability to provide empathic responses to these patients during treatment groups. Perhaps the nurses' knowledge of the patients' diagnosis of BPD altered their perceptions of the BPD patients as "bad," rather than "ill" (Fraser & Gallop, 1993).

Lewis and Appleby (1988) examined whether patients with BPD were believed by psychiatrists to be more in control of their actions, as opposed to other patient populations who might be seen as "ill." Two hundred and forty psychiatrists were assigned to one of the six case histories included in the study. All case histories included information that might be part of a general practitioner's letter of referral for a depressed male patient. The conditions were as follows: Case one indicated a diagnosis of personality disorder; case two indicated no diagnosis; case three gave a diagnosis of depression; case four indicated a diagnosis of BPD and the purpose of the study; case five gave no diagnosis but labeled the patient as female; and case six gave no diagnosis but labeled the patient as "solicitor." The results of the study confirmed the authors' hypothesis that a previous diagnosis of personality disorder would be related to less favorable ratings by the psychiatrists (Lewis & Appleby, 1988). This occurred whether or not the subjects knew the purpose of the study. In addition, even when the psychiatrists in the personality disorder conditions diagnosed the patient themselves with depression, they still tended to rate the patient more critically. The personality disorder label still had an effect on their perceptions even though it was not their own diagnosis. The results of this study show that a past diagnosis of personality disorder was more important in determining attitudes than sex, class, previous diagnosis of depression, and informing subjects of the purpose of the study (Lewis & Appleby, 1988). It was also found that the psychiatrists rated the patients in the personality disorder conditions to be in control of their suicidal urges, confirming the researchers' second hypothesis. They were labeled as manipulating and attention-seeking, implying that their symptoms are less important or less genuine (Lewis & Appleby, 1988).

Book et al. (1978) suggest that negative staff reactions result from misinterpretations of meaning from BPD patients' behavioral expressions of affect. Specifically, they note that arrogance displayed by patients may actually be a cover for underlying fear, or that anger can act as a cover for despondency, and that some people must act in order not to feel. If staff were informed of this, they would be more likely to see that patients with BPD are troubled, rather than manipulative (Book, et al., 1978). Reactions and intense feelings toward the patient should be used in discussion and supervision and can be utilized to gain understanding of oneself and the patient (Book, et al., 1978; Vuksic-Mihaljevic, Mandic, Barkic, & Mrdjenovic, 1998). Other researchers suggest that our knowledge of staff's predictable reactions to patients with BPD provides us with a means for anticipating strong emotional reactions and to examine them (Colson, Allen, Coyne, & Dexter, et al., 1986). This study aimed to identify more specific information about the frequency and type of therapists' CT reactions in working with patients with BPD for the purpose of improving treatment effectiveness.

Specific Hypotheses

1) There would be common positive and negative CT behaviors displayed in session by psychologists who treat patients with BPD, as indicated by self-reported items endorsed on an adapted version of the ICB.
2) Psychologists' self-reported ratings of the frequency of CT behaviors displayed, as indicated by scores on an adapted version of the ICB, would be significantly negatively correlated with psychologists' self-reported ratings of CT management

ability, as indicated by scores on an adapted version of the CFI-R, when in session with their typical patient with BPD in therapy.

3) Psychologists' self-reported ratings of the frequency of CT behaviors displayed, as reflected by scores on an adapted version of the ICB, would be significantly negatively correlated with psychologists' self-reported ratings of working alliance, according to scores on the adapted version of the WAI-Short (Therapist Version), when in session with their typical patient with BPD in therapy.
4) Psychologists' self-reported ratings of empathy, as defined by their total score on subscale items extracted from an adapted version of the CFI-R, would be significantly negatively correlated with psychologists' self-reported ratings of the frequency of CT behaviors displayed, as measured by scores on the adapted version of the ICB, when in session with their typical patient with BPD in therapy.
5) Psychologists with less years of clinical experience would display significantly higher frequencies of self-reported ratings of CT behaviors on an adapted version of the ICB, when working with their typical BPD patients, in comparison to psychologists with a greater number of years experience.
6) Psychologists with less years of clinical experience would display lower self-reported ratings of working alliance, as demonstrated by scores on the adapted version of WAI-Short (Therapist Version), and CT management skills, as identified from scores on the adapted version of the CFI-R, when working with their typical BPD patients, in comparison to psychologists with a greater number of years experience.

7) Psychologists who report a psychodynamic/psychoanalytic theoretical orientation would report significantly higher CT management scores, on the adapted version of the CFI-R, in comparison to psychologists who report other theoretical orientations.

Chapter 2

Method

Participants

An overall sample of 500 psychologists who are members of the American Psychological Association (Division 12, Clinical Psychology; Division 17, Counseling Psychology; and Division 29, Psychotherapy) were asked to participate in the study. All members of Division 12, 17, and 29 were potential participants. A randomization procedure was used to select 500 subjects, identifying a representative sample of psychologists throughout the United States. Demographic information obtained through the questionnaire included: gender, age, ethnicity, number of years practicing therapy, number of years treating BPD patients, highest degree obtained, theoretical orientation, modality of therapy conducted with BPD patients (i.e., group and/or individual), number of patients currently being seen in therapy with a BPD diagnosis, and an estimation of the number seen in the course of the individual's career. Only psychologists who have treated at least three or more patients with BPD in individual therapy, who were older than the age of 18, within the last 24 months were included in the study. Psychologists who had only treated BPD patients in group therapy or patients younger than age 18 were excluded. Psychologists who believed that their survey ratings did not accurately represent their true thoughts, feelings, and behaviors with patients with BPD would also be excluded from the study. Specifically, there were three survey items used to assess

this. Participants who responded other than "somewhat," "very," or "extremely" to more than one item, would be excluded; however, this did not occur in the sample obtained.

Measures

The measures used in the survey were designed to obtain information about the self-reported frequency and intensity of the CT behaviors, attention to CT in clinical practice, and typical working alliance of psychologists who treat patients with BPD. Participants were asked to read the DSM-IV-TR (American Psychiatric Association, 2000) diagnostic criteria for BPD, check a box indicating that they read it, and to consider only those patients who met the criteria when responding to the questionnaire. They were instructed to consider patients who had a co-occurring Axis I disorder, only if they also met criteria for BPD. Additionally, participants were asked to include patients who also had a comorbid Axis II disorder, only if the BPD diagnosis was causing the patients' *primary impairment in functioning*. Psychologists were asked to consider their *typical* adult patient with BPD and their *typical* experience when treating a patient with BPD in individual therapy within the last 24 months. Subjects were asked to take all of their BPD patients into consideration, rather than focusing on their "least successful," "most successful," "most liked," "most disliked," "most sick," or "most healthy" patients. Their responses were to reflect their "typical pattern of behavior" with most all of their BPD patients seen in individual therapy.

Inventory of Countertransference Behavior (ICB). The ICB is a measure developed to assess supervisors' perceptions of CT behavior in individual sessions between counselors-in-training and their patients (Friedman & Gelso, 2000). The items for the scale were originally developed from the researchers' theory about the two dimensions of CT; underinvolvement and overinvolvement, with items reflecting each category. Eleven doctoral-level psychologists, deemed as experts in CT, rated the original item pool on the extent to which they believed the items reflected CT behavior. All items were determined to possess sufficient face validity (higher than a 3 on a 5-point Likert scale), however, one item was deleted based on feedback provided by the experts that indicated it could be confusing or misinterpreted. Thirty-one items were retained in the measure.

Next, data was obtained from 126 supervisors who rated a counselor-in-training from a recent supervision session (within the last two weeks), using the ICB to measure CT behavior (Friedman & Gelso, 2000). Factor analysis was conducted, revealing two subscales. One subscale was comprised of 11 items that "appeared to describe inappropriate therapist behaviors that are disapproving of clients or not affirming in some way." This factor was labeled as negative CT, rather than underinvolvement, a term seen to better describe the behaviors in the items. The second factor was comprised of 10 items that "included therapist behaviors that seemed to be inappropriately familiar or overly supportive. The subscale was labeled positive CT, rather than overinvolvement, to best describe the items. Through the process of factor analysis, 10 items were deleted that did not load at least .30 on one of the factors, leaving a final measure with 21 items. Further, convergent validity was found, as evidenced by the correlation of the ICB to the

CT Index (Hayes, et al., 1997)), a one-item measure of CT. The CT Index was significantly positively correlated with each subscale of the ICB ($p < .001$). Additionally, the ICB was significantly negatively correlated with the CFI-R (Latts, 1996), a measure of CT management ability.

Adapted Inventory of Countertransference Behavior (ICB). For the purpose of the present study, the ICB was adapted to be used as a self-report measure. Psychologists were asked to rate themselves on the 21 items that described CT behaviors. The items were reworded to reflect reference to one's own behaviors when in a *typical* session with a *typical* patient with BPD (e.g., changed from "the counselor rejected the client in session" to "During my work with patients with Borderline Personality Disorder, I typically find myself rejecting the patient in session.") Further, the rating scale was modified to measure the frequency that psychologists engage in these behaviors, as opposed to the extent of the display of the behavior in the original ICB. Specifically, the original scale included a "1" indicating "to little or no extent" through a "5" that signified "to a great extent." The revised scale included a "1" indicating "never" through a "5" indicating "almost always." Because the meaning of the items was not changed, face validity still applies as in the original study. Additionally, analysis of the correlation between the ICB and the CFI-R was conducted to attempt to establish convergent validity (see Results section).

Countertransference Factors Inventory-Revised (CFI-R). The CFI was originally developed by Hayes et al. (1991) as an attempt to assess CT management ability in therapists. From prior research in this area, the investigators hypothesized that there were at least five areas of personal attributes in therapists that allow them to use CT productively or to prevent their CT reactions from interfering with their work. The five factors proposed were self-integration, anxiety management, conceptualizing ability, empathy, and self-insight (discussed in more detail in Related Research section). The researchers enlisted 33 experts on CT and had them rate each of the initial 50 items on a 5-point Likert scale in terms of their importance in managing CT, with a "1" indicating "not important" through a "5" indicating "very important." All items were found to be at least somewhat important, with mean endorsements of 3.4 or higher. Items for the self-insight and self-integration subscales had mean item scores of 4.3, signifying that the experts viewed these factors to play a very important role in the management of CT. Self-insight and self-integration were the two factors most reflective of the therapists' personality structure, whereas, the other three factors related more to others (empathy) or skills (anxiety management and conceptualizing ability). Though these factors were based on theory only, this served as an initial measurement tool for CT management, based on the perceptions of experts in the field.

