Factors that Influence the Therapeutic Relationship with Clients Diagnosed with Borderline Personality Disorder

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Dedication

This study is dedicated to my current and past clients who have been diagnosed with Borderline Personality Disorders. I also dedicate it to my future clients, as I continue in my education and training in the profession of counselling psychology. More broadly, I dedicate this work to those people, diagnosed or not, who are struggling with symptoms of Personality Disorder. In continuing to improve our understanding and treatment interventions in this area, I hope that your relationships, including the therapeutic ones, will likewise improve as a result.

Abstract

This paper investigates factors which influence the therapeutic relationship with clients diagnosed with Borderline Personality Disorder (BPD). The research is clear that therapists will inevitably be confronted with their clients' transference (Tr) and their own countertransference (CTr) within the therapeutic relationship. Tr and CTr are well established phenomena in the literature in relation to psychotherapeutic process and outcomes for clients. What is not as well known, however, is what factors influence the Tr and CTr of the therapeutic relationship with clients diagnosed with BPD. This research study identified therapist, client and treatment factors. Therapist factors include heightened CTr and Self-reflection. Client factors include severity of BPD symptoms, level of motivation and engagement, and personality dissimilarity with the therapist. Treatment factors include level of training with BPD and length of treatment. Clinical applications comprise of CTr management, a higher level of experience BPD, as well as supervision and consultation. Ethical considerations of working with vulnerable clients, and future research recommendations for therapists are also discussed. This study contributes an increased awareness and understanding of the factors which influence the Tr and CTr of the therapeutic relationship with clients diagnosed with BPD.

Key words: Transference, Countertransference, Therapeutic Relationship/Alliance, Personality Disorder, Borderline Personality Disorder, Psychodynamic theory, and Relational psychodynamics.

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Over the past few years, my family has been a critical support system as I became less available, increasingly stressed and fatigued, and essentially shifted certain aspects of myself and my life in ways I could not anticipate when I started this process of becoming a psychologist. They had no doubt that I would be successful in reaching this goal, even if there were days, when I was not so sure myself. Through all my relationships, I was inspired to challenge the consensus, not be afraid to make mistakes, to explore and reflect more deeply and thoroughly about my clients and most importantly, to integrate and ground my personal ethics with my professional ones. Thank you to all of you who challenged these doubts and reassured me that I would make it to this point. You were right!

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Factors that Influence the Therapeutic Relationship with Clients Diagnosed with Borderline Personality Disorder

This study investigates factors that influence the therapeutic relationship with clients diagnosed with Borderline Personality disorder (BPD). The therapeutic relationship is the basic groundwork for the alliance between the patient and therapist (Cabaniss et al., 2011). "It is important to not only provide a safe environment in which clients can talk about their problems, but also allows them to learn about themselves and their relationships through their interaction with the therapist." (Cabaniss et al., 2011, p.7) The therapeutic relationship with clients who are diagnosed with BPD can be a particularly challenging because the diagnosis of BPD is a marker of clinical complexity, severity and treatment resistance. This is due to a history of interpersonal abuse and subsequent acute behavioral symptoms such as disturbances in emotion regulation, behavior, attention, relationship functioning, and self-representation (Keefe & Derubeis, 2019; Levy et al., 2015). BPD is generally understood by its etiology stemming from early unintegrated traumatic interactions with significant others (Orfanos, 2002), and its subsequent relational dysfunction in adulthood is evident in how a client with BPD shows up in the therapeutic relationship. Considering the prevalence of longstanding problematic relational patterns characteristic of BPD, maintaining a safe and effective therapeutic relationship is difficult. Clients diagnosed with BPD unconsciously perpetuate these patterns through the therapeutic relationship. Consequently, a strong positive relationship is needed for therapist and client to be able to withstand heightened Tr and CTr, such as anger and criticism (Maroda, 2010). Since, therapists often get pulled in to engage in iatrogenic behaviors and roles that actually recapitulate feared outcomes (Ganzer, 2018; Levy et al., 2015), they may benefit from gaining a deeper understanding of the dynamics of this therapeutic relationship and the factors which influence it.

Research Problem

Research in the counselling field has thoroughly examined the long-asserted notion that the most curative factor in psychotherapeutic practice is the therapeutic relationship. What brings clients to the therapy room are most often things interpersonal and intrapersonal in nature (Quatman, 2015). However, generally, the asymmetrical nature of the therapeutic relationship often evokes a sense of vulnerability and regression with clients. The relational dynamics of the therapeutic relationship are a major consideration for clients who are especially vulnerable and susceptible to re-enactments of unresolved relational trauma with their therapists. Nevertheless, such relational dynamics between clients and therapists can often be ignored, avoided or even unconsciously re-enacted in destructive ways within the therapeutic relationship. Currently, these factors which influence these re-enactments to transpire between clients with BPD and therapists have been under-investigated in the literature. They need to be acknowledged so as not to continue perpetuating old relationship dynamics through the therapeutic relationship with the therapist.

The current literature on treating BPD and the therapeutic relationship are descriptive case studies and reviews, pointing to some complexities and nuances of working with clients with BPD (Black, 2019, Ganzer, 2018; Kernberg et al., 2008; Kernberg, 2016; Modell, 2012; Ngo-Smith, 2018). There is some literature which has examined the therapeutic relationship with BPD clients from the psychodynamic perspective. Studies by Fonagy (1995), and Bateman (1996) as cited in Vaslamatzis & Rabavilas (2018), for instance, looked at 25 clients with BPD who were treated with a psychoanalytically oriented day hospital program over 18 months. They showed significant improvement of BPD symptoms, and improvement in social and interpersonal functioning. Much of the literature notes that the development of this therapeutic

alliance is a long-term and continuous process, due to the issue of danger and mistrust manifesting itself in the therapeutic relationship (Summers & Barber, 2015). Psychodynamically oriented approaches, however, require years of extra training and supervision for therapists. Many of the therapists where psychiatrists, clinical psychologists or psychoanalysts with over 20 years' education and experience treating clients diagnosed with PD's. Some interventions for BPD include: Traditional Psychoanalysis (PA), Transference-Focused Psychotherapy (TFP), Supportive Psychodynamic Psychotherapy (SPP) and Long-Term Psychodynamic Psychotherapy (LTPP). "Intensive group psychotherapy programs, for examples, show promise for reducing attachment pathology and improving interpersonal functioning." (Khademi et al., 2019, p. 47) Whether in individual or group oriented therapeutic relationships, a client's willingness to disclose self-harming behaviors; to reflect on and discuss the enactment of particular relational patterns; and unravelling their roots in the therapy room, are signs of progress (Craciun, 2017).

"The relationship itself is likely to be an agent of change in psychodynamic psychotherapy that the client can learn from, and a direct source of support that can foster growth and change." (Cabaniss et al., 2011, p. 7) Clients with BPD repeat former patterns of behavior during treatment in the Tr and CTr which can negatively impact the therapeutic relationship by breaking down boundaries. Weak boundaries can manifest in the therapist sharing personal information or doing special favors like allowing sessions to go over time. Once such patterns are identified and better understood as Tr/CTr enactments, Tr interventions can shed light on the therapeutic relationship (Diamond & Meehan, 2013). "While dealing with clients with BPD, reducing negative Tr and repairing ruptures in the therapeutic relationship are vital steps to preserving the treatment and may be the major ongoing priority related to the Tr." (Cabaniss et al., 2011, p. 227) Promoting increased awareness and improvement of underlying maladaptive

relational behaviors has therefore attracted ongoing interest in clinical efficacy (Bradley & Westin, 2005; Clarkin et al., 2004; Miller, 2019; Summers & Barber, 2015). At this point, however, these factors are not clearly defined in the literature. Therefore, gaining more understanding about Tr/CTr in the therapeutic relationship with clients diagnosed with BPD would be a significant contribution to the counselling literature.

Purpose of the Study

The purpose of this study is to identify and better understand factors which influence the Tr/CTr dynamics of the therapeutic relationship with clients diagnosed with BPD.

Research Question

What factors influence the therapeutic relationship with clients diagnosed with BPD?

Significance of the Study

There remains a gap in the literature regarding the use of psychodynamic modalities, and specifically Tr and CTr, with clients with BPD. This gap can be addressed by focusing on the relational dynamics of this therapeutic relationship, and gaining more understanding of what influences it from a more relational perspective. When working with clients with BPD without the structure of a well-defined therapeutic relationship, collaborative efforts towards goals are difficult. Additionally, this can be useful for psychotherapists when working with clients with BPD who take a while to develop trust in the therapist or the belief that the therapist will safely and effectively carry out the goals of psychotherapy (Summers & Barber, 2015). Even seasoned practitioners grapple with personality disordered clients with whom they can become unconsciously entangled (Vaslamatzis & Rabavilas, 2018). This is because observing and identifying Tr is confusing, especially for novice therapists. It may be difficult to distinguish

between the clients' feelings and perceptions about the therapist based on the constructed therapeutic alliance and the feelings that have roots in the Tr (Summers & Barber, 2015).

Besides psychodynamically based interventions, there are several other therapeutic approaches that are typically used to treat clients diagnosed with PD's. These include: Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Emotion Focused Psychotherapy (EFT), Attachment-Based Family Therapy (ABMT), Mentalization-Based Psychotherapy (MBT) and Interpersonal Psychotherapy (IPP). There are several studies examining the efficacy of DBT for BPD, for instance. "DBT has been more effective than community-based and treatment-as-usual, and is currently the only empirically supported treatment for BPD." (May, et al., 2016, p. 63) The DBT program takes approximately 6 months to 1 year of skills training, which includes individual and group-based intervention (May et al., 2016). Additionally, many clients undergo DBT treatment more than once, particularly in the case of more severe symptomology, as in the case for BPD. "Clients who were in treatment for one or two years were thought to suffer from more complex constellations of problems, or something where their symptoms are always going to go up during periods of stress in their life." (Craciun, 2017, p. 183) Therapists may often be unaware of a clients' self-destructive behaviors characteristic of BPD. Therefore, interventions for BPD are more intensive and require more time for clients to experience symptom reduction. The therapeutic relationship with clients with BPD takes longer to develop because the patterns of volatility and relational resistance can take time to make themselves known (Craciun, 2017). With a longer-term approach, clients become more comfortable with sharing symptoms typically associated with a diagnosis of borderline personality disorder (Craciun, 2017). Many trauma informed approaches are usually highly manualized, and time-sensitive. The risk with many manualized cognitive based treatments such

as CBT and DBT, is that they downplay the role of the therapeutic relationship, and "the emotionally removed and silent therapist creates a vacuum the client may work hard to fill." (Maroda, 2010, p. 51). Furthermore, a principal weakness of studying and applying evidence-based therapies for BPD is that they often do not account for vast individual variability in response to treatment (Dahl et al., 2014).