Several years later, Latts (1996) sought out to revise and validate the CFI. She revised the items to reflect therapists' behaviors and qualities in the context of therapy in the five areas associated with CT management; representing the "process by which CT management occurs" rather than the "personality traits associated with the ability to manage CT successfully" (Latts, 1996). The survey was changed to 40 items, with eight

items corresponding to each subscale. The best eight items were selected in terms of their contribution to the internal consistency of the subscale and other empirical data. The CFI-R was completed by supervisors who indicated their degree of agreement with each item, with a "1" indicating "strongly disagree" through a "5" indicating "strongly agree," as in the original scale. Participants in the original study were 280 therapists-in-training and their supervisors, who were given the CFI-R, as well as multiple other measures to which the study attempted to find correlations between the subscales and these various measures appearing to measure similar constructs. The results indicated that four out of the five subscales did not correlate with the other measures as hypothesized. Conceptualizing ability subscale scores were correlated with therapists' report of having a strong theoretical framework, which drives their practice (a 13-item questionnaire created for use in the study). Use of theory was also correlated with overall CT management scores. Latts (1996) indicated that the lack of convergent and discriminant validity on the CFI-R subscales was likely based on the poor validity of the measures chosen. The subscales correlated most strongly with the other subscales themselves.

An important significant finding, however, was that overall CT management scores on the CFI-R were significantly correlated with supervisors' ratings of therapist effectiveness, according to scores on the Counselor Evaluation Rating Scale (CERS), providing support for the concurrent validity of the CFI-R. When factor analysis was conducted on the CFI-R, one factor emerged, indicating that all of the items appear to be tapping the same underlying construct; possibly CT management. Due to the high correlation between each subscale of the CFI-R and the CERS total score, it is likely that

the CFI-R measures something similar to counselor effectiveness (Latts, 1996). Latts (1996) recommended that the subscales be retained in this measure, though subscale scores should be interpreted with caution. Rather, subscale scores appeared to be different facets, though closely related, of overall CT management and have clinical utility in terms of providing feedback to therapists.

Adapted Countertransference Factors Inventory-Revised (CFI-R). For the purpose of this study, the 40-item version of the CFI-R was used, with a modification of the items to reflect psychologists' self-report of their agreement with the items (retaining the original rating scale). The items were reworded to reflect reference to one's own experiences when in a *typical* session with a *typical* patient with BPD (e.g., changed from "the counselor is able to comfort him/herself when feeling anxious during sessions" to "during my work with patients with Borderline Personality Disorder I typically am able to comfort myself when feeling anxious during sessions.")

Working Alliance Inventory (WAI). The WAI is a measurement developed by Horvath (1989) to assess the three components (tasks, bond, and goals) proposed in Bordin's (1979) pantheoretical theory of the working alliance (discussed in detail in Related Research section). The original pool consisted of 91 items proposed to reflect each of the three dimensions. Seven experts in the field of working alliance were asked to rate the relevance to the working alliance for each potential item on a 5-point Likert scale, with a rating of "1" indicating "not related" to the alliance through a rating of "5" of "very relevant." The percentage of agreement between the experts was calculated and

items with less than 70% agreement were rejected. The experts also identified which of the three dimensions that each of the items best reflected.

Next, the remaining item pool was rated by 21 randomly selected psychologists by use of the same procedure. Additional items were rejected that did not meet the 70% agreement criteria. The top-rated items for each of the three dimensions were retained to make up the final 36-item scale, with 12 items corresponding to each of the three dimensions of the scale. A client and a therapist version were then developed, allowing for both therapists and clients to be the respondents.

Clinical trials were conducted to determine reliability of the WAI, with estimates in the adequate range. Further, convergent, concurrent, and predictive validity were established for the WAI. Data from the clinical trials resulted in a revision of the Likert scale included in the instrument, changing it from a 5-point to a 7-point Likert scale.

A shortened form of the WAI was later developed for both the therapist and client versions (Tracey & Kokotovic, 1989). Tracey & Kokotovic (1989) studied the factor structure of the full WAI, supporting its validity for measuring a general alliance factor, as well as task, bond, and goal factors. They noted that the most valid way to represent data from the WAI was with one overall alliance score. The researchers selected four items from each of the subscales, based on the highest factor loading, and formed a new WAI-Short. The WAI-Short had comparable scores for validity as the longer format and a similar factor structure.

Adapted Working Alliance Inventory-Short (WAI-Short, Therapist Version). The WAI-Short, Therapist Version was used in this study, although a slight adaptation was made. The WAI-Short, Therapist Version, asks the therapist to insert the name of the patient into a blank in the sentence for each item. The present study asked the psychologists to consider their "typical experience in working with a patient with borderline personality disorder." Additionally, it asked participants to think about their experiences after the third therapy session, the time frame for which the working alliance has been found to be fully formed and predictive of outcome, with recognition that the alliance is likely to change across the course of treatment (Horvath & Greenberg, 1994).

Other studies examining the working alliance construct with varying populations have also made minor adaptations to the WAI. One study (Glueckauf, et al., 2002) reworded the items to fit the context of family therapy and created a separate version with simplified wording for adolescents. Lehrman-Waterman and Ladany (2001) used the WAI to assess trainees' perceptions of their alliance with their supervisors. Therefore, the adaptations made for this study appeared to be consistent with changes other researchers have made without compromising the validity of the measure.

Procedures

All members of the American Psychological Association were identified through the 2002 Membership Directory book. Five hundred participants were selected by way of a random sampling procedure. A random numbers table was used to select a page to begin the sampling procedure in the APA Membership Directory. Once a beginning page

was obtained, every fifth member on the page was examined for their division membership. If the member belonged to Divisions 12, 17, or 29, they were included in the sample. If they did not belong to any of those divisions, they were excluded. Five more names were then counted and examined for Division membership until reaching the end of the page. Next, 10 more pages were counted and the same procedure took place until a sample of 500 subjects was obtained (including name and address).

A cover letter soliciting participation, an individually stamped addressed envelope, and a stamped postcard was provided to each potential participant. Personally signed and individually stamped packets have been associated with increased personal contact with the participant, a variable associated with enhancing response rate in mail surveys (Weather, Furlong, & Solorzano, 1993). The letter used yellow colored paper and comic sans ms font to enhance its attractiveness, a variable also found to increase response rates (Weather, et al., 1993). The letter described the participants' invitation to contribute to an important study about the beliefs, attitudes, and experiences of psychologists who treat patients with BPD. The letter indicated that their participation was critical to enhancing our understanding of this high-risk, difficult-to-treat population and that the information will be used to improve training, supervision, and continuing education programs for those responsible for treating these patients. It was indicated that the researchers are sensitive to the difficulties in treating patients with BPD, as well as the potential associated risks and liabilities, while highlighting the importance of open and honest survey responses. Potential participants were asked to take 20 minutes to complete the survey questionnaire, which maintained their anonymity. Participants were asked to answer as truthfully as possible and not to include their name. They were asked

to return the completed survey in the stamped envelope provided. In addition, subjects were asked to return the stamped postcard with their name on it separately from the survey. The investigator used the postcard to track who has responded to the survey, without associating any names with survey responses. Individuals who did not return postcards were contacted after 30 days in a follow-up mailing of another copy of the survey packet. Those participants interested in receiving a copy of the results of the survey, in an abstract form, were asked to contact the researchers at the PCOM mailing address.

Data obtained was coded and entered into an SPSS file by the investigator. A random sample of 25% of the surveys was independently verified against the data recorded in SPSS by the investigator. Any errors found were corrected in the database.

Chapter 3

Results

A total of 500 survey packets were mailed to an identified list of potential participants throughout the United States. In response to the first mailing, 133 surveys were returned to the researcher and 36 packets were returned to sender with an incorrect address. Of the 133 returned packets, 43 participants were eligible to participate in the study and 90 participants were ineligible, as a result of not meeting the inclusionary criteria of having treated at least three patients with borderline personality disorder in the past two years. A second mailing was sent to all non respondents. This mailing yielded a return of 66 surveys, of which 15 participants met the inclusionary criteria and 51 were not eligible to participate for the above reason. Additionally, eight more surveys were returned to sender with the incorrect address. The overall response rate for both mailings was 39.8%, slightly lower than the expected 50% rate of response for a typical mail survey using a follow-up mailing (Rea & Parker, 1997). The final sample included data from 58 participants. No further participants were eliminated due to the validity check items. An analysis of the data yielded support for four of the seven hypotheses, which are explained in the following sections.

Demographic Characteristics

The sample consisted of 34 male and 24 female psychologists, who were primarily White (94.8%). The majority of the sample was between the ages of 51 and 60 (82.8%) with greater than 15 years of clinical experience (75.9%). All but one of the subjects had a doctorate degree (98.3%) and all but four were licensed in their state(s) of practice (93.1%). Most of the sample treated between zero to five (58.6%) or six to ten (31%) patients with borderline personality disorder in the past 24 months, while about half have treated more than 30 patients with borderline personality disorder during the course of their careers (48.3%). At the time of the survey, the majority of the sample (87.9%) was treating between zero and five patients with this diagnosis. Tables 1, 2, and 3 provide more details of the demographics of the sample.

Validity Check Items

Three items were included in the survey to check whether the participants believed that the survey items accurately reflected their experiences in treating a typical patient with BPD, their ability to be open and honest in their ratings, and their ability to determine their "typical" experience when treating patients with BPD. Participants were asked to respond to these three items on a 5-point scale, from "not at all," "a little," "somewhat," "very," to "extremely." Any participants who responded to more than one item with "a little" were not to be included in the study; however, there were no participants eliminated based on this criteria. In fact, 67.2% of the participants believed

Table 1

Characteristics of the Sample

Demographic	Frequency	Percent
Gender		
Male	34	58.6
Female	24	41.4
Age		
Younger than 30	0	0
31 – 40	4	6.9
41 – 50	16	27.6
51 – 60	28	48.3
Over 60	10	17.2
Ethnicity		
White (Not of Latin Origin)	55	94.8
African-American	1	1.7
Asian/Pacific Islander	0	0
Latino/Latina	0	0
Other	2	3.4

Note. Total Sample consisted of 58 participants.

Table 2

Clinical Practice of the Sample

Demographic	Frequency	Percent
Years of Clinical Experience		
Less than 5	1	1.7
5 to 10	6	10.3
11 to 15	7	12.1
Greater than 15	44	75.9
Theoretical Orientation		
Psychoanalytic/psychodynamic	18	31.0
Behavioral/cognitive-behavioral	19	32.8
Humanistic/existential	2	3.4
Family systems	1	1.7
Other/eclectic	18	31.0

Note. Total Sample consisted of 58 participants.