Generally, the literature supports relationally oriented approaches for clients with a history of interpersonal abuse, or who have chronic difficulty establishing stable and meaningful relationships, as is typically associated with BPD (Doering et al., 2010; Diamond & Meehan, 2013; Ganzer, 2018; Jones et al., 2020; Keefe & Derubeis, 2019; Kernberg, 2019). More specifically, the literature supports engaging Tr and CTr for this client group (Kalsched, 2015; Keefe, & Derubeis, 2019; Kernberg et al., 2008; Levy et al., 2006; Levy et al., 2015). Mainly due to the unconscious nature of such dynamics, Tr and CTr were not always well understood, tolerated or applied in therapeutic practice. Nevertheless, relationship patterns are mutually projected and enacted, ever present within the structure of the professional relationship (Kalsched, 2015). Part of the problem is understanding that Tr, broadly speaking, refers to a relationship. We may not talk about that relationship, or think about it, especially if the experiences are intense or negative, but it is there nonetheless (Quatman, 2015). While this study focuses in on relational and psychodynamic concepts, as opposed to more cognitive or behavioral ones, Tr and CTr are always present in the relationship between client and therapist. The study can help therapists understand how the therapeutic relationship with clients diagnosed with BPD is unique. More specifically, this study can help therapists irrespective of the therapeutic modality, and can identify and help understand what factors influence the underlying Tr and CTr dynamics in the therapeutic relationship with BPD clients. Having a better

understanding of these dynamics in the therapeutic relationship could help therapists understand that Tr builds relationship, and that it is not simply a by-product of the therapeutic process to be otherwise ignored or avoided.

Not only is there Tr between the client and therapist in the therapeutic relationship, but there is also Tr to the system, the agency, the court, the child welfare system, and/or environment generally within which the enactments take place (Ganzer, 2018). Often clients associate their therapists with these systems. Therefore, a well contained and separate therapeutic relationship is important in creating safety in not just other relationships in the clients' life, but in the context of the community and other larger systems. Therapists can be better prepared to encourage more mutually beneficial relationship dynamics and help their clients meet therapeutic goals, as well as mitigate risks and promote more enduring relational stability outside the therapeutic relationship. Understanding the factors which influence this therapeutic relationship can benefit the client in transferring how they can also relate to their community and in the larger societal and cultural context.

Researcher Position

Through personal accounting, researchers should become aware of how their own positions and interests are imposed onto the research process (Kirby et al., 2006). Issues related to the therapeutic relationship with BPD clients has been one of my professional interests for many years. A deeper investigation into this professional niche, however, provoked personal resistance and reactions which needed to be addressed. While caring about a research topic can sustain the researcher through the end of the project, caring may also mean that the researcher likely has a position in relation to the topic and that needs to be accounted for and made visible (Kirby et al., 2006). I also care about the topic deeply because it allows me to safely reflect on

the dynamics of old relational patterns within my family of origin. Gaining a deeper understanding of BPD, and relational dynamics within a professional framework created the necessary distance while I reconciled how my own life and personality has been influenced by those in my family with histories of interpersonal abuse. Coming to terms with the disconcerting familiarity I had with perpetually unhealthy and compromising relational re-enactments has been an arduous personal process through this project. I have come to expect that the process of building consciousness evokes incredible vulnerability and fear of the unfamiliar in a turbulent process of long-term change. Deeply engrained beliefs, values, assumptions and memories have been disrupted, which has demanded a recalibration my own sense of self as a result.

Awareness of my professional dynamics with those who have experienced interpersonal trauma has also grown. I can take more accountability for potential biases and projections since becoming increasingly sensitive to the relational needs of my clients. After all, I have adapted to meet them within my personal and familial relationships. However, this creates risk of becoming complicit in instigating, enacting and perpetuating problematic relational patterns within therapeutic relationships, potentially due to my own unresolved needs. In other words, the identity of the helper is easily fulfilled through relationships with vulnerable clients through which unconscious, cyclical and self-serving dynamics feed into old familiar Tr/CTr patterns. My research into this topic has unearthed aspects of my own personality which I have had the opportunity to begin reflecting on more deeply in the context of my professional practice insofar as how I might inevitably influence my clients and their therapeutic process. For example, I may attempt, through our relationship, to absolve them of the responsibility of attending to their own needs. Despite good intentions, education and supervision, mitigating these risks requires the

consistent recognition of my position of power within the therapeutic relationship because it is normally the covert biases that are harmful, not the overt biases (Kirby et al., 2006).

Theoretical Framework

This study considers the constructs of transference (Tr) and countertransference (CTr) as part of the overall psychodynamic framework guiding this research. These constructs are inherently relational. The therapeutic relationship is a central focus of psychodynamic psychotherapy, in which talking about and learning from the therapeutic relationship is Tr (Cabaniss et al., 2011). Psychodynamic theory provides an appropriate framework for the therapeutic relationship because it is robust yet sophisticated enough to investigate the factors which influence the unconscious and affective experience of the intersubjective; and it does so more than any explanation from an otherwise cognitive orientation (Haynal, 2018). However, the literature on personality disorders and the therapeutic relationship is lacking. This study addresses this gap and adds to the literature by identifying these factors which influence the therapeutic relationship with clients diagnosed with BPD from a relational psychodynamic perspective.

Relational Psychodynamic Theory

Psychodynamics is the idea that a part of our experience in past relationships can also co-exist in present and future relationships. The premise is that repetitive patterns in relationships are rooted in the past, and these established relational patterns occur in the Tr and CTr between clients and therapist as a dynamic interplay (Maroda, 2010). Modern psychodynamically oriented therapists understand that therapeutic work occurs within a social context (Haynal, 2018; Orfanos, 2002). The relational perspective generally is epistemological shift in the way psychotherapeutic treatment is conceptualized; it has expanded the clinical focus from a one-

person perspective to an interpersonal or two-person perspective (Fulmer, 2018; Orfanos, 2002). Moreover, the relational position is not interested in the single mind as a unit of study. It interested in the relationship as a unit of study; it places the conscious and especially the unconscious relationship between the client and therapist at the heart of the therapeutic effort (Orfanos, 2002, p. 510).

A level of ambiguity and uncertainty are features of all human relatedness (Orfanos, 2002). Therefore, the reliance of mutual and reciprocal functioning is intrinsic to being in any type of relationship, including the therapeutic one. This perspective takes into account the feelings, thoughts, and behaviors of both client and therapist (Fulmer, 2018; Ganzer, 2018) in which they will inevitably repeat past patterns of feeling, thinking and behaving (Maroda, 2010). For clients with BPD, however, this can create feelings of ambivalence which can lead to identity confusion or crises (Fulmer, 2018). Research so far contends that clients who have experienced trauma are appropriately treated by psychodynamic psychotherapy (Summers & Barber, 2015). Therefore, it can be particularly useful for the therapist to have an insight about the therapeutic relationship through the understanding of the relational constructs of Tr and CTr when working with clients who exhibit maladaptive relational patterns.

Review of Key Concepts

In order to contextualize this study into the theoretical framework of relational psychodynamics, I reviewed seminal and current literature on psychodynamic theory and its central concepts of Tr and CTr. These constructs are referred to as unconscious relational mechanisms, or the Tr/CTr dynamic or matrix, of the therapeutic relationship. The definition and literature regarding the diagnosis of BPD as per the DSM-5 is also reviewed and applied in the context of the therapeutic relationship with clients diagnosed with BPD.

Transference (Tr)

Tr is a core concept of how the therapeutic relationship is understood in psychodynamic therapies, originally regarded as a reconstruction of the client's repressed past transferred onto the dynamic of the therapeutic relationship (Cabaniss et al., 2011). "Tr is the sum of the feelings that a patient has about the therapist." (Cabaniss et al., 2011, p. 217) Some of those feelings have to do with real characteristics of the therapist, while others have to do with feelings about other people from the past, being now displaced onto the therapist (Cabaniss et al., 2011). Tr reactions within the therapeutic context relate to a client's perception of relationships, rather than objective or logical reality. There has been a shift in awareness of Tr towards a co-constructed relational phenomenon, and therefore, it has become relevant for clinical practice and the therapeutic relationship. More recently, we have relied on broader definitions of Tr, which include all therapist interventions explicitly referring to the patient–therapist interactions (Hersoug et al., 2009; Høglend et al., 2011; McIntyre & Schwarts, 1998).

When working with chronically complex clients with BPD, there is a need to consider that relational factors may be at play within the therapeutic relationship and "determine whether the feedback is primarily a Tr reaction or is in fact a piece of reality about you." (Yalom, 2005, p. 223) Invariably, the sources of intense, irrational feelings towards the therapist are so varied and so powerful that transference will always occur (Yalom, 2005). Therefore, the therapist is seen unrealistically due to 1) true transference or displacement of affect from a past relationship, 2) conflicted attitudes towards authority that becomes personified in the therapist, and 3) the tendency to view therapists with superhuman features (Yalom, 2005). Tr becomes the process of clients acting and reacting towards the therapist as if the therapist were a significant figure from their past (Yalom, 2005).

Relationship dynamics, and specifically Tr, can provide therapists with a rich source of information to examine and process with clients (Fulmer, 2018; Qautman, 2015). If the Tr is engaged, the therapist also invests in the business of feeling better, not simply attending to the client out of a detached, intellectual curiosity (Fulmer, 2018). Tr, from this perspective, is not just the material that comes up in the therapeutic space for the purposes of awareness building and subsequent analysis; it is a key contributing factor of the unconscious enactment taking place within the overlap of two distinctly subjective experiences.

Countertransference (CTr)

CTr can be defined as the totality of what the therapist experiences and feels about their client (Heimann, 1950 and Kernberg, 1965, as cited in Dahl et al., 2014; Quatman, 2015) The discussion of CTr is prevalent for the relationship-oriented therapist where the therapist must be in a process of self-reflection to appropriately counter-balance Tr (Levy et al., 2015). Additionally, it is recognized now that CTr is a normal state of affairs and can advance therapeutic work (Orfanos, 2002). According to Yalom (2005) Tr is powerful and ubiquitous; it can be either an effective therapeutic tool and a relevant source of data about the client, or as Maroda (2010), states, a set of shackles that encumbers the process or becomes an impediment to the therapeutic relationship. CTr implies that the therapist is not simply engaged with the material the client brings to session, but that the therapist also does the work of remaining present with their client through negative or difficult CTr experiences.

With clients who exhibit a borderline personality dysfunction, CTr experiences may be particularly amplified as in other relationships in the clients' lives. The relationship can come to an impasse if the therapist is unaware or unwilling to move through uncomfortable emotions and experiences with their clients. Tr is not only just being felt or spoken about, but also enacted

powerfully, often through emotionally charged interactions and power struggles (Maroda, 2010). Consequently, Tr is more likely to persist or intensify if the therapist ignores CTr; and if denied overtime the best-case scenario is failed treatment (Maroda, 2010).

The inevitability of the therapist repeating their own past is rarely discussed in psychoanalytic training (Maroda, 2010). Rather, the emphasis is placed on CTr reactions, like affection and boredom, or even irritation and anxiety (Maroda, 2010). All clients need the therapist to complete "the cycle of affective communication that they initiate in the treatment" (Maroda, 2010, p. 221). Maroda (2010) asserts that client's value honest emotional feedback, and CTr may be insisted upon by clients in an effort to perpetuate the most engrained relational patterns. "Any conflict is not located in the person, but rather conflict may best be explained as both intrapersonal and interpersonal." (Orfanos, 2002, p. 510). This, however, does not absolve the therapist of their responsibility to ethically respond to their clients. As Yalom (2005) acknowledges, unattended CTr runs the risk of hijacking the session from the client, or transforming it into the therapists' own therapy session. The therapist is to check-in on his/her internal experience in a process of verification (Yalom, 2005).

The Transference-Countertransference Matrix (Tr/CTr Matrix)

The relational psychodynamic perspective is essentially concerned with this elusive intrapsychic space, which constitutes the internalization of interpersonal experiences of past relationships manifesting through Tr and CTr within current relationships. The relational paradigm refers to the interplay of these constructs in the therapeutic relationship as the Tr/CTr matrix. The Tr/CTr "matrix is mutually determined and shaped by the conscious and unconscious beliefs" (Orfanos, 2002, p. 512) of both client and therapist. Operating from within an unconscious containment of the therapeutic alliance makes it somewhat ethereal in nature and

therefore difficult to navigate therapeutically. So, in the absence of the framework of an analytical setting, the unconscious contents of the therapist and those of the client can come to be confused with one another (Pattis-Zoja, 2004). Within this framework, therapists can use Tr/CTr intentionally, in which the therapists themselves become a part of a broad spectrum of psychotherapeutic tools (Keefe & DeRubeis, 2019).

The focus of the Tr/CTr matrix is on analyzing how the unconscious gets enacted between the client and the therapist; the ways "in which small but subtle interactions and enactments dominate the clinical situation." (Orfanos, 2002, p. 508), and "working with the integration of unconscious suffering and pain." (Ovchinnikova, & Wright, 2015, p. 734) Within the Tr/CTr matrix the clients' own sense of reality is greatly respected and encouraged; within this two-person perspective, observations and perceptions about the therapist are encouraged and it becomes likely therefore, that conflicts, entanglements and repetitive re-enactments of past patterns will develop in the most warping features of the client's past experiences (Maroda, 2010; Orfanos, 2002, p. 511). Maroda (2010) views conflict as relational, particularly if that client is critical and difficult, such as is typically the case for clients with BPD. The therapist becomes involved in something like digesting their client's emotional experiences before attempting to give them back. Yet, giving them back may often not even be necessary, since what the therapist has meanwhile processed may appear in the therapeutic communication or enactment on its own (Pattis-Zoja, 2004). Together with the therapist, the BPD client can more directly experience their unconscious defenses and relational patterns, and offer them to the therapist for the purpose of consciously reconstructing more adaptive and meaningful narratives. Ultimately moving towards a more coherent sense of themselves and others as they relate outside the therapeutic relationship.

Borderline Personality Disorder (BPD)

"A personality disorder (PD) is an enduring disturbance in how an individual experiences and interprets themselves, others, and the world." (American Psychiatric Association [APA], 2013) "It is understood as an exaggeration, rigidity, or breakdown of normal personality processes that consequently promotes dysfunctional behaviors." (DSM-5, 2013, p. 663; APA, 2013) Borderline personality disorder (BPD), as outlined by the Diagnostic and Statistical Manual, 5th Edition is a chronic disorder that includes symptoms such as frantic efforts to avoid real or imagined abandonment, unstable relationships, identity disturbance, impulsive and dangerous behaviors, recurrent suicidal threats or self-mutilating behaviors, affective instability, feelings of emptiness, difficulties controlling anger, and/or stress-related paranoid thoughts or dissociation (DSM-5, p. 663; APA, 2013). "The lifetime prevalence of BPD is approximately 6%." (May et al., 2016, p. 63)

A personality structure based on a healthy representation, on the other hand, is robust, flexible and resilient; it can function to adapt to a range of relational dynamics. Conversely, BPD is usually characterized by impoverished and dysfunctional intra- and interpersonal relationships (Levy et al., 2006; Levy et al., 2015), such as conflicts and disrupted intimacy; difficulties in understanding the motivations of others; inflexible core beliefs; idiosyncratic ways of interpreting experiences; disorganization and inconsistency and lack of nuance and integration in conceptions of self and other; and the avoidance of core emotional and interpersonal problems (Keefe & Derubeis, 2019). In short, unstable interpersonal relationships are the hallmark of BPD (Rabavilas, 2018). BPD is conceptualized as a personality that has not been given reasonable opportunity to adapt due to excessive and chronic stress, trauma, neglect, or loss; it can be further thought of as fractured, integrated or disintegrated personality to various degrees (Keefe

& Derubeis, 2019; Kernberg et al., 2008). A severe degree of identity diffusion characterizes a borderline personality pathology which subsequently results in disorganized relational patterns, maltreatment, maternal hostility and boundary confusion, family disruption, and overall family stress (Kernberg, 2019).

It is well accepted that relational patterns will always be transferred to some extent onto the therapist and the therapeutic space. Psychotherapy inevitably disrupts a client's stability; therefore, it is important to recognize that there is likely to be less tolerance, capacity and flexibility for collaboration, at least initially. Therefore, integration of the personality includes establishing the therapeutic relationship and exploring past and present relationships (Levy et al., 2015). Facilitating stable and deep improvements in relational security for clients with BPD, however, may indeed necessitate more intensive interventions (Levy et al., 2015). Since there is heightened vulnerability and risk associated with unconscious relational dynamics with this group of clients, it is prudent for therapists to know and consider what unique factors may be interfering, sabotaging, or otherwise impacting this therapeutic relationship, treatment progress and outcomes. Otherwise, these dynamics could potentially lead to further reinforcement of personality and relational dysfunction, and/or harm to the client and therapist. "Encouragingly, many clients have been observed to improve over the course of psychotherapies specialized to treat BPD." (Keefe & Derubeis, 2019, p. 765) Building tolerance, capacity and flexibility to be in relationship can start within the therapeutic relationship through mutually beneficial exchanges, learning that there is safety in mutually agreed upon and reciprocated relational dynamics of the therapeutic relationship.

Methods

Ten empirical studies were chosen to answer the research question: "What factors influence the therapeutic relationship with clients diagnosed with Borderline Personality Disorder?" In this section, I explain the process of article selection for this study and outline the design and methodologies of each study in an effort to approach the research question critically as it applies to clinical counselling practice. This will include identifying and synthesizing information about research paradigms, sampling methods, participants, data collection instruments, and analysis methods in each study in terms of their rigor by considering validity, reliability, strengths, and limitations. Secondary research undertakes a background literature review, formulating objectives and questions, and describing inclusion criteria, a search strategy for the literature, assessment criteria, data extraction and data synthesis (Taylor & Francis, 2013). Thematic analysis of these studies will allow for thorough deduction and synthesis of relevant themes across the studies which will be discussed in the sections that follow.

Article Selection Criteria

Researchers systematically search for and analyze research articles and reports accessed through various databases and libraries (Taylor & Francis, 2013). I accessed literature through ProQuest, Taylor and Francis, SAGE, and EBSCO databases.

The data sources for this study were selected based the following key words*: Transference, Countertransference, Therapeutic Relationship/Alliance, Personality Disorder, Borderline Personality Disorder, Psychodynamic theory, Psychoanalytic Psychotherapy, and Relational psychodynamics.*

The studies were selected according to a criterion of factors which include: Original research, methodological design that allows secondary analysis, and peer reviewed articles

published within the past 20 years. Additionally, I searched for sources that used a psychodynamic or psychoanalytic theoretical framework and included the central concepts of Tr and CTr.

Initial literature searches were limited to studies published within the last 10 years. The studies found during this phase of exploration were then used to extrapolate original research from the listed references via citation tracking. This process revealed several authors whose original research best informed this study. Ultimately, the search was expanded to include original research within the last 20 years. Six studies included PD's and/or other related diagnosis, such as depression, in their inclusion criteria. Two studies considered BPD specifically in terms of the therapeutic relationship and treatment. All of the studies look at therapist countertransference and/or the therapeutic relationship, but not always specifically with clients with BPD. There were not enough original research studies which considered the therapeutic relationship with BPD clients from the psychodynamic perspective. Therefore, I gathered studies which looked at PD's more broadly and used psychodynamic/psychoanalytic concepts such as defence mechanisms, Tr and CTr. This allowed me to ensure that a thematic analysis could be performed and reliably address the research question. Consequently, findings could be generalized and applied to clinical work with BPD clients potentially increasing treatment efficacy, as well as safety, within the therapeutic relationship.

Nine of the ten studies included for this study are quantitative in their design. One qualitative study fit the selection criteria. While I originally attempted to include more qualitative studies, it was later determined that most of the recent qualitatively designed empirical studies pertinent to the research question would not be sufficient in addressing the research question due to lack of rigor in research methodologies. Much of the literature on relational psychodynamic

theory and therapeutic work with BPD clients is qualitative, such as descriptive case studies and vignettes that considered relevant conceptual elements such as Tr and CTr. I included one qualitative study and two studies which used a combination of methods which systematically illustrated clinical examples of therapeutic relationship dynamics as well as contextualized this study in practical clinical application to clients with BPD. It was important to include studies which demonstrated rigor regardless of methodological design in order to reliably complete a thematic analysis of the factors that influence the therapeutic relationship with BPD clients.

In the following sections I will provide an overview of the philosophies and outline the methodologies used in the 10 studies. This will include research paradigms from which the studies considered their research, as well as specific methodological choices that researchers made regarding sampling and recruitment, data collection methods and instruments, analysis and results. Reviewing these studies will add to the current understanding of what factors therapists may need to consider when working with clients with BPD, helping to achieve positive treatment outcomes for vulnerable clients with BPD. Additionally, the ethics and clinical applications of this analysis will also be discussed in later sections.

Research Paradigms

The majority of the 10 studies were designed according to the positivist paradigm (Colli et al., 2014; Fatter & Hayes, 2013; Liebman & Burnette, 2013; Lingiardi et al., 2015; Rossberg et al., 2007; Spinhoven et al., 2007; Westerling et al., 2019). Seven studies looked at the therapeutic relationship with BPD clients using positivist approaches, specifically correlational or quasi-experimental methods. Two studies used a post-positivist paradigm (Nissen-Lie et al., 2020; Rosenberger & Hayes, 2002) in which the researchers considered the factors influencing the therapeutic relationship with BPD clients. These studies used collaborative approaches such

as a longitudinal case study design with participant researchers. One qualitatively designed study used the constructivist paradigm to describe the therapeutic relationship with this client group. This study utilized a naturalistic design to explore factors which might be influencing it (Putrino et al., 2019).

A research paradigm is a general perspective and philosophical worldview of the researcher(s) about reality based on a constellation of theories, research questions and methods that share central concepts, values and themes (Creswell & Creswell, 2018; Neuman & Robson, 2009; Kirby et al., 2006). Underlying beliefs and values of these paradigms influence how new knowledge is created (Kirby et al., 2006). Research paradigms inform what can be known about the research topic, as well as how a study is conducted. A positivist paradigm creates new knowledge about the influences of Tr/CTr on the therapeutic relationship with BPD clients using different data collection methods than a constructivist paradigm. In the following sections, each paradigm is discussed in the context of the respective 10 studies.