Table 3

Participants' Treatment of Patients with Borderline Personality Disorder

Demographic	Frequency	Percent
Number treated in past 24 months		
0 – 5	34	58.6
6 – 10	18	31.0
11 – 15	2	3.4
More than 15	4	6.9
Number currently treating		
0 –5	51	87.9
6 – 10	5	8.6
11 – 15	1	1.7
More than 15	1	1.7
Number treated in course of career		
0 – 10	8	13.8
11 – 20	12	20.7
21 – 30	10	17.2
More than 30	28	48.3

Note. Total Sample consisted of 58 participants.

Table 4

Frequencies and Percentages of Validity Check Items

Item	Frequency	Percent
Accurate reflection of experiences		
Not at all accurate	0	0
A little accurate	1	1.7
Somewhat accurate	15	25.9
Very accurate	39	67.2
Extremely accurate	3	5.2
Open and honest in ratings		
Not at all open and honest	0	0
A little open and honest	0	0
Somewhat open and honest	1	1.7
Very open and honest	35	60.3
Extremely open and honest	22	37.9
Determine and accurately reflect "typical" experience		
Not at all accurate	0	0
A little accurate	0	0
Somewhat accurate	13	22.4
Very accurate	41	70.7
Extremely accurate	4	6.9

that the survey items were "very accurate" in reflecting their typical experience in treating a patient with BPD. Of the 58 participants, 57 indicated that they were either "very open and honest" or "extremely open and honest" in their ratings, while one subject indicated "somewhat open and honest." Similarly, the majority of the sample indicated that they believed they were "very accurate" in their determination and reflection of their "typical" patient with BPD in their survey responses (70.7%). Table 4 illustrates the frequencies and percentages of these responses in more detail.

Countertransference Behaviors

Frequencies and percentages were calculated for all of the ICB items. Results of the participants' rating of their CT behaviors, as reported on an adapted version of the ICB, indicated that about half of the subjects "sometimes" or "often" typically find themselves over supporting their patient with borderline personality disorder in session, changing the topic, being critical of the patient, agreeing too often, inappropriately taking on an advising tone, and distancing themselves from the patient during the session, as indicated in Table 5. It is particularly relevant that 48 out of 58 participants indicated that they sometimes or often were critical of their patient during the session.

Similarly, according to calculated descriptive statistics, the five most commonly reported CT behaviors (both positive and negative) with borderline patients reported by the participants of the study were (in rank order, beginning with the most common): being critical of the patient during the session ($M = 3.12$, $SD = .77$), distancing myself from the patient during the session ($M = 2.78$, $SD = .68$), over supporting the patient in

Table 5

Frequent CT Behaviors "Sometimes" or "Often" Typically Engaged in By Therapists Treating Their Typical Patients With BPD

Item	Frequency	Percent
Over supporting the patient in session (+)		
Never	2	3.4
Rarely	20	34.5
Sometimes	29	50.0
Often	7	12.1
Always	0	0
Changing the topic during the session (+)		
Never	3	5.3
Rarely	22	38.6
Sometimes	25	43.9
Often	7	12.3
Always	0	0
Being critical of the patient during the session (-)		
Never	2	3.4
Rarely	8	13.8
Sometimes	29	50.0
Often	19	32.8

Always	0	0
Agreeing too often with the patient during the session (+)		
Never	7	12.1
Rarely	22	37.9
Sometimes	27	46.6
Often	2	3.4
Always	0	0
Inappropriately taking on an advising tone (-)		
Never	5	8.6
Rarely	22	37.9
Sometimes	27	46.6
Often	4	6.9
Always	0	0
Distancing myself from the patient during the session (-)		
Never	2	3.4
Rarely	15	25.9
Sometimes	35	60.3
Often	6	10.3
Always	0	0

Note. Total Sample consisted of 58 participants. (+) = positive CT behavior item. (-) = negative CT behavior item. Only 57 participants responded to "changing the topic during session".

the session ($M = 2.71$, $SD = .73$), changing the topic during the session ($M = 2.63$, $SD = .77$), and inappropriately taking on an advising tone with the patient during the session ($M = 2.51$, $SD = .75$).

The results also indicated a set of CT behaviors (including both positive and negative) that psychologists were least likely to engage in with their patients with borderline personality disorder. The five least common behaviors were (in rank order, beginning with the least common): acting in a dependent manner during the session ($M = 1.29$, $SD = .46$), spending time complaining during the session ($M = 1.33$, $SD = .51$), behaving as if I were absent during the session ($M = 1.52$, $SD = .63$), behaving as if I were somewhere else during the session ($M = 1.55$, $SD = .73$), and inappropriately apologizing during the session ($M = 1.60$, $SD = .62$). The most common positive CT behavior reported by the participants was over supporting the patient in session, while the most common negative CT behavior was being critical of the patient during the session. Refer to Table 6 for the means and standard deviations for all of the items of the ICB.

Countertransference Behavior and Countertransference Management

A one-tailed Pearson product-moment correlation was calculated to examine the relationship between participants' self-report of CT behaviors, as indicated on an adapted version of the ICB, with their self-report of CT management ability, as indicated on an adapted version of the CFI-R. There was a significant negative correlation ($r = -.309$, $p < .05$) between the participants' self-report of CT behavior and

Table 6

Mean Scores and Standard Deviations for the Items on the ICB

Item	Mean	Standard Deviation
Colluding with the patient	2.0526	.66604
Rejecting the patient	2.0517	.78186
Over supporting the patient	2.7069	.72568
Befriending the patient	2.1228	.92717
Being apathetic toward the patient	2.2241	.77331
Behaving as if I was somewhere else	1.5517	.72963
Talking too much	2.4483	.67985
Changing the topic	2.6316	.77070
Being critical of the patient	3.1207	.77409
Spending time complaining	1.3276	.50914
Treating the patient in a punitive manner	1.6379	.69328
Inappropriately apologizing	1.6034	.61955
Acting in a submissive way	1.7241	.74441
Acting in a dependent manner	1.2931	.45916
Agreeing too often with the patient	2.4138	.75008
Inappropriately taking on an advising tone	2.5172	.75490
Distancing myself from the patient	2.7759	.67650
Engaging in too much self-disclosure	1.6379	.74217

Behaving as if I was absent	1.5172	.62804
Inappropriately questioning the patient's motives	1.8448	.72067
Providing too much structure	2.3276	.80324

Note. The ICB contains a scale of "1" through "5," with a "1" indicating "never," a "2" indicating "rarely," a "3" indicating "sometimes," a "4" indicating "often," and a "5" indicating "always."

CT management, as predicted in hypothesis 2. As the participants' CT behaviors increased, their ability to manage their CT decreased, when treating their typical patient with borderline personality disorder. This negative correlation also further establishes convergent validity between the ICB and CFI-R instruments (Friedman and Gelso, 2000), indicating that they are measuring related constructs (i.e., if one is managing CT he or she is not displaying CT behaviors).

Countertransference Behavior and Working Alliance

The relationship between participants' self-report of CT behavior, as indicated by their responses on an adapted version of the ICB, and their self-report of working alliance with their typical patient with borderline personality disorder at about the third session, as indicated by their responses on an adapted version of the WAI-Short (Therapist Version), was examined through a one-tailed Pearson product-moment correlation. This calculation yielded a significant negative correlation between therapists' CT behaviors and their typical working alliance with patients with BPD ($r = -.342, p < .01$), supporting hypothesis 3. As the participants' CT behaviors increased, their reports of working alliance with their borderline patients decreased. Though it was not predicted, it is interesting and important to note that the psychologists' self-report of working alliance was positively correlated with their self-report of CT management ability ($r = .598, p < .01$). As ratings of the therapists' CT management increased, ratings of working alliance increased with their patients with BPD.

According to the mean scores for individual items on the WAI-Short (Therapist Version), participants reported lower levels of alliance with their patients with BPD in particular areas of treatment. Specifically, the lowest reported rating was "My patient and I have different ideas on what his/her true problems are" ($M = 3.64$, $SD = .91$, on a scale of "1" to "7," with a "1" indicating "not at all" and a "7" indicating "yes/totally"), in comparison to the participants' ratings on other items related to working alliance. The second and third lowest rated items were (in rank order): "My patient and I agree on the steps to be taken to improve his/her situation" ($M = 4.17$, $SD = 1.11$), and "My patient believes the way we are working with his/her problem is correct" ($M = 4.28$, $SD = 1.06$). The three highest rated items by the participants were (in rank order, beginning with the highest rated item): "I appreciate my patient as a person" ($M = 5.21$, $SD = .89$), "My patient and I are building a mutual trust" ($M = 4.93$, $SD = 1.07$), and "I am confident in my ability to help my patient" ($M = 4.57$, $SD = 1.19$), as detailed in Table 7. Based on these ratings by participants, it is clear that the participants perceive themselves to be having difficulty agreeing with their patients with BPD about the goals and tasks of therapy but, in comparison, have less difficulty feeling as though they have established a therapeutic bond. It should be noted that even the highest rated items yielded a relatively

Table 7

Mean Scores and Standard Deviations for the Items on the WAI-Short (Therapist Version)

Item	Mean	Standard Deviation
agree on steps to be taken to improve situation	4.1724	1.11036
new way of looking at the problem	4.4828	1.12766
believe my patient likes me	4.5614	.88676
doubts about what we are trying to accomplish	4.4655	1.12726
confident in my ability to help patient	4.5690	1.18636
work toward mutually agreed upon goals	4.5172	1.03010
appreciate my patient as a person	5.2069	.89362
agree on what is important to work on	4.4655	1.12726
building a mutual trust	4.9310	1.07380
different ideas on what the real problems are	3.6379	.91188
establishing an understanding about changes needed	4.3276	1.03259
way we are working on the problem is correct	4.2759	1.05619

Note. Wording of the items was shortened to fit on the table. The WAI consists of a "1" through "7" rating scale indicating agreement with the item. A "1" indicates "not at all," a "2" indicates "very little," a "3" indicates "a little," a "4" indicates "sometimes," a "5" indicates "quite a bit," a "6" indicates "very much," and a "7" indicates "yes, totally."

low level of working alliance (see section on Overall CT Behaviors, CT Management, and Working Alliance Ratings).