Positivism

Four of the 10 studies were correlational in their design methods (Colli et al., 2014; Fatter & Hayes, 2013; Lingiardi et al., 2015; Westerling et al., 2019) and three were quasi-experimental in design (Liebman & Burnette, 2013; Rossberg et al., 2007; Spinhoven et al., 2007). These 7 studies used a combination of quantitative correlational and quasi-experimental methods in an attempt to understand how therapist Tr and CTr influence the therapeutic relationship with BPD clients. Both designs use structured data collection and analysis methods which attempts to uphold objectivity in all aspects of research design. This is accomplished by ensuring internal and external validity of design as well as reliability and validity of the instruments used to collect data (Kirby et al., 2006). Analysis software is also typically used to quantify and measure the

data and minimize bias, as well as to report on findings with as much accuracy as possible. The premise is that the researcher can logically deduce, explain and predict phenomena in the world via theory testing. Positivism assumes that reality is made up of objective data and facts that researchers can measure; it values generalizability, the ability to reliably apply findings outside the studied population and/or environment (Neuman & Robson, 2009). Great value is also placed on the principles of prediction and replication, where researchers can causally explain a phenomenon as well as repeat a study and get very similar of identical results (Neuman & Robson, 2009).

Researchers operating from this paradigm are concerned with controlling certain aspects of the physical and social environments they are studying. The correlational studies considered relationships between variables such as clients' BPD diagnosis, therapist's CTr, and years of clinical experience. The quasi-experimental studies tested theories about what influenced the therapeutic relationship with BPD diagnosed clients (Liebman & Burnette, 2013), which interventions were best suited to treat BPD (Spinhoven et al., 2007), or to predict CTr of the therapist (Rossberg et al., 2007). All three quasi-experimentally designed studies control for quasi-independent variables such as BPD diagnosis, age, gender, years of clinical experience, or treatment intervention used. This allows researchers to test theories while allowing for some manipulation of a quasi-independent variable without random assignment to intervention groups.

Strengths and Limitations

Since this relationship dynamic with BPD clients is complex, with multiple variables to consider, this level of structure and control in research design allows for researchers to test theory more reliably. In the positivism paradigm, predicting relationships between variables, and making inferences and conclusions about the data is seen as more accurately representing the

phenomenon or reality being studied. However, the aversion to risk or bias inherent with this research paradigm may be a limitation in understanding aspects of the therapeutic relationship with BPD client which may span more broadly outside of the variables being tested. This approach may also miss nuances suggested by the complexity of the disorder of BPD, the constructs of Tr and CTr, as well as the nature of this therapeutic relationship.

Role of the Researcher

From the positivist approach, the role of the researcher is to be as removed from the study design as possible to limit potential influence or bias, typically having limited or no direct interaction with study participants. The researchers partake in designing and organizing the overall structure of the study methods such as recruitment, interpretation of the data and reporting on findings.

Post-Positivist Paradigm

The postpositivist paradigm assumes that outcomes are due to a complex array of causative factors that are in interaction with the result (Giddings & Grant, 2007), making researcher objectivity impossible. This approach combines the values of quantitative and qualitative research; however, ultimately steers away from an artificial division between the researcher and the researched (Kirby et al., 2006), positing that reality is socially and culturally constructed. Post-positivism destabilizes the positivistic notion of absolute truth, provable hypothesis, and unbiased, value-free researchers (Taylor & Francis, 2013). In these studies, the researchers are attempting to support rather than prove their hypothesis through a variety of methods that are not confined by a linear process of cause and effect (Giddings & Grant, 2007). Researchers maintain that the scientific method and maintaining rigor is the best approach; however, they believe that methods are guided by the research question and often incorporate

non-traditional approaches (Giddings & Grant, 2007). For example, Rosenberger and Hayes (2002), used independent raters as part of a triangulation method during data analysis which is a method used to introduce the element of a more objective or outsider perspective. This paradigm attempts to maintain internal reliability through the use of quantitative methods, while acknowledging the qualitative, unpredictable, and contradictory essence of human nature (Giddings & Grant, 2007).

Strengths and Limitations

This paradigm is conducive to the study of Tr/CTr with BPD clients because the combination of methodologies may be more sensitive to understanding the complexities and nuances of this therapeutic relationship. Having insider knowledge of the study does not preclude the researchers, rather it can be argued that it enhances the creation of new knowledge in attempting to measure and describe the unique factors of the therapeutic relationship with BPD clients. Therefore, an overarching paradigm that supports this premise of inter-relatedness via its design may also be more effective in adding to the literature in more a meaningful and collaborative way. However, the close proximity of the researcher to the study directly influences the results and interpretation of findings. Therefore, some limitations of this paradigm include increased risk of bias and less rigor in its design resulting in limiting its generalizability.

Role of the Researcher

In the 2 post-positivist studies by Nissen-Lie et al. (2020) and Rosenberger and Hayes (2002) the researchers were also participant therapists, and involved in all aspects of the research from recruitment, sampling, data collection to analysis and reporting of findings. Researchers using this paradigm are closer to and more involved in the research process than positivist

researchers while still attending to the possible impact of their bias on research findings (Creswell & Poth, 2018).

Constructivist Paradigm

This approach holds the view that reality is based less on objective data and facts, and more on the ideas, beliefs, and perceptions that people have about that reality (Neuman & Robson, 2009). Interpretive researchers using the constructivist paradigm, view reality as being constantly constructed, tested, reinforced or changed according to the social traditions and institutions in which it has been embedded (Neuman & Robson, 2009). Moreover, inductive reasoning, rather than theory or hypothesis testing, is used to explain, describe, illustrate, accurately represent and/or demonstrate the inner world and perspectives of those being studied (Neuman & Robson, 2009). One study uses the constructivist paradigm to guide its research. Putrino et al. (2019) investigated psychotherapists' CTr toward patients with BPD. The researchers completed a thematic analysis of interview or therapy session data which is characteristic of naturalistic, exploratory and descriptive research methods of the constructivist paradigm.

Strengths and Limitations

This descriptive method which captures the insider point of view of psychotherapists working with BPD clients could potentially yield richer data about relational dynamics and factors which influence the therapeutic relationship. Potentially, this approach may begin to identify aspects of the therapeutic relationship which have not yet been recognized. A limitation of the study by Putrino et al. (2019), however, is that it collected retrospective accounts of therapeutic interactions with BPD clients. The constructivist approach sacrifices accuracy, reliability and generalizability of their findings in an effort to gain depth of understanding.

However, when studying a qualitative phenomenon such as the therapeutic relationship with BPD clients, the qualitative research design may augment existing literature on a topic that is yet to be researched more thoroughly. Additionally, it can add new perspectives, considerations and questions to help guide further research.

Role of the Researcher

As evidenced in Putrino et al. (2019), researchers using the constructivist approach can be intimately involved in all aspects of the research including design, recruitment process, sampling of participants, data collection, analysis, and reporting on findings. This level of intimacy allows for the emic perspective to emerge with this paradigm from which the researchers can deeply understand findings and their implications.

Data Sampling

A research sample is a unit of analysis and/or measurement within a population being studied; it can be a person, event, written documents or observations (Taylor & Francis, 2013). Sampling techniques among the research projects differ insofar as which sampling elements are analyzed based on different assumptions about knowledge generation and validation (Taylor & Francis, 2013). Therefore, how the population was sampled for clients with BPD and the professionals who treat them is an important consideration in determining factors which affect the therapeutic relationship.

Research samples are gathered using either probability or non-probability methods, which will be reviewed in this study. All ten studies used a non-probability sampling method such as purposive, convenience or snowball sampling (Colli et al., 2014; Fatter, & Hayes, 2013; Liebman & Burnette, 2013; Lingiardi et al., 2015, Nissen-Lie et al., 2020; Putrino et al., 2019; Rosenberger & Hayes, 2002; Rosberg et al., 2007; Spinhoven et al., 2007; Westerling et al.,

2019). Three of these studies used convenience sampling only (Fatter, & Hayes, 2013; Liebman & Burnette, 2013; Lingiardi et al., 2015). Additionally, three studies used a probability sampling method of simple random sampling, in combination with a non-probability method (Colli et al., 2014; Lingiardi et al., 2015; Spinhoven et al., 2007).

More specific sampling methods will be outlined as well including recruitment, sample size, inclusion and exclusion criteria. Concepts such as type I and II errors and power analysis will be discussed because this helps researchers determine whether they have appropriate sample sizes for their studies. Reliability and validity will also be reviewed in terms of how sampling improves the generalizability of results in quantitative studies and how it helps to increase the dependability and transferability of results in qualitative studies. Reliability refers to the extent that a data sample can be analyzed to produce the same or similar research outcomes. Since there is more control in the design and execution in the nine quantitative studies, there is less variability in the results, therefore, results based on these samples can be more reliably generalized to other clinical populations and contexts. Dependability, on the other hand, refers to the credibility and trustworthiness of the sampled data and participants and what the sample can tell us about the therapeutic relationship with BPD clients, so it is transferable to other contexts (Taylor & Francis, 2013).

Lastly, in considering the importance of understanding how data was sampled, client and therapist participant characteristics will be discussed in this section. Six studies were sampled between 71 – 335 client participants and up to 560 therapist participants (See Table 1). Having good internal validity in a study limits bias such as selection bias. Generally, however, larger samples in quantitative studies generally help establish good internal reliability and validity, minimizing the effects of biases. When working with vulnerable clients with BPD, these biases

and threats to internal validity need to be considered and addressed by the researchers. In qualitative studies, researchers do not focus on generalizability, instead researchers address issues of dependability, credibility, trustworthiness and transferability.

Sampling and Recruitment Methods in Quantitative Studies

Quantitatively designed studies attempt to recruit and collect samples from a population in an effort to produce results that are representative of the population being studied. The primary goal of sampling in quantitative studies is to collect enough data from a smaller representative sample in order to make accurate and generalizable claims about the larger group (Taylor & Francis, 2013; Neuman & Robson, 2009). Therefore, stricter sampling criteria are applied in quantitative research to improve the reliability and validity of results.

The BPD client population are a very specific subgroup and make up a very small proportion of the general population. Therapists with experience working with BPD clients are an even smaller group. Even among the clinical population, these groups would make up a relatively small proportion of participants to sample. Therefore, researchers could not reasonably randomly select participants from the general population based on their criteria due to the specificity of the samples needed. As such, most of the ten studies used samples from settings where BPD clients were already being referred or treated for BPD and/or where therapists were already employed such as inpatient and outpatient hospital programs, private mental health practices, educational institutions and specialized treatment programs. Among the studies, researchers recruited psychology students, therapist trainees and supervisors as well as practicing therapists, or employees from these various settings. In order to sample enough participants this convenience sampling method helped to ensure that the researchers were able to gather large enough sample sizes of clients with BPD and/or therapists who had experience working with

BPD clients. This non-probability method accesses a more convenient portion of the general population, recruiting from which is relatively.