Countertransference Behavior and Therapist Empathy

A one-tailed Pearson product-moment correlation was calculated to examine the relationship between participants' self-report of CT behaviors, as indicated on an adapted version of the ICB, and their self-report of empathy for their patients with borderline personality disorder, as indicated by the empathy subscale items of an adapted version of the CFI-R. The results of this calculation revealed that there is a significant negative correlation between CT behavior and empathy ($r = -.370$, $p < .01$), providing support for hypothesis 4. As psychologists' level of empathy for their patients with BPD increases, their CT behaviors tend to decrease.

Years of Clinical Experience and CT Behavior, Working Alliance, and CT Management

It was hypothesized that more experienced psychologists would report less CT behaviors (hypothesis 5), while they would report better working alliances and CT management ability when treating patients with borderline personality disorder (hypothesis 6). It was found through a Pearson product-moment correlation that participants' self-report of CT behavior, working alliance, and CT management are correlated with each other (See Table 8). Considering this correlation, it was possible to conduct a Multivariate of Analysis of Variance (MANOVA) test, however, there was no

Table 8

Correlations Between Participants' Total Scores on the ICB, WAI, and CFI-R

	Total Scores		
Total Scores	ICB	WAI	CFI-R
ICB			
Pearson Correlation	1	- .342**	- .309*
Significance (1-tailed)		.005	.013
N	56	55	52
WAI			
Pearson Correlation	- .342**	1	.598**
Significance (1-tailed)	.005		.000
N	55	57	52
CFI-R			
Pearson Correlation	- .309*	.598**	1
Significance (1-tailed)	.013	.000	
N	52	52	53

* $p < .05$, one-tailed. ** $p < .01$, one-tailed.

relationship found between number of years of experience and these other variables, failing to support hypotheses 5 and 6. It is also noteworthy that the sample contained a disproportionate amount of highly experience clinicians (more than 15 years of experience). As an attempt to equalize the two groups, any participants with less than 15 years of experience were combined into one group and compared to the more experienced group in the analysis. Even when combining the participants with "less than 5," "5 to 10," and "11 to 15" years of experience, the total number of subjects was only 14, in comparison to 44 participants who reported more than 15 years of clinical experience. This factor may have impacted on the results (see discussion section).

CT Management and Theoretical Orientation

It was predicted that psychologists who reported a psychodynamic/psychoanalytic theoretical orientation would report significantly higher CT management ability when working with patients with BPD, according to their self-reported ratings on an adapted version of the CFI-R. An independent samples T-test was conducted to compare the means of these two sets of scores. Subjects were divided into two groups for the purpose of this analysis; those who endorsed a psychoanalytic orientation and those who did not. No differences were found in CFI-R scores between those participants with a psychodynamic
theoretical orientation and those without it. The data did not support that there were any differences in self-reported CT management ability as it is related to a psychodynamic theoretical orientation, failing to support hypothesis 7.

Overall CT Behavior, CT Management, and Working Alliance Ratings

It should be noted that the sample did not report a particularly frequent typical occurrence of CT behavior in sessions with their typical patient with BPD. This would be expected, given it is a survey of psychologists' *typical behavior* with a *typical patient with BPD*. The overall mean score of the total ICB scale for all of the participants was 2.1 (on a 5-point scale) (*SD* = .34), indicating that the participants rarely typically engage in CT behavior with their typical patient with BPD. Similarly, the participants reported that they typically agree with statements illustrating their ability to manage their CT reactions to their typical patient with BPD, with an overall mean score of 4.5 (on a 5-point scale) on all of the items (*SD* = .75). The reported levels of working alliance, however, indicated typically poor alliances with their typical patients with BPD after about the third session. The overall mean score for all 12 items was 4.17 (on a 7-point scale) (*SD* = .34), indicating that psychologists felt that only "sometimes" their patients with BPD agreed with them regarding the goals and tasks of therapy, as well as were able to form a therapeutic bond.

Chapter 4

Discussion

The present study clearly demonstrated that psychologists who work with patients with BPD typically display CT transference behaviors during sessions. They are aware of such behaviors and are willing to report it in an anonymous survey. A pattern of several common CT behaviors emerged from the survey. At least half of the participants surveyed reported "sometimes" or "often," typically finding themselves over supporting, changing the topic, being critical, agreeing too often, inappropriately taking on an advising tone, and distancing themselves from the patient during sessions with their typical patient with BPD. Of these six common behaviors, three are classified as positive CT and three as negative CT, however, they are all potentially harmful to therapy by definition of the construct of CT. Over supporting the patient, changing the topic, and agreeing too often with the patient are considered to be positive CT behaviors, while being critical, inappropriately taking on an advising tone, and distancing themselves from the patient during the session are considered to be negative CT behaviors.

It is interesting that when first examining the common CT behaviors identified, there seems to be some contradictions. For example, over supporting the patient seems to be the opposite behavior of being critical of the patient, while agreeing too often with the patient seems to be the opposite of taking on an advising tone. However, these opposite behaviors are consistent with the phenomenon that clinicians have discussed in the literature. Specifically, it has been noted that when treating patients with BPD, therapists begin to flip-flop their own behaviors, mirroring the patients' pathology (Layden, et al.,

1993; Linehan, 1993). This study also revealed that it is most uncommon that psychologists treating patients with BPD act in a dependent manner, spend time complaining, behave as if absent, act as if they were somewhere else, and inappropriately apologize during their sessions.

The CT behaviors identified in this study are the first empirical findings related to the CT displayed and self-reported by clinicians who treat patients with BPD. Other researchers have identified CT reactions common when treating patients with BPD that are based on clinical experience or observation, without empirical support (Kroll, 1988). Further, these CT reactions have been identified by authors as thoughts about patients, feelings about patients, and behaviors toward patients. Book et al. (1978), for example, identified common CT constellations experienced by treatment teams on an inpatient psychiatric unit working with BPD patients. They identified internal as well as external therapist CT reactions such as feelings of guilt, rescue fantasies, crossing of professional boundaries, rage, feelings of helplessness, anxiety, and terror (Book, et al., 1978). From a research perspective, this is problematic in terms of the commonly accepted thinking about CT reactions. Specifically, it is generally accepted that CT reactions can be experienced internally and/or expressed outwardly. The internal experience (i.e., thoughts and feelings) is unavoidable (due to the interaction between the therapists' and patients' schematic interpretations of session material) and can be potentially helpful if the therapist is able to recognize it and manage it appropriately within the session. The behavioral expression of CT has been shown empirically to be harmful to the therapeutic process and treatment outcome (Gelso, et al., 2002). Therefore, the experience of CT

must be discussed by distinguishing between the internal experiences and the behavioral expression.

When attempting to compare Book et al.'s (1978) list to the empirical findings of CT behaviors in the present study, there are some comparisons that can be made. Specifically, over supporting the patient with BPD and agreeing too often could be associated with what Book and colleagues (1978) called rescue fantasies. Conversely, depending upon the schema of the therapists, being overly supportive and agreeable with patients could be attributed to the therapists' feelings of guilt about lack of therapeutic progress or anxiety about addressing more serious session material. Similarly, being critical of BPD patients and taking on an advising tone in session might be a result of therapists' rage toward patients or an expression of the therapists' frustrations as a result of feelings of helplessness, depending upon the schema operating in the individual therapist. Perhaps future research should aim to develop scales to assess therapists' internal CT feelings (i.e. anger, guilt, helplessness, etc.) and therapists' schemas associated with helping patients with BPD. This would provide us with more detailed information about the full range of therapists' experiences of CT when working with BPD patients.

It appears that the diagnostic features present in patients with BPD tend to elicit a common set of CT responses from the clinicians who treat them. It is unclear exactly how this impacts the outcome of psychotherapy; however, this study does confirm that the display of CT behaviors is related to poorer ratings of working alliance with patients with BPD, as predicted. Specifically, as psychologists' CT behaviors increased toward patients with BPD, working alliances were perceived to decrease, supporting the inverse

relationship found in previous literature that did not include a specified patient population (Ligiero & Gelso, 2002; Rosenberger & Hayes, 2001). This repeatedly found relationship between psychologists' display of CT behaviors and lower ratings of working alliance suggests that CT behaviors may be a mediating variable between working alliance and psychotherapy outcomes, if not a direct predictor. Previous research has also demonstrated the relationship between CT management ability and psychotherapy outcome (Gelso, et al., 2002). The present study has found a correlation between self-reported CT management and working alliance, with reports of greater CT management ability being associated with stronger ratings of working alliance. Further, as predicted, this study found that as CT behavior increases, CT management decreases when working with patients with BPD. Consequently, it is feasible to hypothesize that psychologists' display of CT behavior and their ability to manage their CT mediate the relationship between the working alliance and psychotherapy outcome that is strongly supported in the literature (Horvath, & Symonds, 1991), though this requires further empirical investigation.

The therapeutic relationship is particularly relevant when treating patients with BPD, considering that disturbances in interpersonal functioning are part of the diagnostic criteria for BPD (American Psychiatric Association, 2000). Linehan (1993) noted that the relationship between the therapist and patient is sometimes the only thing that might keep a suicidal patient from harming him or herself. Lack of working alliance is also likely to be a stimulus for therapy drop out (Marziali, et al., 1999). This study empirically found disturbingly low ratings of working alliance by psychologists who treated patients with BPD. The study revealed several specific difficulties in their

working alliances. Psychologists reported problems between the patient and therapist in agreeing on what the patients' real problems are and agreeing on the correct way to deal with the problems in therapy. This is the first study to empirically examine psychologists' working alliance with their patients with BPD in this way. Perhaps particular attention to the goals and tasks of therapy with patients with BPD may have a positive impact on working alliance, which is associated with a reduction in CT behaviors, and ultimately improved therapy outcomes.

The psychotherapy outcome literature informs us that therapists' feelings of empathy toward their patients, as well as their working alliance and various other factors, is an important variable in predicting positive treatment outcomes. This study predicted that as psychologists' empathy increased for their typical patients with BPD, their CT behaviors would decrease. The results revealed support for this hypothesis, as a significant negative correlation was found ($p < .01$). Due to its correlation with other variables such as empathy and working alliance, which are shown to be predictors of psychotherapy outcomes (Beutler, et al., 1994), it is likely that therapists' display of CT behaviors in session is linked directly to negative psychotherapeutic outcomes. Further, display of CT behaviors have been found to be negatively correlated with CT management ability in this study and others (Friedman & Gelso, 2000), while CT management has been positively correlated with positive therapy outcomes in one study (Gelso, et al., 2002). The present study strengthens support for the idea that psychologists' skills at managing their CT leads to a reduction of harmful CT behaviors, which in turn enhances positive treatment outcomes. Future research should continue to

study this relationship empirically and attempt to expand its examination of patients with BPD and other patient populations, across various treatment settings.