For instance, studies by Colli et al. (2014) and Lingiardi et al. (2015) sampled therapist and client participants from two large associations of psychodynamic and cognitive-behavioral psychotherapy, and from treatment centers which specialized in the treatment of personality disorders. These two studies took further steps to mitigate sampling bias that may result from using a convenience sampling method. These researchers combined the convenience method with a probability sampling method of simple randomization. They chose participants at random while also gathering the sample sizes they needed for their studies. Even though these samples were randomly chosen from a convenient sample, this does not eliminate the risk of selection bias and therefore may still limit the reliability and generalizability of results. Sampling from a setting where researchers have access to client and therapist participants who meet specific criteria may under-represent participants outside of that setting or timeframe of the study. Consequently, the sample may over-represent certain qualities or characteristics of participants in the samples that may not initially be apparent and may influence the results, nonetheless.

Another non-probability method used in addition to the convenience sampling method in the quantitative study by Fatter and Hayes (2013) was snowball sampling. Student and therapist trainee participants were invited to participate. As part of the informed consent process, they gave consent that their clinical supervisors would also be invited to participate, creating further links to other potential participants for the study. This type of sampling is specifically referred to as snowball sampling; the sampling ‘snowballs’ until the sample size is sufficient. Furthermore, saturation is achieved when enough data is theoretically collected, during which new data from a sample no longer add new information about the hypothesis or research questions. Snowball

sampling begins with participants that the researcher knows and has access to, making it a type or convenience sampling (Taylor & Francis, 2013). Liebman and Burnette (2013) also reported use of a 'word of mouth' method to recruit their sample of therapist participants who were providing mental health treatment from a variety of settings.

Overall, three studies by Colli et al. (2014), Lingiardi et al. (2015), and Spinhoven et al. (2007) combined the probability method of simple random sampling with a non-probability sampling method such as convenience or snowball sampling method. Recruitment from these samples for therapists was mainly done via email, either as a direct invitation to participate in the study or via word-of-mouth referral through other professionals that knew them. Recruitment for client participants was completed via referrals by private and community professionals such as physicians who have access to this group of clients. Clients were also recruited during the intake processes of the mental health institutes and public outpatient programs that they were referred to for treatment.

Sample Size

Determining appropriate sample size depends on the study design and purpose. A researcher's decision about sample size is determined by whether they can address the research question or hypothesis with the highest degree of accuracy possible. Furthermore, an important principle of sample sizes is that the smaller the population, the bigger the sampling ratio has to be for accurate results (Neuman & Robson, 2009). Having an appropriate sample size helps correct for sampling error, which is the deviation between sample results and randomization of a population (Neuman & Robson, 2009). Before the data collection stage in a quantitative study, a researcher should conduct a power analysis to determine if a sample size will be sufficient to reach the desired 0.05 level of significance. It is not known how many of the nine quantitative

studies completed a power analysis for their samples because this was not reported. The purpose of doing a power analysis is to help determine the smallest sample size suitable to reach the desired level of significance (Neuman & Robson, 2009).

The studies by Colli et al. (2014), Fatter and Hayes (2013), Liebman and Burnette (2013), Lingiardi et al. (2015), Spinhoven et al. (2007), and Westerling et al. (2019) have large patient samples, N = 71 – 335 (See Table 1). Three studies, (Fatter, & Hayes, 2013; Liebman & Burnette, 2013; Lingiardi et al., 2015) have large therapist samples, N = 100 – 560 (See Table 1). These studies conducted more complex data analysis for which larger samples sizes are necessary. Researchers in these studies aimed to have large enough samples of clients who met the clinical diagnostic criteria for PD, including BPD, specifically. However, a large sample does not necessarily guarantee a representative sample.

A power analysis mitigates the risks of type I or II errors. Type 1 error is caused by rejecting the null hypothesis when it is true, whereas a type II error is caused by accepting it even though it is not true (Neuman & Robson, 2007). In other words, type I error occurs when the researcher says that a relationship in the data exists when in fact none exists. A type II error occurs when a researcher says that a relationship does not exist, but in reality, it does Neuman & Robson, 2007). The power analysis usually deals with type II errors. If a sample is too small to have sufficient power in reaching the 0.05 level, then the risk of conducting the type II error increases. As the odds of making one type of error decline, the odds of making the opposite error increase (Neuman & Robson, 2007). Therefore, putting the ideas of statistical significance and the two types of error together, the 0.05 level of statistical significance is a compromise between Type I and Type II errors (Neuman & Robson, 2007).

Clinician samples were generally smaller than patient samples throughout the studies. People diagnosed with BPD make up a very small and homogenous proportion of the population and are disproportionately represented among those who are referred to or access mental health services. Even smaller and more varied, is the population of therapists who are equipped and experienced in treating BPD. This is evident in sample sizes across all ten studies, which varied between 1 to 560 participants. In the studies by Niessen-Lie et al. (2020), Rossberg et al. (2007), Spinhoven et al. (2007), and Westerling et al. (2019) the therapists' samples were considerably smaller than data collected from patient samples (See Table 1). For instance, Westerling et al. (2019) collected data from a sample of 335 patient participants, and a sample of 19 therapists. Rossberg et al. (2007) included 54 patients with PDs and 11 therapists. This sampling size discrepancy occurred in the studies because the same therapists would often treat multiple clients within the same treatment setting. The small sample size for therapists may also be because not many therapists have training and/or experience with BPD clients specifically. Without a proper sample size, the study's internal validity may be compromised. For instance, if a sample of therapists is too small, the results may not establish enough support for sufficiently reliable results. The implications of not having an appropriate sample size for either therapists or clients is that the risk of making type II errors increases and researchers accept the null hypothesis when in fact it does not have sufficient support from the data. Specifically, making or accepting conclusions about which factors may influence the therapeutic relationship with BPD clients, may not ultimately be supported by the sampled data.

Generally, larger samples of therapists and clients with PD or BPD may allow for the data to more accurately point to the factors that impact the therapeutic relationship, such as level of clinician experience, CTr management or number of sessions. However, therapist sample sizes

in particular have a very wide range. Therefore, ascertaining common themes from the data may be fraught with variations or irregularities. This may contribute to risks of bias such as measurement and confirmation bias. This variance in the sample sizes may also contribute to a decreased generalizability of results. If there are a limited number of clinicians who regularly treat clients with BPD, or who have experience with clients with BPD in general, it may be sensible to take caution in not over-generalizing, based on these samples.

Inclusion and Exclusion Criteria

Inclusion criteria varied between studies, however, in the studies which included therapy sessions, researchers included therapists with some level of experience working with clients diagnosed with PD's and/or BPD. Liebman and Burnette (2013), for instance, limited their sample to available clinicians who were providing mental health treatment to clients at the time of the study to ensure that reports would be based on current experiences with clients. Additionally, the psychodynamic approach with experienced professionals was prioritized which could imply that in order to have success, a certain approach must be utilized to have therapeutic success, which may or may not be accurate for all clients with BPD.

For client participants in the quantitative studies, researchers included clients who were between 18 and 60 years old who had a diagnostic assessment at the time of intake and/or existing diagnosis of a PD. Three studies included clients diagnosed with BPD specifically (See Table 1). All client participants in these studies provided consent. The exclusion criteria required that clients do not have another primary diagnosis such as psychotic disorders, bipolar disorder, dissociative identity disorder, antisocial personality disorder, attention deficit/hyperactivity disorder, intellectual disability, and/or addictions. In clinical practice, however, it is common that clients present with co-morbidities, such as depression, for example. Furthermore, since clients

with BPD are an especially vulnerable population, being recruited through a trusted source, such as an existing professional, may be an important factor in consent and follow through with treatment. There may be a difference between the clients who consented and followed through with the study versus those who did not, or who dropped out for other reasons. This population is difficult to capture due to the realities and complexities of PD's, both in diagnosis and treatment. Therefore, these samples may have under-represented the more complex or lower-functioning clients with BPD and over-represented clients who are more willing and active participants in the therapeutic process, based on these criteria.

Sampling and Recruitment Methods in Qualitative Studies

Qualitative studies are also concerned with the depth of investigation on a particular subject or population, therefore, are more likely to use non-probability sampling methods in which the purpose is to collect cases that clarify and deepen understanding about a research topic (Neuman & Robson, 2009; Taylor & Francis, 2007). Qualitative studies often explore a subgroup of a population which yields a depth of knowledge about a specific topic such as in the study by Putrino et al. (2019) which sampled psychotherapists about their therapeutic experiences with BPD clients. Qualitative researchers assume knowledge is dynamic and context dependent, therefore, qualitative sampling focuses less on a samples' representativeness or generalizability, and more on dependability and transferability. In other words, whether that sample can be trusted to transfer to other contexts.

Two non-probability sampling methods used in the qualitative study by Putrino et al. (2019) include purposive and convenience sampling, which are complementary approaches. Researchers are "interested in purposively gaining localized, personal accounts from people who have experienced a particular phenomenon and are willing to participate." (Taylor & Francis,

2013, p. 191) In other words, the primary concern of purposive sampling is to find cases that will enhance what the researcher learns about a topic by sampling a select group of participants which describes or captures that specific group or context. Convenience is a method by which researchers recruit participants to which they already have access, consent, incentive and/or willingness to participate. In the qualitative study by Putrino et al. (2019) researchers already know they wanted to recruit therapist participants who had experience working therapeutically with clients diagnosed with PD's, BPD or depression. This sample of therapists could therefore provide researchers with dependable data based on their experiences working with BPD clients.

These methods have drawbacks insofar as asking participants for highly subjective data from which it can be difficult to establish credible, consistent and dependable results. Therefore, in qualitative studies, triangulation is an important method for establishing more dependability in the results. It assumes that if you get similar outcomes by using different methodological approaches then both the data and research outcomes are dependable (Kirby et al., 2006). This also limits the effects of selection bias, maturation effects, testing effects or experimenter expectancy. These biases threaten the dependability of the results and need to be considered and addressed by the researchers. Putrino et al. (2019), for instance, used independent auditors who looked at the interview data provided by participants. They viewed the primary team's work and provided feedback to ensure organization of the core ideas and that thematic analysis was balanced among all team members. In this way, the results of the study are corroborated by more than one researcher or research team, increasing dependability and transferability of results.

Purtino et al. (2019) also used a snowball sampling method. Snowball sampling is another type of non-probability sampling in which researchers recruit further participants from their original sample. This method relies on a multistage technique in which cases spread out

from links to the initial participants (Taylor & Francis, 2013). In snowball sampling, generally, as more participants are needed for the sample, the original and/or current participants are asked to invite others who may be interested in participating in the study. A link could be a professional relationship or student-supervisor relationship where a participant who was initially recruited is somehow linked to the next, based on a given set of criteria.