This is not only the first empirical study to demonstrate these relationships with a specific patient population, but it the first to obtain data from therapists' own report of their behaviors and alliances, rather than supervisor or researcher observation and review of cases. This study provides evidence that therapists' self-report can be a valid method to measure CT behavior, providing the opportunity to broaden the number of clinicians and patient populations surveyed.

The ICB and the CFI-R were originally developed as instruments for supervisors to rate therapists-in-training on these two constructs, as it was viewed that this would be the most objective method of gathering data (Friedman & Gelso, 2000; Latts, 1996). The present study slightly modified these measures to be used as self-report inventories, in order to enable psychologists to report on their own perceptions of their CT behaviors and CT management ability when treating their typical patient with BPD. Because a significant negative correlation was found when using both the self-report method and when using supervisors' ratings, the present study provides support that self-report is a valid method to measure these constructs. Future investigations should seek to replicate these findings and to validate these measures for use as self-report inventories.

Also to be considered is that previous studies examined CT reactions more generally, while the present study focused its investigation of CT with a particularly challenging patient population. It would be interesting for future research to see whether similar correlations between CT behavior, CT management, and working alliance would be found with other less challenging populations. The psychotherapy outcome literature

suggests that both patient and therapist characteristics contribute to treatment outcome. This study attempted to make sense of the patient variable of BPD diagnosis and also attempted to explore several therapist variables.

Psychologists' number of years of clinical experience was examined in this study, in relation to its impact on CT behaviors, CT management, and working alliance when treating typical patients with BPD. Specifically, it was predicted that psychologists with less clinical experience would display more CT behaviors than more experienced psychologists, along with possessing less CT management ability and lower perceptions of working alliance when treating their typical patient with BPD, in comparison to more experienced clinicians. The results of this study did not find support for these hypotheses, despite what previous research has suggested (Williams, et al., 1997).

There are several important things to consider in interpreting these findings related to level of experience. First, it is noteworthy that the sample primarily consisted of psychologists who had more than 15 years of experience, the highest level included in the survey (75.9%). Due to the lack of representation of psychologists belonging to the other three levels of experience indicated on the survey (i.e., less than 5 years of clinical practice, 5 to 10 years, and 11 to 15) the three groups were combined into one group of "less experienced" psychologists to be compared statistically to the "more experienced" groups, with more than 15 years of experience. Even with the combining of the lower three levels, the two groups of "less experienced" and "more experienced" remained highly disproportionate, with 14 and 44 subjects, respectively. Perhaps there were not enough participants in the less experienced group to yield statistical results (see limitations of the study). Further, perhaps there may have been differences found

between psychologists with less than 5 years of clinical experience and those with 11 to 15 years, for example, which could not be examined. It is possible that other factors could also be interfering after 15 years of practice, such as psychologists' burnout. Additionally, perhaps there is something unique about patients with BPD that leads even experienced clinicians to display CT behaviors at the same rate as less experienced clinicians, when they may not do so with other patient populations. The relationship between number of years of clinical experience and CT behaviors, CT management, and working alliance still remains unclear. Future research should continue to investigate this important therapist variable.

The positive side of having a sample consisting primarily of experienced psychologists is that all of the previous studies that have examined CT empirically have included data obtained about therapists-in-training, according to their supervisors' ratings, a limitation in terms of the ability to generalize the results from these studies. Because the present study replicated previous findings about the relationship of CT behaviors to CT management and working alliance (Friedman & Gelso, 2000; Ligiero & Gelso, 2002) using a participant pool of highly experienced clinicians, this improves the ability to say with certainty that the relationship between CT and these other variables truly exists.

Another therapist variable that was examined in this study was psychologists' theoretical orientation. With the roots of the CT construct originating in the psychodynamic literature, it was predicted that those psychologists who have been trained in a psychoanalytic or psychodynamic orientation would better manage their CT, due to the presumed focus on the construct of CT in their training. Previous literature

suggested that theoretical orientation might be a factor in clinicians' self-report of feelings and behaviors toward patients (Little & Hamby, 1996). Support for this hypothesis was not proven in this study. There were no differences in CT management found between psychologists who reported a psychodynamic/psychoanalytic orientation and those who reported another theoretical orientation. The survey item asked the participants for the theoretical orientation that they used in their current clinical practice rather than the theoretical orientation that they were trained in. This study perhaps made an erroneous assumption that psychologists had formal training in the orientation that they reported currently practicing. Future studies may want to explore this therapist variable with larger samples or with other patient populations, specifying the orientation that therapists were trained in and the orientation of their current clinical practice in the survey items.

Implications for Training, Supervision, and Clinical Practice

As demonstrated in this study, managing CT can be a serious problem for psychologists who treat patients with BPD. Subsequently, this impacts on establishing a working alliance with the patient and on having a positive treatment outcome. The chronicity of the disorder, combined with frequent dramatic, emotional, or erratic behavior (Reid & Wise, 1995) has likely contributed to the well-documented presence of therapists' negative views about working with patients with BPD (Book, et al., 1978; Colson, et al., 1986; Gallop, et al., 1989; Fraser & Gallop, 1993; Lewis & Appleby, 1988).

Therapists' experiences in working with patients with BPD create a schema for the "typical" patient with BPD, as suggested in the literature on schema development (Singer, Sincoff, & Kolligian, 1989). Attached to the various beliefs that encompass these schema are associated feelings. Therapists then respond to their thoughts and feelings in session, sometimes with good self-monitoring and sometimes with poor self-monitoring of their behavioral responses. As a result of this study, we have a better understanding of the ways in which psychologists respond behaviorally to patients with BPD. Specifically, we know that at least half of psychologists typically sometimes or often are critical of the patient in session, distance themselves from the patient, over support the patient, change the topic, take on an advising tone, and agree too often with the patient. Knowledge of these common patterns of responding can be helpful to clinicians, supervisors, and training programs in terms of developing strategies to prevent these potentially harmful responses from occurring. These common CT behaviors should serve as "cues" for therapists and supervisors that further investigation of the therapeutic interaction is needed when these behaviors occur in therapy with a patient with BPD. Once a CT behavior is discovered to have taken place, there is need to assess why the behavior has occurred and what damage has resulted to the patient and in the working alliance. The goal is to prevent future CT behaviors and to have the opportunity to repair the working alliance, if needed.

In order to accomplish this goal, clinicians must first be educated about BPD, free from the bias and judgment of the instructor or supervisor. Lack of accurate information has been associated with the negative treatment of patients with BPD (Miller & Davenport, 1996). Next, clinicians must learn about CT and the schematic view as a

framework for understanding how and why CT occurs. Graduate training programs and continuing education courses need to increase the attention paid to discussing CT in their therapy coursework, case presentations, practicum seminars, and internship colloquiums. They may want to offer entire courses that specifically address difficult patients, such as those with BPD, highlighting the experience of CT and developing skills to manage it. Supervisors will need to be tuned-in with their supervisees who treat patients with BPD in order to immediately identify signs that the therapist has engaged in CT behaviors in session. Supervisors and the clinicians themselves will need to be sharp in recognizing schema that could likely lead to, or has already resulted in, CT behavior.

Schema modification is an intervention that is commonly used by therapists who practice cognitive-behavioral therapy (Beck, 1995). This intervention will first be briefly described, followed by a discussion of how the techniques can be applied to therapists and supervisors to modify their own schema. The schema modification process in therapy begins with the patient and therapist working together to identify the patient's schema that underlie the current patient pathology and to understand how and when these schema typically become activated. Once this has been understood, a specific problematic situation is identified for the patient, followed by the automatic thought that is activated in that situation. Next, the meaning attributed to the automatic thought is defined, along with the resulting emotions and behavioral responses. Further, the therapist and patient work to identify a new and modified belief of the original problematic core belief. To follow is an examination of the evidence that contradicts the old belief and supports the new belief. This ultimately leads the patient to endorse the modified belief, which then ideally elicits a new set of emotional and behavioral

responses that are more adaptive for the patient in the identified situation. A more detailed discussion of this and other cognitive-behavioral therapy techniques is beyond the scope of this paper, however, the reader is referred to *Cognitive Therapy: Basics and Beyond* by Judith S. Beck (1995) for further reading.

This same schema modification process can be applied to therapists who are working with patients with BPD (Layden, et al., 1993). For example, if therapists have a core belief that "being a therapist means I am superior in knowledge to my patients and other professionals," when they encounter a patient with BPD in therapy who continues to return to the same abusive relationship, therapists may have the automatic thought, "I told her this would not be good for her but she didn't listen." This is likely to result in the therapist becoming angry with the patient. Therapists may then display CT behaviors in session such as being critical of the patients and speaking to them in an advising tone, two of the commonly identified CT behaviors that occur for therapists working with patients with BPD. Perhaps modifying this belief to "being a therapist means that I have acquired much knowledge that I will try to pass on to my patients and other professionals, though they may not choose to accept it at this point in time," could help therapists to change their expectations that others should be willing to accept, or be capable of accepting, their interventions or suggestions, diffusing feelings of anger and resulting CT behavior.

To illustrate further, supervisors may become aware that therapists they are supervising are repeatedly failing to confront patients with BPD who are not complying with the treatment contract. This therapist behavior is a display of the common positive CT response of over supporting the patient in session. It is then important for supervisors

to work with therapists to identify the schema that is supporting this response. Upon discussing this with therapists, it might be revealed that they believe "all of my patients must like me or I am not a good therapist." Supervisors could then discuss the rationality of this thought (i.e., examining the evidence) with the therapists and help them to see how this belief is interfering with their ability to address important therapeutic issues. Supervisors could assist the therapists in modifying this belief to "it would be nice if all of my patients liked me; however, they all will not, and this is not related to my abilities as a therapist." This modification of the belief allows therapists to shift their thinking to avoid weighing their own worth as a therapist on whether or not a patient likes them. Possessing this modified belief would likely enable therapists to avoid fear of angering a patient and to address the patient's non compliance with treatment.