One strength of snowball sampling is that it works well when studying very small and specific subsets of the population such as those diagnosed with BPD or professionals using specialized treatment approaches. It is, in this way, a complimentary approach to purposive sampling as well. A limitation of this sampling technique, however, may be that the referral source potentially carries forward a certain bias to the next referral, who then carries that to the next, and so on. Generally, non-probability sampling such as snowball sampling attracts claims of bias (Taylor & Francis, 2013). Because the original participants are chosen by the researchers whereas other participants are beings referred by participants, studies like the on by Putrino et al. (2019) risk including homogeneous samples of therapist participants who may share particular biases regarding the BPD client. These biases, consequently, may become over-identified in the sample. The level of credibility and dependability of a sample depends on how these biases are addressed. There is a risk of reinforcing a particular bias about clients with BPD, making results less dependable and therefore transferable to other contexts. Researchers who utilize these sampling methods need to be cautious of not deviating away from their research topic by being clear about their inclusion and external criteria for instance. On the other hand, a shared experience of CTr reactions towards BPD clients in the study by Putrino et al. (2019) may provide valuable insights. These therapist participants may have already worked with the other

therapists who have a level of experience with this specific group of clients and therefore can help saturate the data about the topic fairly quickly and easily.

Sample Sizes

Sample sizes in qualitative studies which use interviewing methods such as the study by Putrino et al. (2019) are not necessarily known or set by the researchers in advance. Sample sizes are also difficult to determine ahead of time when researching small subgroups of a population where it may be unknown how many participants a researcher could reasonably recruit for their study. In qualitative studies, the researcher would continue to interview participants until the same general themes continued to emerge from the data and no new findings were revealed (Neuman & Robson, 2009). Furthermore, the number of people interviewed in a study is usually dictated by the time and resources available to the researcher (Neuman & Robson, 2009).

Inclusion and Exclusion Criteria

Putrino et al. (2019) sampled 43 clinical psychologists from varying theoretical orientations (i.e. Cognitive Behavior Therapy, Psychoanalysis) with whom they had previous contact. Researchers included therapists who were available and willing to participate in a 30-minute semi-structured interview and had previously worked with patients with BPD or depression.

Participants

Two major sample groups were studied, including therapists and clients. Therapist participants included psychology students, clinical psychologists, psychotherapists or psychiatrists, with varying levels of experience, were included in the samples throughout the ten studies (See Table 1). Three studies sampled only therapists (Fatter & Hayes, 2013; Liebman & Burnette, 2013; Putrino et al., 2019), and seven studies included client samples (See Table 1).

Client samples included people over the age of 18 who met the criteria for a main diagnosis of PD or BPD and were in treatment either before or during the study (See Table 2). Regarding all participant characteristics generally, Caucasian women made up the large majority of both the therapist and client samples (See Table 2). Most therapists sampled were Caucasian including three studies reporting 100% Caucasian participants in their samples (See Table 2). Overall, the studies sampled between 50 - 82% female therapist participants, and between 50 - 94% female client participants. One study, by Niessen-Lie et al. (2020), however, comprised of five males and two female therapists, and a near equal split of female/males in the client sample.

Therapist Participants

The samples of therapists include mostly women therapists who are training to work with or have a level of experience working with clients with BPD. Years of experience ranged between 1-3 years for students and trainees, and 10 - 40 years' experience for psychoanalysts or psychiatrists (See Table 1). For instance, Rosenberger and Hayes (2002), sampled one 34-year-old therapist with 3 years of experience, whereas Liebman and Burnette (2013) sampled 560 clinicians with <5 - 20+ years of clinical experience (See Table 1). Professionals with higher levels of experience treating PD's may yield different results than a trainee or student. Specifically, therapists with more clinical experience could have deeper insights into the psychodynamics of their clients' Tr, their own CTr and how this may impact the therapeutic relationship. These studies point to level of therapists' experience or training as being factors which influence the professional relationship with BPD clients in terms of CTr management. Caution may be warranted for under or over-stating the significance of this factor based on these samples due to variance in terms of professional experience and training. There may be

differences between relatively new therapists or trainees and experienced ones, which have not been thoroughly explored.

Most therapist participants sampled applied the psychodynamic or cognitive behavioral interventions due to already being employed by the hospital or mental health programs which used these approaches in treating BPD clients. An overrepresentation of therapists who used these approaches may be a consideration among these samples. Moreover, therapists' professional designations varied within the samples. Some professionals were psychiatrists, others clinical psychologists, psychoanalysts or social workers. Most therapists sampled across the ten studies were designated as clinical psychologists. Liebman and Burnette (2013), for example, included therapists from various disciplines including Psychology (N = 257), psychiatry (N = 81), and social work (N = 231). This may pose a challenge for the investigation because there could be a wide variety in practices and orientations between these professions, encompassing medical, mental health, and community work. Professionals would likely approach clients with BPD from different perspectives and training backgrounds creating further variance among samples. Considerations of each professional designation when working with BPD clients may look different depending on what their outcome priorities are. For example, a psychiatrist may consider intervention such as medication or a hospital outpatient group therapy program, while a psychoanalyst may suggest weekly sessions for long-term psychodynamic psychotherapy. Additionally, a clinical psychologist might offer a year of bi-weekly cognitive behavioral therapy with regular at home exercises.

Clients may also be biased towards one professional approach or designation over another, or rather, may perceive them differently. This is something that is not specifically explored in the studies, however, it may be important to consider since clients with BPD might

respond differently to the various approaches such as relational, cognitive or behavioral approaches used by a psychologist as opposed to a psychiatrist, as this could confound any differences between therapeutic approaches or designations, potentially obscuring results. The study by Nissen-Lie et al. (2020), for instance, was the only empirical study to have looked at whether patients' characteristics predict therapists' emotional countertransference differently depending on whether their therapeutic approach used transference work. Therefore, it is important that treatment outcomes based on a clinician's experience be considered with other factors such as professional training and type of designation, or clients' Tr about their therapists' designation, which may influence the professional relationship.

The other aspect to consider is the generally homogenous sample of Caucasian female therapists. This may inadvertently under represent a potentially more diverse sample of therapists who work with PD or BPD clients who may have a slightly more varied perspective or experience in clinical practice. For instance, male therapists, therapists who are ethnically diverse, who have professional experience outside conventional psychotherapeutic practices, or those who practiced psychotherapy outside of America or Europe. This is relevant for this study, especially because there is a parallel between characteristics in the client samples throughout the studies, both being mainly middle-aged Caucasian females. This may point to unique factors within the Tr and CTr dynamic within the therapeutic relationship which may warrant further exploration. For example, it might heighten Tr and CTr dynamics between the therapist and client and potentially make therapeutic intervention more challenging, longer or otherwise interfere with the treatment process, ultimately impacting results.

Client Participants

Client samples were also generally homogenous in their demographics. Client samples were included in seven of the ten studies (See Table 1). All client participants in these studies were adults with mean age ranging from 30 - 45 years. The majority were middle-aged Caucasian women with a main diagnosis of PD or BPD who consented to psychotherapeutic treatment in either private practice, hospital inpatient and outpatient settings, or public health treatment centers. While part of the issue may be an existing bias within the literature and in clinical practice about the client with BPD, this may also reinforce the impression or bias that people with BPD are mostly middle-aged Caucasian women who have access to regular mental health care treatment. However, it might just be an indicator of who a therapist might likely encounter when working with a client with BPD. This age group of clients may have more capacity and access compared with those who are younger (18 - 30 years old), students, or retired and elderly clients. This may be a factor to consider because it may underrepresent these people who may also meet the criteria but do not have the same level of support such as time away from work, transportation, or access to technology.

Clients who are ready and willing participants in treatment, generally, are typically more motivated throughout the therapeutic process and may therefore experience more positive outcomes as a result. Sampling clients with BPD who have consented to participate in therapeutic intervention, versus those who have not consented or dropped out, can reinforce a bias that therapeutic work with BPD clients is unique or challenging in ways that have not yet been confirmed by research. Clients with BPD may also consent to participate in therapy or a treatment program for more complex reasons. Moreover, client samples included those who were already participating in treatment or who have had experience with therapeutic intervention in

the past. Therefore, they may have made varying degrees of progress towards their goals. It may be that clients with BPD may need ongoing or long-term intervention to be successful which may help explain, at least partially, why the bias exists in the literature that BPD clients are difficult to treat, and tend to repeat treatment. It should be considered that the overall sample of clients in these studies may exclude a portion of the population that is not as easy or convenient to gather data from.

Conclusion

Various sampling methods were used among the ten studies: simple random sampling, convenience, purposive and snowball sampling. Moreover, a combination of probability and non-probability methods were used in most of the quantitative studies such as convenience and random sampling. The weakness of using random sampling is that it is difficult to gain a large enough sample when studying a very specific group or context such as the therapeutic relationship with clients with BPD. Due to stricter sampling criteria, probability sampling methods may also make it costlier and more difficult to gain enough sample data to address the research hypothesis or question adequately. The advantage of using random sampling is that is establishes a certain level of internal reliability and validity in the study by mitigating risks of type I and II errors and studies have more generalizability.

Strengths of non-probability sampling methods, such as purposive, convenience and snowball sampling methods, used in both quantitative and qualitative studies, include gathering data from a specified sample to deepen understanding about a research topic. With appropriate sample sizes these data sampling methods can yield data in qualitative studies that are dependable and transferrable to other clinical contexts which provide treatment for clients with BPD.

From case study to large samples of over 500 clinicians, both probability and non-probability sampling were used throughout the studies. These various sampling methods provided researchers with data about a very small subgroup of the population that is difficult to collect data from due to the specificity and vulnerability of clients with BPD. As a result, these samples capture unique attributes about BPD clients and the therapists who work with them, which could reveal influential factors for this distinctive therapeutic relationship.

Data Collection

This section provides an overview of data collection methods and instruments used across the 10 studies. Researchers used either the longitudinal or cross-sectional study design to structure their data collection methods. Data collected longitudinally allows researchers to observe and record changes to variables over time and may be useful for studying the development and maintenance of the therapeutic relationship. Cross-sectional data collection attempts to provide a clear depiction of who is being studied at one point in time. It is a useful method to collect diagnostic data or therapists' CTr toward clients with BPD.

Quantitative data collection methods were used in nine of the studies, and qualitative methods were used in one study. Various data collection instruments, such as structured and semi-structured interviews and questionnaires, provided researchers with data collected from therapist participants including data about CTr, professional designation, theoretical approach, years of experience, and demographics. Most of the data was collected from therapist participants. Diagnostic and demographic data was collected from client participants. In the following section, five of the most commonly used instruments across the studies are examined more closely in terms of how they inform factors which influence the therapeutic relationship

with clients diagnosed with BPD. Ultimately, the way in which data is collected influences what researchers can know and learn about therapeutic relationship with a particular group of clients.

Longitudinal Data Collection

Data was collected longitudinally in 7 of the research studies (Colli et al., 2014; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Rosenberger & Hayes, 2002; Rossberg et al., 2007; Spinhoven et al., 2007; Westerling et al., 2019). Data was collected from participants before, during and/or after psychotherapeutic treatment in an attempt to capture information such as change in the severity or improvement of BPD symptoms and/or therapist CTr over time. Westerling et al. (2019) for instance, collected survey data from the Experiences in Close Relationships-Short Form (ECR-S) from client participants, and the Therapist Response Questionnaire (TRQ) from therapist participants at 3, 6, 12, 18, 24 months, and at 4–6 weeks after termination.