To further understand therapists' CT behaviors and the link to working alliance found in this study, it is important to consider that just as CT behaviors may lead to a reduction of the working alliance, a poor working alliance may lead to CT behaviors. This is particularly likely to occur when working with patients with BPD, given their difficulties in interpersonal functioning. Clinicians may become frustrated at their lack of ability to form an alliance with their patient with BPD and find themselves becoming critical, taking on an advising tone, and distancing themselves from the patient in session; the most common negative CT behaviors identified in this study. Conversely, at other times, clinicians may recognize the lack of alliance that exists between themselves and their patients with BPD, consequently engaging in positive CT behaviors as an attempt to improve the alliance. To accomplish this, therapists may become overly supportive, change the topic in session to a less threatening one for the patient, and overly agree with

the patient to avoid confrontation or challenges that may lead the patient to be angry with the therapist; the three common positive CT responses identified empirically in this study. It is likely that the type of therapist CT behavioral response depends on the type of schema that has been elicited from the therapist. More specifically, if therapists have a belief that "patients with BPD cannot be helped," they might find themselves being critical of the patient and lecturing the patient in an advising tone, for example. Therapists who are able to identify their own beliefs and feelings that lead to CT behaviors with their patients with BPD have the opportunity to address this on their own or in supervision.

To enhance the learning process about CT, supervisors and training programs may want to use popular films or written vignettes that depict therapists engaging in boundary-crossing, poor professional, and counter-therapeutic behaviors in exercises, aimed at identifying the beliefs of the therapists that may have led them to engage in the CT behaviors. This could help therapists-in-training and clinicians in supervision to better understand the relationship between their own thoughts and feelings and their behavioral responses in session, with the goal of preparing them to engage in this type of analysis on their own, on an ongoing basis, throughout their careers.

Some researchers have already studied the importance of supervision and support for therapists who work with patients with BPD. Marsha Linehan has incorporated therapist consultation groups as a required component of Dialectical-Behavior Therapy, the only empirically-supported treatment for patients with BPD (Linehan, 1993). The purpose of the consultation groups is to provide support for the therapist, offering a fresh perspective to keep the therapist engaged in the therapy. Further, one study showed that

nurses who were given educational information about patients with BPD were found to possess more positive attitudes about these patients (Miller & Davenport, 1996). Shearin & Linehan (1992) also found that reframing clinicians' thinking about their patients with BPD resulted in a reduction of their patients' suicidal behavior. These studies support the recommendations of this researcher to increase and improve training and supervision of clinicians working with patients with BPD. A structured analysis of therapist schema is recommended for all therapists working with patients with BPD, regardless of their theoretical orientation, given the potential for schema about BPD patients to result in CT behaviors that would reduce the effectiveness of treatment. Cognitive-behavioral supervision has been found to be associated with benefits to the supervisees and has been supported in the literature as an effective approach to supervision (Milne & James, 2000).

It is important for supervisors or trainers to validate for therapists that they *will* experience internal CT responses toward their patients and that it is a normal and necessary part of the therapeutic interaction (Gelso & Carter, 1994). Layden and colleagues (1993) have identified their own list of typical automatic thoughts of therapists who work with patients with BPD. Several of these include: "there is nothing I can do to help this patient," "this patient will not appreciate anything I do, so I might as well not tax myself too hard," and "letting myself care about this patient means I'm a pushover – I must be tough and detached in order to prove that I cannot easily be manipulated" (pp. 122-123). Therapists need to be taught to identify internal CT, as such, and to consider what useful information it might provide to the therapy. For example, if a patient with BPD consistently challenges most things the therapists say, the therapists may find themselves becoming angry with the patient. If the therapists are aware of this anger,

they could consider the patient's behavior and their own emotional response as data for the session. The patients have likely demonstrated firsthand for the therapist how they act with other people in their lives, while the therapists are likely experiencing feelings similar to others in the patients' lives (Glickauf-Hughes, 1997). The therapists may chose to place this item on the agenda for discussing with patients for the benefit of helping them to develop insight about the impact of their behavior on their relationships.

Additionally, therapists will need to have strategies on hand to cope with the internal reactions that they do not discuss with the patient, thwarting off CT behavioral responses. Strategies might include relaxation techniques, self-talk, rewarding themselves following challenging sessions, engaging in regular supervision or consultation for difficult cases, and/or referring patients to another clinician if the feelings are not able to be managed effectively. Layden and colleagues (1993) have provided a list of positive self-statements that therapists can use as a part of their preparation for sessions with borderline patients. Some of these include: "I must remember that my patient's anger stems from hurt, insecurity, and fear, and therefore I won't take it personally," "act professionally and be a real person," and "I am a good therapist and a good person – I do not need to be lauded to the sky, nor do I need to panic if I'm undervalued – I don't need to prove anything – I need only apply my skills to try to help my patient" (pp. 125 and 128).

Dialectical-behavior therapy has a mandatory set of "rules," with an order of priority, for addressing particular therapist and patient behaviors (Linehan, 1993) that should serve as a guide for clinicians that treat patients with BPD. These "rules" are discussed upfront with the patient at the beginning of therapy and the patient must agree

in order for therapy to proceed. First, any behaviors that are considered to be "life-interfering" must be confronted in session. The idea is that if the patient is not alive to receive therapy, he or she cannot get better. Any behaviors that potentially interfere with life (i.e., suicidal talk, gesture, or action) take priority over other patient behaviors or therapy topics. The second area of concern is "therapy-interfering" behaviors. These are behaviors that both the therapist and patient might engage in such as missing sessions, arriving late, changing the topic, failing to do homework, abuse of the after-hours number, etc. and are immediately confronted by the therapist or patient in session. If the therapy is not able to progress without interference, then the patient will not have the opportunity to get better, therefore, this is highly important. The final area addressed is "quality-of-life interfering" behaviors. These could be behaviors such as patient substance abuse, an abusive interpersonal relationship, or problematic employment patterns; things that could inhibit the patient's quality of life. This structure provides the therapist and the patient with BPD with an understanding and rationale for the importance of discussing particular behaviors, many of which have the potential to elicit CT reactions.

Patients with BPD tend to drop out of therapy and have poor treatment outcomes, leaving both the patient and therapist feeling frustrated and unsatisfied. Knowledge of psychologists' typical patterns of CT behaviors that have been revealed in this study are the first step toward improving the attention paid to CT, in improving training, supervision, and the clinical practice of therapists who treat patients with BPD, ultimately enhancing treatment outcomes with these patients who are suffering immensely due to their symptoms.

Limitations of the Study

As with all research methodologies, there are limitations to the survey design of the present study. Specifically, the psychologists who were surveyed in the study are those who belonged to the American Psychological Association, Division 12, 17, and/or 29. It is possible that psychologists in Divisions 12, 17, or 29 differ in some way from other psychologists who treat patients with BPD but do not belong to these particular divisions of APA.

Further, a limitation of mail survey research is that when response rates are less than 100%, external validity is compromised (Weather, et al., 1993). Perhaps those psychologists who responded to the survey would differ from nonresponders in some unknown way. This study yielded a response rate of 40%, slightly lower than the anticipated 50% to 60% (Rea & Parker, 1997). Of those returned, only data from 29% were able to be used in the analysis. There are several reasons that might explain the low response rate, as well as the low number of usable surveys from those returned. The first is related to the pool from which the participants were selected. Initially, it seemed that selecting potential participants who belonged to clinical divisions of APA would provide a pool of potential participants who are engaged in clinical practice with patients. For participants to be included in the study, they needed to have treated at least three adult patients with BPD in the past 24 months. Seventy percent of those who responded did not meet this criteria. A significant number of respondents included a note indicating they treated children only, were working only in academics, were retired, or purposefully do not accept patients with BPD for therapy. Another portion of respondents indicated

that they have treated many patients with BPD in the past, but not the required number in the specified time frame. It seems reasonable that many potential participants saw that they were excluded from the study and did not send back the survey packet as requested, resulting in a lower than anticipated response rate. Second, selecting a sample based on division membership increased the likelihood that participants were engaged in exclusively academic activities, as opposed to clinical practice or both. This risk was taken so as to achieve a national sample, increasing the ability to generalize the results. The sample obtained does represent psychologists from the east, west, and mid-American states. One respondent was from Alaska. Perhaps an alternative way of increasing the response rate in the future would be to obtain mailing lists of psychologists who are employed at treatment centers to increase the likelihood that they would meet the inclusion criteria.

It is of interest that the literature indicates that 33% of outpatients and 63% of inpatients are estimated to meet the criteria for BPD (Anonymous, 2001; Widiger & Frances, 1989), however, such a large number of respondents reported that they have not treated at least three patients in the past 24 months. It is not clear how many of 141 unusable surveys were completed by psychologists who work in a clinical setting, treating adults, but did not treat patients with BPD, as participants were not asked this question in this survey. Future surveys may want to include questions that could provide examiners with more information about those participants who are not eligible to participate. Further, future researchers could consider expanding the inclusionary criteria to include clinicians who have treated at least three patients with BPD in the past five years or five patients in the course of one's career, for example. However, these changes

have the potential to create problems in clinicians' recall of their typical experience. Other researchers may also choose to include other groups of therapists, such as social workers and master's level mental health professionals to increase the number of participants that could be surveyed.

The small sample size obtained through the survey procedures used in this study limits the extent to which generalizations can be made to the overall population of psychologists in the United States. The size of the sample may have accounted for the reason that differences were not found on participants' ratings on the ICB, CFI-R, and WAI as a function of their level of work experience. The numbers may have been too small to detect differences. Future research should strive to refine the procedures used in this study to yield a greater response rate and to reduce the number of participants excluded, as discussed.

The survey consisted of various self-report questionnaires. Two basic problems characterize self-report measures: bias of the participants in their responses and failure of the measure to assess the construct of interest (Kazdin, 1998). Psychologists in this study were asked to rate their own perceptions of their characteristics, behaviors, and working alliances when doing therapy with borderline patients, as opposed to directly measuring these qualities, behaviors, and alliances while in actual sessions with patients or in comparison to other patients without a BPD diagnosis. It is possible that the psychologists surveyed may recall their experiences and behaviors with BPD patients in therapy in some distorted way, altering their self-report. Additionally, despite the anonymity of the survey, some participants may have responded in a socially desirable way. The cover letter that was sent with the survey packet attempted to acknowledge the

difficulty in working with a BPD patient population, indicating that negative feelings are normal to many of those who treat BPD patients, in order to increase the chances that participants would respond openly and honestly.