Longitudinal data collection highlighted that working with personality disordered clients may demand more process rather than outcome-oriented treatment interventions. Collecting data about the therapeutic relationship throughout treatment allowed researchers to gain an understanding about the nuances of the Tr/CTr dynamic between therapist and client and how the therapeutic relationship with clients diagnosed with BPD may change over time. For example, in the study by Rossberg et al. (2007) the Feeling Word Checklist-58 (FWC-58), and the Global Assessment of functioning (GAF; See Table 3) were administered to therapist participants 2 weeks after admission and 2 weeks before discharge during an 18-week treatment protocol. The researchers were looking at how therapists' CTr was correlated with improvement in symptoms and relational functioning using psychodynamic psychotherapy.

There are limitations and risks of collecting data longitudinally. This data cannot describe the process or necessarily tell the researchers why these changes may have occurred. Longitudinal data may be more costly and time consuming for both researchers and participants completing multiple questionnaires or interviews during the study, especially with high drop-out rates and low response rates. Westerling et al. (2019) noted that clients with BPD tended to have higher rates of drop-out and biased reporting, as well as low response rates. Of the 291 initial client participants who agreed to follow up, 26% of participants completed the first follow up whereas only 7% completed the follow up at 18 and 24 months (Westerling et al., 2019). Participant attrition across time may suggest systematic differences between participants who dropped out and those who completed treatment, which would not have been captured (Westerling et al., 2019). Therefore, the results may be biased towards clients who completed the study. This study did not investigate attrition bias however, which is a limitation because we do not know what factors may have led to some clients dropping out while others completed the study. This bias could impact the validity and generalizability of a study.

Cross-Sectional Data Collection

Four studies used the cross-sectional data collection method (Colli et al., 2014; Fatter & Hayes, 2013; Liebman & Burnette, 2013; Putrino et al., 2019). In contrast to longitudinal data collection, cross-sectional data collection captures data about a population at one point in time; it does not capture the process of change or determine cause and effect (Neuman & Robson, 2009). This method is often used in studies to collect observational and descriptive data about a population within a certain context such as clients diagnosed with BPD or therapists who treat BPD. These observations may help to establish relationships between variables, clarifying what factors appear to be worth exploring further.

The cross-sectional method is useful in collecting data about a population at one point in time and then making reasonably accurate inferences about possible relationships between different variables within the data such as the relationship between clients' level of motivation and therapists' CTr. In other words, it allows researchers to focus on one independent variable (CTr) and one or more dependent variables (client diagnosis, motivation, etc.). Niessen-Lie et al. (2020), for instance, collected data about therapists' emotional CTr and client factors such as motivation and feelings of disengagement. Therapists in this study felt less inadequate CTr as client motivation increased. This data can be helpful to this investigation in describing therapists' CTr in this specific context as well as for making observations about the differences between clients who completed treatment for BPD and those who dropped out.

However, the use of cross-sectional data collection is limiting because the nature of the therapeutic relationship is change and process oriented. Clients with BPD generally struggle to establish healthy relational dynamics and maintain stability in their relationships in the long term, the therapeutic relationship being no exception. Therefore, collecting data about clients' motivation to engage in psychotherapy in relation to therapists CTr with unstable clients, may not be sufficient data to make meaningful inferences about treatment processes underlying this relationship due to higher levels of volatility in the relational dynamics with BPD treatment. If studied over time, however, researchers may be able to observe differences between early and late treatment phases in clients' motivation to engage in the therapeutic relationship and complete BPD treatment. They could therefore make inferences about why changes in motivation and CTr may occur over longer periods of time. The cross-sectional method may not be as useful when it comes to examining processes of change inherent to psychotherapy and the treatment process. However, this method may be helpful in observing, describing and gaining a

better understanding of specific therapist or client factors which appear to influence the therapeutic relationship and treatment outcomes.

Quantitative Methods of Data Collection

Nine of the 10 studies used quantitative data collection methods, which means that data was gathered according to rules and procedures meant to systematically measure variables about a research topic. These 9 quantitative studies used multiple well-validated data collection instruments such as questionnaires or structured interviews (Colli et al., 2014; Fatter & Hayes, 2013; Liebman & Burnette, 2013; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Rosenberger & Hayes, 2002; Rossberg et al., 2007; Spinhoven et al., 2007; Westerling et al., 2019). These data collection instruments provided researchers with information about variables of interest. For example, Spinhoven et al. (2007) used structured questionnaires and interviews such as the Borderline Personality Disorder Severity index-IV (BPDSI-IV) which measures current severity and frequency of BPD symptoms. Therapist participants were also asked to provide information about CTr during therapeutic sessions such as in the study by Nissen-Lie et al. (2020) which used the Feeling Word Checklist-58 (FWC-58) and the Inventory of Interpersonal Problem-circumplex version (IIP-64; See Table 3). Seven studies used several different questionnaires and surveys to obtain self-report data (See Tables 2 & 3). Examples include: The Session Evaluation Questionnaire (SEQ), Counselor Rating Form—Short version (CRF–S); The Brief Symptom Inventory (BSI), and the Adjective Checklist (ACL; Rosenberger & Hayes, 2002). Quantitative methods attempt to establish a high level of reliability and validity when measuring relevant variables and constructs by using well-validated and standardized instruments to ensure that researchers make reliable inferences and conclusions about their data.

Data Collection Instruments

Twenty-one data collection instruments were used across the 10 studies. They included structured interviews and various types of questionnaires such as surveys and inventories. With the exception of demographic questionnaires, instruments were used to measure theoretical constructs which are difficult to define and directly measure. Many instruments are easy to distribute electronically, inexpensive and do not take long to complete. Information about multiple variables collected through these instruments can be examined and analyzed more accurately due to the systematization of the information they offer. Therefore, these instruments allow researchers to study many variables and deduce findings from large amounts of data, making more accurate inferences and more generalizable interpretations of the findings (Kirby et al., 2006; Neuman & Robson, 2009). By using well-validated data collection instruments, these studies can provide reliable sources of information about the factors which influence the therapeutic relationship with BPD clients.

Five of these 21 instruments are examined in more detail throughout this section (See Table 2). These include: 1) The Therapist Response Questionnaire (TRQ), 2) Working Alliance Inventory (WAI), 3) The Countertransference Inventory – Revised (CFI–R), 4) BPDSI-IV (DSM-IV BPD), and 5) Shedler-Western Assessment Procedure 200 (SWAP-200). The first three instruments are chosen because they broadly measure concepts related to the therapeutic relationship. The last two are chosen to examine how participants were assessed for BPD through the use of structured clinical interviews to provide current, accurate and unbiased data. It is important that we know how patient participants were assessed for BPD as this affects validity of the study and generalizability of findings to this clinical population. These instruments are relevant in deducing factors influencing the therapeutic relationship in relation specifically to

clients diagnosed with BPD. Strengths and limitations of these instruments are evaluated based on whether the researchers could reliably collect enough data needed to address their research questions.

Structured Interviews

Structured interviews were used in five of the quantitative studies to screen participants and assess client participants for BPD (Colli et al., 2014; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Putrino et al., 2019; Rossberg et al., 2007; Spinhoven et al., 2007). The structured clinical interview consists of a controlled interaction where the interviewer asks a set of questions according to an interview schedule, in precise order, to elicit information about expressions of opinions or belief from the participant (Kirby et al., 2006). The interviewer's role is neutral, inflexible, and pre-determined, meaning that there is no unsolicited interaction between researcher and interviewee because doing so would add variation to the data (Kirby et al., 2006). Participant data is controlled for confirmation and social desirability biases through systematic data collection and not allowing for the inclusion of subjective data or feedback about the instrument or the study. In other words, structured interviews control for responses which may over-report socially desirable traits and/or under-report socially undesirable traits or attitudes. This ensures stronger internal reliability than a self-report measure could provide. Additionally, the structured format allows for these instruments to be validated across populations and contexts, making it useful across a variety of clinical settings.

The Shedler-Western Assessment Procedure 200 (SWAP-200), used by Colli et al. (2014) and Lingiardi et al. (2015) is a structured interview which provides a comprehensive assessment of personality and psychological functioning (See Table 2). The instrument provides a personality diagnosis expressed as the matching of the patient assessment on 12 personality

disorder scales, as described in the DSM-IV axis II disorders i.e. Borderline, avoidant, dependent, histrionic, etc. (Westen & Shedler, 1999). The SWAP-200 is reported to be a well validated instrument with strong construct validity (.80) and convergent validity (.66; Westen et al., 2006, 2007; Tanzilli et al., 2016). Blagov et al. (2012) reported moderate to high test-retest reliability coefficients (.64 - .94), high interrater reliability (.82), good internal consistency (.73) and mean reliability coefficient for scales of DSM-IV PD's (.90; Blagov et. al., 2012; Westen et al., 2006; See Table 2). According to Tanzilli, et al. (2016), the SWAP-200 is a reliable instrument in the assessment of personality pathology. Additionally, the SWAP-200 was normed on 530 clinicians (psychiatrists and psychologists) reporting on 267 patients, as well as on a clinician retest sample (N = 94). Therefore, the two studies which used this instrument had reliable diagnostic data from which they were able to accurately infer about how a BPD diagnosis might impact therapists' CTr responses in the therapeutic relationship.

Nissen-Lie et al. (2020) and Rossberg et al. (2007) used the DSM-III-R (SCID-II), which is a structured clinical interview used to assess personality disorders. Spinhoven et al. (2007) used the BPDSI-IV (DSM-IV BPD), a criteria-based semi-structured interview which is not a diagnostic instrument but forms a quantitative index of the severity and frequency of BPD symptoms. According to the researchers, the BPDSI-IV demonstrates excellent interrater reliability and sensitivity to change during treatment as well as excellent reliability and moderately strong internal consistency (See Table 2). Therefore, inferences made about how the therapeutic relationship may be influenced by the severity of BPD symptoms were based on reliably collected data.

Therapists, upon entering the therapeutic relationship, require up-to-date information about their clients' diagnosis. Five studies used structured interviews to screen and assess client

participants in their research (Colli et al., 2014; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Rossberg et al., 2007; Spinhoven et al., 2007), whereas the remaining 2 studies which included client participants (Rosenberger & Hayes, 2002; Westerling et al., 2019), relied on past self-reported diagnostic information. This was a limitation in these studies because if diagnostic data is out of date or inaccurate, clients may present differently than expected in treatment; the severity or frequency of symptoms might be different then their provided data may suggest. Collecting older diagnostic data could inadvertently inflate or distort correlations with other variables, such as CTr. For example, if the severity of BPD symptoms were reported to be higher in previous assessment data, but the client exhibited less severity during psychotherapeutic treatment, the data collected about type or intensity of therapists' CTr could be inaccurately reported. As a result, researchers risk losing internal reliability in their studies. Therefore, having current diagnostic information would be an important consideration for therapists working with clients with the BDP diagnosis. Using structured interviews ensures that researchers have current information about their client's diagnosis of BPD and therefore ensures that reliable data is used to measure the impact it has on the therapist and on the therapeutic relationship.