It is a limitation of this study that the ICB and CFI-R measures used were adapted to measure psychologists' self-reported CT behaviors and management, rather than supervisors' ratings of supervisees' CT behaviors and management skills, as the original measures were designed. Further, the rating scale in the ICB was changed to measure the frequency of the CT behaviors, as opposed to the extent to which supervisees engaged in CT behaviors. The measure has not previously been used in this way, therefore, its current factor structure and validity are in question. Additionally, the measure was designed to examine CT behaviors with general patients in psychotherapy, not necessarily severely characterologically disturbed individuals with BPD, as was used in this study. Further, therapists' ratings on the WAI-Short (Therapist Version), which were used in this study, are less predictive of psychotherapy outcome in comparison to patients' ratings, limiting the utility of the information yielded.

An additional limitation is that this study does not account for an accurate diagnosis of the patients considered in the psychologists' ratings. Participants were provided with a copy of the DSM-IV-TR (American Psychiatric Association, 2000) criteria for BPD and asked to review it, however, diagnostic accuracy cannot be assured. A related limitation is that the psychologists were asked to consider their "typical" reactions and behaviors with BPD patients. There is no way to control for the fact that the participants may choose to consider their "least favorite" or "sickest" BPD patients as typical or that they may choose their "favorite" or "healthiest" BPD patient as typical

when choosing their ratings. The instructions will ask that participants choose their "typical" BPD patient, rather than their most sick or healthy patients. It may be difficult for participants to select a vision of their "typical" patient with BPD, considering the potential for variability of clinical presentation with the present DSM-IV-TR (American Psychiatric Association, 2000) criteria. Furthermore, there is no way to know if some or all of the psychologists' CT reactions may be elicited by other co-occurring Axis I or Axis II disorders that the patients may have. Lastly, the accuracy of retrospective recall is a common limitation in self-report measures (Kazdin, 1998).

Despite the limitations discussed, this study was an important exploratory empirical investigation of CT with borderline patients. It is hoped that the suggestions provided with help in the design of future studies.

Conclusions

In summary, this study has replicated the findings of previous studies that have found a negative correlation between therapists' CT behaviors and their CT management ability. It has also provided support for previous findings that have demonstrated a negative correlation between therapists' CT behaviors and working alliance, as well as a positive correlation between therapists' CT management and working alliance, strengthening the support that therapists' CT management ability is linked to positive treatment outcomes. This study also added a new variable, therapist empathy, finding that it was negatively correlated with therapists' display of CT behaviors, as predicted. Because both working alliance and therapist empathy are variables that are positively

correlated with positive treatment outcome, this further strengthens support for CT management as a psychotherapy outcome variable and worthy of continued study.

Additionally, this study has added to the literature by identifying a common set of CT behaviors that psychologists frequently engage in when treating patients with BPD that has been shown empirically, rather than by clinical observation or case studies. It has also provided empirical support for the common claims of the difficulties in forming a working alliance with patients with BPD. This study demonstrated a relatively low level of working alliance, as perceived by the psychologists treating patients with BPD.

This study is the first to empirically study the CT reactions of experienced therapists and the first to study CT with a specified patient population. It attempted to examine psychologists' level of experience and theoretical orientation as they related to ratings of CT behaviors, CT management, and working alliance. Though no significant relationships were found, it is worthwhile for future research to continue to examine therapist variables that may be important to CT.

Future research should also strive to develop inventories to measure therapists' internal experiences of CT. Such scales should include items that reflect the common thoughts and feelings experienced by therapists in response to the patient or session material. These measures could serve to help identify schema that exist for individual therapists, as well as identify patterns of schema common to therapists treating specific patient populations.

The findings of this study have many implications for the training and supervision of therapists. It was found that psychologists perceived much difficulty in their typical working alliances with patients with BPD. They found the greatest problems in the area

of problem identification and agreement on how to solve the patients problems. Therapists must spend more time in therapy sessions focusing on problem identification and in providing the rationale for proposed interventions, as an effort to improve the alliance in these known strained areas.

It was also shown in this study that psychologists are sometimes too often critical of patients with BPD, take on an advising tone, and find themselves detaching from patients in session. Further, therapists sometimes too often over support their patients with BPD, agree too much, and find themselves changing the topic in session with these patients. It has been recommended that additional training, supervision, and support is needed for clinicians treating patients with BPD. Specifically, all therapists are challenged to examine their own schema about patients with BPD to better understand their potential to engage in CT behaviors, both positive and negative, that would be potentially harmful to therapy. Therapists must acquire skills to manage their internal CT responses and therefore must become aware of their thoughts and feelings when treating these patients. The common CT behaviors identified by the present study must serve as cues for therapists and supervisors that a CT process is occurring in therapy and that immediate intervention is needed to prevent further damage to the alliance. The schema modification technique, used in cognitive-behavioral therapy (Beck, 1995), is recommended as a method for clinicians and supervisors to use to restructure their beliefs that trigger CT behavior. This technique is recommended for all therapists, regardless of their theoretical orientation used when treating patients.

In summary, this study supports previous research about the relationships between CT behavior, CT management, and working alliance. Additionally, it examined the

patient variable of BPD diagnosis, identifying the unique experience of psychologists who treat this population. The study also examined therapist variables, such as level of empathy toward their patients with BPD, their level of clinical experience, and their theoretical orientation. Empathy was related to CT behavior, CT management, and working alliance as predicted, however, no differences were found based on psychologists' level of clinical experience or theoretical orientation. This study offers some reasons why these hypotheses failed to be supported, along with the limitations of the study, offering suggestions for the design of future studies pursuing this area of research. The value of this study is that it enhances our understanding of therapists' treatment experience with borderline patients, while continuing to raise questions worthy of future study.

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Appendix

Survey Packet

Dear Psychologist:

You have been randomly selected to participate in an exciting research study aimed at learning more about the experiences of psychologists who treat patients with borderline personality disorder. If you currently treat or have treated adult patients with borderline personality disorder in the last 2 years, you are eligible to take part in the study. Your participation is voluntary and you may decide not to participate or to discontinue your participation at any time, with no consequences to you.

While most patients elicit various reactions from their therapists, borderline patients may present unique challenges to many psychologists. We ask your help in better understanding these reactions by completing the enclosed survey packet and mailing it back in the stamped envelope provided. The items in the questionnaire ask you about your thoughts, feelings, and behaviors with your typical borderline patient while conducting therapy. Completion of the survey will take about 20 minutes of your time. Your responses are completely anonymous and will be reported in aggregate form, along with hundreds of other survey responses. Please be as open and honest as possible. Additionally, please return the enclosed postcard separately from your survey packet, indicating to us that you have responded. This method will avoid unnecessary follow-up mailings of this survey to you.

It is possible that completing this survey may make you feel uncomfortable and realize something that you did not previously know about yourself. A small percentage of people may find this mildly disturbing. Remember that you will not be identified, even by the researcher, and that this is an evaluation of your experiences in treating borderline patients, not an evaluation of your performance as a psychologist.

You will not receive any information about the questionnaires that you complete. However, if you wish to obtain an abstract copy of the entire survey results, please contact the researchers at the address below.

We greatly appreciate your help in making our research project a success!

Very Truly Yours,

Michelle Saxen Hunt, M.A., M.S., LPC
Psy.D. Candidate

Rosemary Mennuti, Ed.D.
Dissertation Chair, Clinical Professor

INSTRUCTIONS:

For the purpose of this investigation, the DSM-IV, TR (2000) diagnostic criteria will be used to define patients diagnosed with Borderline Personality Disorder (301.83). Please review the following criteria before answering the questions that follow:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following (p. 710):

(1) frantic efforts to avoid real or imagined abandonment. *Note*: Do not include suicidal or self mutilating behavior covered in criterion 5.

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). *Note:* Do not include suicidal or self-mutilating behavior covered in criterion 5.

(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

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

(7) chronic feelings of emptiness

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

(9) transient, stress-related paranoid ideation or severe dissociative symptoms

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorder. Fourth edition: Text revisions.* Washington, DC: American Psychiatric Association.

- ☐ Please check this box indicating that you have reviewed and understand these criteria

Demographic Questions

INSTRUCTIONS:

Please take 15-20 minutes to complete the following survey. Carefully read the instructions for each portion before responding. Return the entire packet to the primary investigator in the enclosed envelope. Check the box corresponding with your answer:

Have you treated patients with Borderline Personality Disorder (according to the DSM-IV-TR criteria) in therapy **in the past 24 months**? *(Include patients who have a co-occurring Axis I disorder. Include patients with a co-occurring Axis II disorder ONLY if BPD is the Axis II disorder causing the MOST IMPAIRMENT IN FUNCTIONING.)*

- ☐ Yes
- ☐ No – If not, please stop here and return the survey packet to the primary investigator.

Your Gender:

- ☐ Male
- ☐ Female

Your Age:

- ☐ Under 30
- ☐ 31 – 40
- ☐ 41 – 50
- ☐ 51 – 60
- ☐ Over 60

Your Ethnicity:

- ☐ White (Not of Latin Origin)
- ☐ African-American
- ☐ Asian/Pacific Islander
- ☐ Latino/Latina
- ☐ Other: _____

Your Highest Degree Obtained:

- ☐ Doctorate
- ☐ Master's
- ☐ Other: _____

Years of Experience of Clinical Practice:

- ☐ Less than five years
- ☐ Five to ten years
- ☐ Eleven to fifteen years
- ☐ Greater than fifteen years

Are you licensed as a psychologist?

- ☐ Yes – Please indicate what state: _____
- ☐ No

INSTRUCTIONS: The following questions refer to your clinical practice as a psychologist. Check the box corresponding to your answer:

Theoretical Orientation that guides your case conceptualization and practice:

- ❑ Psychoanalytic/Psychodynamic
- ❑ Behavioral/Cognitive-Behavioral
- ❑ Humanistic/Existential
- ❑ Family Systems
- ❑ Other: _____

The following is my best estimate of the number of patients with Borderline Personality Disorder that I have treated **in the past 24 months** (over age 18):

- ❑ 0-5
- ❑ 6-10
- ❑ 11-15
- ❑ over 15

The treatment that I have provided to patients with Borderline Personality **in the past 24 months**, has been in the following treatment modalities (check all that apply):

- ❑ Individual therapy
- ❑ Group therapy
- ❑ Family therapy
- ❑ Other _____

The following is my best estimate of the number of patients with Borderline Personality Disorder that I currently am treating (over age 18):

- ❑ 0-5
- ❑ 6-10
- ❑ 11-15
- ❑ over 15

The following is my best estimate of the number of patients with Borderline Personality Disorder that I have treated in the course of my career as a psychologist (since obtaining current degree):

- ❑ 0-10
- ❑ 11-20
- ❑ 21-30
- ❑ over 30

Adapted from the ICB (Friedman & Gelso, 2000)

INSTRUCTIONS:

Please think about the patients with Borderline Personality Disorder that you have treated in individual therapy in the past 12 months. Patients precipitate all types of reactions in the clinicians who treat them in therapy. We are interested in your experiences in working with patients with Borderline Personality Disorder, a particularly challenging and high-risk population. Please be advised that **your responses are anonymous**, therefore, we ask that you answer as openly and honestly as you can. This is not an evaluation of your performance as a psychologist. You cannot be identified and the survey results will be reported in an aggregate form. Your responses will help us to better understand the experiences of clinicians, aimed at improving training programs and continuing education about patients with Borderline Personality Disorder.

Using the rating scale below, indicate the frequency that you engage in the described behavior with your **TYPICAL** borderline patient. **Please consider ALL of your borderline patients, not just your "most sick" or "most healthy" patients**. Circle the one number that **BEST DESCRIBES** your typical behavior in an individual therapy session with a borderline patient. *(Remember to include patients who have a co-occurring Axis I disorder. Include patients with a co-occurring Axis II disorder ONLY if BPD is the Axis II disorder causing the MOST IMPAIRMENT IN FUNCTIONING.)*

- ☐ *Check here if you have not treated at least 3 patients with Borderline Personality Disorder in Individual Therapy in the past 24 months. If you have not, please stop here and return your survey packet to the primary investigator in the enclosed envelope.*

During my work with patients with Borderline Personality Disorder, I typically find myself ...

	Never	Rarely	Some times	Often	Always
1) ...colluding with the patient in the session.	1	2	3	4	5
2) ...rejecting the patient in the session.	1	2	3	4	5
3) ...over-supporting the patient in the session.	1	2	3	4	5
4) ...befriending the patient in the session.	1	2	3	4	5
5) ...being apathetic toward the patient in the session.	1	2	3	4	5
6) ...behaving as if I was somewhere else during the session.	1	2	3	4	5
7) ...talking too much in the session.	1	2	3	4	5
8) ...changing the topic during the session.	1	2	3	4	5
9) ...being critical of the patient during the session.	1	2	3	4	5
10) ...spending time complaining during the session.	1	2	3	4	5
11) ...treating the patient in a punitive manner during the session.	1	2	3	4	5
12) ...inappropriately apologizing during the session.	1	2	3	4	5

During my work with patients with Borderline Personality Disorder, I typically find myself ...

	Never	Rarely	Some-times	Often	Always
13) ...acting in a submissive way during the session.	1	2	3	4	5
14) ...acting in a dependent manner during the session.	1	2	3	4	5
15) ...agreeing too often with the patient during the session.	1	2	3	4	5
16) ...inappropriately taking on an advising tone with the patient during the session.	1	2	3	4	5
17) ...distancing myself from the patient during the session.	1	2	3	4	5
18) ...engaging in too much self-disclosure during the session.	1	2	3	4	5
19) ...behaving as if I was absent during the session.	1	2	3	4	5
20) ...inappropriately questioning the patient's motives during the session.	1	2	3	4	5
21) ...providing too much structure during the session.	1	2	3	4	5

Adapted from WAI-Short (Therapist Version) (Tracey & Kokotovic, 1989)

INSTRUCTIONS: The following statements describe some of the different ways a person might think or feel about his or her patient. As you read the sentences, consider your **TYPICAL patient with Borderline Personality Disorder** when responding. Circle the number that **BEST DESCRIBES** your typical experience in working with a borderline patient **after about the third therapy session**. *(Remember to include patients who have a co-occurring Axis I disorder. Include patients with a co-occurring Axis II disorder ONLY if BPD is the Axis II disorder causing the MOST IMPAIRMENT IN FUNCTIONING.)*

	Not at All	Very little	A little	Some-times	Quite a bit	Very Much	Yes/ Totally
1) My patient and I agree on the steps to be taken to improve his/her situation.	1	2	3	4	5	6	7
2) What we do during the session gives my patient a new way of looking at the problem.	1	2	3	4	5	6	7
3) I believe my patient likes me.	1	2	3	4	5	6	7
4) I have doubts about what my patient and I are trying to accomplish in session.	1	2	3	4	5	6	7
5) I am confident in my ability to help my patient.	1	2	3	4	5	6	7
6) My patient and I work toward mutually agreed upon goals.	1	2	3	4	5	6	7
7) I appreciate my patient as a person.	1	2	3	4	5	6	7
8) My patient and I agree on what is important to work on.	1	2	3	4	5	6	7
9) My patient and I are building a mutual trust.	1	2	3	4	5	6	7
10) My patient and I have different ideas on what his/her real problems are.	1	2	3	4	5	6	7
11) My patient and I are establishing a good understanding between us of the kind of changes that are good for him/her.	1	2	3	4	5	6	7
12) My patient believes the way we are working with his/her problem is correct.	1	2	3	4	5	6	7

Adapted from CFI-R (Latts, 1996)

INSTRUCTIONS: The following questions again refer to your TYPICAL experience in treating patients with Borderline Personality Disorder. As stated, **your responses will remain anonymous**. Please try to answer as openly and honestly as possible. Using the rating scale below, circle one number that **BEST DESCRIBES** your agreement with the statements about your work with a **typical patient with Borderline Personality Disorder in individual therapy**. (*Remember to include patients who have a co-occurring Axis I disorder. Include patients with a co-occurring Axis II disorder ONLY if BPD is the Axis II disorder causing the MOST IMPAIRMENT IN FUNCTIONING.)*

During my work with patients with Borderline Personality Disorder, I typically ...

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1) ...am able to distinguish between reactions that are "pulled" from me by the patient and those that stem from my own areas of unresolved conflict.	1	2	3	4	5
2) ...have a stable sense of identity which is reflected in my therapeutic work.	1	2	3	4	5
3) ...am generally aware of personal areas of unresolved conflict which may be touched upon while doing therapy.	1	2	3	4	5
4) ...usually restrain myself from excessively identifying with the patient's conflicts.	1	2	3	4	5
5) ...am able to identify with the patient's feelings and still maintain the capacity to disengage from the identification process.	1	2	3	4	5
6) ...am often aware of my feelings that are elicited by patients.	1	2	3	4	5
7) ...understand the background factors in my life that have shaped my personality and use this understanding in the therapeutic work.	1	2	3	4	5
8) ...at the appropriate times, stand back from a patient's emotional experience and try to understand what is going on with the patient.	1	2	3	4	5
9) ...am able to use my reactions to patients as clues to patients' feelings or dynamics.	1	2	3	4	5
10) ...am comfortable in the presence of patients' strong feelings.	1	2	3	4	5
11) ...am able to comfort myself when feeling anxious during sessions.	1	2	3	4	5
12) ...usually remain emotionally attuned with the patient when otherwise feeling uncomfortable during sessions.	1	2	3	4	5
13) ...am often aware of my personal impact on patients.	1	2	3	4	5
14) ...make an effort to emotionally identify with the patient when the patient discusses material that is uncomfortable for me.	1	2	3	4	5

During my work with patients with Borderline Personality Disorder, I typically ...

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
15) ...effectively distinguish between the patient's needs and my own needs.	1	2	3	4	5
16) ...am generally able to step back and cognitively process my own reactions to patients.	1	2	3	4	5
17) ...am often aware of my fantasies triggered by patient material or affect.	1	2	3	4	5
18) ...usually comprehend how my feelings influence me in therapy.	1	2	3	4	5
19) ...can usually identify dynamics of the counseling relationship.	1	2	3	4	5
20) ...lack a theoretical understanding of the therapeutic work to help guide my interventions with patients.	1	2	3	4	5
21) ...am able to deal effectively with my own anxiety when seeing patients.	1	2	3	4	5
22) ...possess psychological balance which is reflected in my work.	1	2	3	4	5
23) ...am able to contain my anxiety in the presence of patients' strong emotions.	1	2	3	4	5
24) ...tend to empathize so much with the patient's feelings that the patient is actually impeded from growing.	1	2	3	4	5
25) ...can usually identify with the patient's inner experience.	1	2	3	4	5
26) ...fail to convert my feelings during sessions into conceptualizations that are useful in guiding the work.	1	2	3	4	5
27) ...have the capacity to stand back from my own emotional experience and observe what is going on with myself with regard to patients.	1	2	3	4	5
28) ...am able to alternate easily between emotional identification with the patient and objective understanding.	1	2	3	4	5
29) ...usually recognize my own negative feelings toward patients.	1	2	3	4	5
30) ...am comfortable with myself when working with patients.	1	2	3	4	5
31) ...am comfortable being close to patients.	1	2	3	4	5
32) ...effectively recognize the boundaries between myself and my patients.	1	2	3	4	5
33) ...become immobilized by anxiety when working with patients, not knowing how to respond or intervene.	1	2	3	4	5

During my work with patients with Borderline Personality Disorder, I typically ...

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
34) ...am perceptive in my understanding of patients.	1	2	3	4	5
35) ...manage my need for approval with patients.	1	2	3	4	5
36) ...possess a conceptual understanding of the therapeutic work which enables me to make sense of my own reactions to patients.	1	2	3	4	5
37) ...allow my own personal problems or conflicts to interfere with the therapeutic work.	1	2	3	4	5
38) ...tend to deal with my anxiety in the presence of strong patient emotions by disengaging from the work.	1	2	3	4	5
39) ...conceptualize my role in what transpires in the counseling relationship.	1	2	3	4	5
40) ...am not aware of the motivation behind my behavior with patients.	1	2	3	4	5

INSTRUCTIONS: Please check off the box corresponding with your response to the following items about this survey.

1) Please indicate the extent to which you feel that the survey items completed are an **accurate reflection of your experiences** in treating a typical patient with borderline personality disorder:

- ❑ Not at all accurate
- ❑ A little accurate
- ❑ Somewhat accurate
- ❑ Very accurate
- ❑ Extremely accurate

2) Please indicate the extent to which you were **open and honest in your ratings of your experiences** in treating your typical patient with borderline personality disorder:

- ❑ Not at all open and honest
- ❑ A little open and honest
- ❑ Somewhat open and honest
- ❑ Very open and honest
- ❑ Extremely open and honest

3) Please indicate the extent to which you were able to **determine and accurately reflect your "typical" experience** with a typical patient with borderline personality in these survey items:

- ❑ Not at all accurate
- ❑ A little accurate
- ❑ Somewhat accurate
- ❑ Very accurate
- ❑ Extremely accurate

Thank you for your time to complete this survey. Please return it to the primary investigator in the enclosed stamped envelope. Additionally, please mail the enclosed postcard separately from your packet.