Self-Report Instruments

A range of self-report instruments was used in the seven studies to obtain data from participants; these include questionnaires, surveys, checklists and rating scales (See Tables 2 & 3). These included online instruments which collected demographic data from both client and therapist participants. The data included information about gender, age, and ethnicity. Data about discipline, theoretical approach, education level, and years of experience was additionally collected from therapists (See Table 1). Data about employment, education and socioeconomic status, and diagnostic information was also collected from clients (Colli et al., 2014; Liebman &

Burnette, 2013; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Rossberg et al., 2007; Spinhoven et al., 2007; Westerling et al., 2019).

The questionnaire remains the most popular method to formally and conveniently collect a lot of information from study participants (Kirby et al., 2006). For instance, the Therapist Response Questionnaire (TRQ) is a validated and formalized data collection instrument that was used by multiple studies (Colli et al., 2014; Lingiardi et al., 2015; Westerling et al., 2019). It is designed to assess CTr patterns in psychotherapy via 79 items measuring a wide range of thoughts, feelings, and behaviors expressed by therapists toward their patients, across eight countertransference dimensions (Westerling et al., 2019). The TRQ is reported to be a robust instrument with good construct validity. Convergent validity showed very high intercorrelations between all the factors, demonstrating high internal reliability of all 9 subscales and items (See Table 2). Additionally, this questionnaire was normed on a large sample size of patients diagnosed with PD (N = 332) as well as therapists and psychiatrists with at least 3 years of clinical experience. Authors from the Westerling et al. (2019) study specifically used this instrument to measure associations between CTr and patient attachment in the therapist-patient relationship. The TRQ quantified associations as well as provided data about how the associations changed as treatment progressed. CTr reactions reliably predicted personality traits in their clients using data from this instrument. Researchers could therefore infer that therapists' CTr can be impacted by different personality disorders, including BPD.

Checklists, rating scales and inventories are types of self-report questionnaires which collect similar data as the questionnaire would but are generally easier and quicker to complete. Examples include: The Feeling Word Checklist-58 (FWC-58), a self-report measure used to assess therapists' CTr; the Inventory of interpersonal problems-circumplex version (IIP-64), a

self-report instrument designed to assess interpersonal problems; and, The Global Severity Index (GSI); and the Experiences in Close Relationships-Short Form (ECR-S; See Table 3). Fatter and Hayes (2013), and Rosenberger and Hayes (2002), both used the Countertransference Inventory – Revised (CFI–R). This 40-item instrument collects data about the therapists' CTr management by measuring several variables (See Table 2). Construct validity of the CFI-R was established via experienced therapists (N = 122), however, it demonstrated limited construct validity when measuring subscales altogether. Evidence of content validity was gathered via 33 expert therapists and convergent validity was normed on 345 experienced therapists (Latts, 1996; Van Wagoner et al., 1991; Hayes et al., 2011). This inventory demonstrates high internal reliability estimates for each subscale (.91 - .92) as well as acceptable overall internal reliability (.94; Hayes et al.,2011. Additionally, the CFI-R rated highly for content validity (Hayes et al., 2011). The CFI-R was used to reliably associate the level of CTr management a therapist had to certain personality traits.

The Working Alliance Inventory (WAI) is another example of a self-report instrument used by Rosenberger and Hayes (2002) and Spinhoven et al. (2007). This instrument assesses the quality of the relationship between the therapist and client. It contains 36 items, composed of three 12-item subscales, which measure across three domains: Task, Goal, Bond. (Horvath & Greenberg, 1989; Horvath, 2000). The WAI is a commonly used and extensively validated measure of the therapeutic alliance. In the study by Spinhoven et al. (2007) client participants completed the WAI-P, measuring the contribution of the therapist to the alliance, from the client's perspective. Therapist participants completed WAI-T, rating the contribution of the client to the alliance. The WAI was normed on two samples: 1) 231 adult clients and their therapists in ongoing therapy 2) 235 adult clients from several outpatient facilities (Hatcher et al.,

2006; See Table 2). The samples demonstrated adequate person and measure reliabilities (S1=.92; S2=.88; Hatcher et al., 2006). This instrument demonstrated excellent internal consistency of the WAI-P (.94) and WAI-T (.95), and good construct and convergent validity (r = .76; Kokotovic & Tracey, 1990; Rosenberger & Hayes, 2002; Spinhoven et al., 2007; See Table 2). The WAI also moderately predicts therapy outcomes (r = 0.24; Martin et al., 2000; Horvath, 1989; Busseri & Tyler, 2003). Using data from this instrument, researchers were able to determine the quality of the therapeutic relationship in terms of working towards mutually agreed upon goals, agreement on treatment plan, feelings of mutual respect, and acceptance and understanding. This allowed them to make inferences about how the diagnosis of BPD influences the therapeutic relationship from both the therapists' and the clients' perspectives.

These instruments are a convenient, quick and inexpensive way to collect large amounts of information in a short time. While strengths are evident especially when collecting data from large samples such as in the studies by Colli et al. (2014), Fatter and Hayes (2013), Lingiardi et al. (2015), Spinhoven et al. (2007), and Westerling et al. (2019) there are limitations to consider as well. Some challenges in collecting data this way are low response rates, incomplete data and attrition, especially with electronic self-report measures. The use of questionnaires and checklists may be a convenient approach; however, convenience may not outweigh accuracy or completeness of the data collected. Self-report questionnaires are inherently more limited by various biases, such as participants' demand characteristics and limited insight, and social desirability bias (Neuman & Robson, 2009). Client participants could complete questions based on what they think researchers want or according to social expectations and norms. Additionally, the researchers cannot know if the instructions or questions are properly understood by the respondents, which may limit reliability. Therapist participants who provided self-report data at

multiple times throughout the study via multiple instruments (Lingiardi et al., 2015; Spinhoven et al., 2007; Westerling et al., 2019) may also be at higher risk of providing incomplete or biased data. The Young Schema Questionnaire (YSQ) is an example of a self-report questionnaire which requires a therapist to complete a 205-item scale to measure 16 core beliefs or early maladaptive schemas about each client they were working with. This was one tool among 4 in the study by Spinhoven et al. (2007). The length of some of these questionnaires, in combination with the frequency at which they are required in some studies, could potentially make these instruments more inconvenient and time consuming, potentially compromising the reliability of the data collected.

Overall, self-report data collection instruments can quickly yield reliable data about specific elements of a research topic, such as the diagnosis of BPD and therapists CTr. This data among the 9 quantitative studies contributed to a more thorough understanding of how BPD might impact therapist CTr in the therapeutic relationship. Researchers were able to make inferences from this data about factors that influence the therapeutic relationship with clients diagnosed with BPD and generalize to other clinical contexts or populations.

Qualitative Methods of Data Collection

Qualitative studies are interested in collecting non-numerical data to gain a descriptive, in-depth and rich understanding about experiences such as the therapeutic relationship. One type of data collection method is semi-structured interviews which is conducive to this investigation due to the interactive nature of therapeutic relationships and being more oriented towards the process of change and the development of relationships. Qualitative data collection methods can inform researchers about various experiences of CTr which ultimately can be useful in better understanding which factors influence the therapeutic relationship with clients diagnosed with

BPD. There are some limitations with the qualitative study method to consider in this investigation in terms of data collection. These include lapsed time between work with clients and interviews, having the different researchers conducting interviews, and not using video recordings to collect interview data. These issues can impact the level of trustworthiness, dependability, credibility, and rigor of the study by which the qualitative approach is evaluated.

Putrino et al. (2019) used a qualitative approach and conducted retrospective semi-structured interviews to investigate therapists' CTr experiences. The semi-structured interview is an open-ended instrument commonly used in qualitative studies. It collects more nuanced and personal data from participants by asking a set of open-ended questions according to a guide, with some variation in the order and format of questions (Kirby et al., 2006). There is room for the researcher to make adjustments as the interview is in progress, especially when they are very familiar with the topic and questions (Kirby et al., 2006).

A team of researchers in the study by Putrino et al. (2019) interviewed 43 psychotherapists who worked with clients diagnosed with either BPD or Major Depressive Disorder (MDD) within the past year. Researchers wanted to know about therapists' emotional and physical reactions when they were working with these clients. They asked the therapists to describe their feelings and bodily sensations in order to gain an in-depth understanding about therapists' perceptions and CTr about clients diagnosed with BPD and determine whether their reactions differed between the diagnoses. Collecting data directly from the participant via verbal communication adds rigor, dependability and credibility by removing the added element of a structured instrument such as a questionnaire. These nuances are difficult to gather with self-report instruments. Semi-structured interviews allowed therapists the time to more closely reflect upon and describe the various CTr reactions in relation to the diagnosis of their clients. This

method allows participants to describe and explain CTr in their own words and draw further attention to certain elements of the relationship with client diagnosed with BPD. Data from experienced therapist participants can especially more thoroughly inform the research question and give researchers more data about the therapeutic relationship in relation to BPD which they may not have had initially considered. An example of such insights might be that therapists could provide researchers with specifics about their CTr and label specific CTr sensations and physical reactions which would increase dependability in systematic collection and coding of CTr data. Experienced therapists could also make informed guesses or connections between certain client or treatment factors, and their own perceptions about BPD as compared with other diagnosis, while they directly discuss the therapeutic relationship with researchers in real time. This adds value to the study by taking the time to gather data in a way that gives researchers a level of structure, yet allowing participants to delve deeper into the topic to provide a more thorough understanding of CTr with this specific group of clients. This can also increase trustworthiness of the data because the therapists also analyze and report on the data they had themselves collected. They are a part of the entire process, fully immersed and familiar with the data, participants and the topic.

There are several limitations to qualitative data collection methods, however, and they can impact the study's trustworthiness, dependability, credibility, and rigor. One issue in the study by Putrino et al. (2019) is that researchers did not specify the time lapse between therapy sessions and interviews, which could impact the trustworthiness and credibility of the data. This study reports a maximum of one year since the completion of therapy with a client, however, as more time passes, therapists' memories may become increasingly inaccurate and distorted. Data from a therapist who worked with a client diagnosed with BPD one month before the interview

may provide more credible information than a therapist who worked with a client a year ago. Therapists would be able to recall CTr in the therapeutic relationship more clearly and in more detail if the interactions are more recent. Therefore, if most of the interviews took place closer to a year prior to the interview, researchers would be unable to collect as much data and the level of trustworthiness and credibility in the data would decrease.

Another issue of conducting semi-structured interviews is about who conducts them. This study used a team of researchers to conduct the interviews with therapist participants. This may compromise the dependability of the data collected since different researchers collected data from participants. If different researchers conducted semi-structured interviews with the therapists, there may be differences in focus, language, comfort level or familiarity with the topic of BPD, and/or bias about this client group. Therefore, it improves the trustworthiness and dependability of the data collection method if the same researcher conducts the interviews, making the process more consistent and minimizing variation in the interview data between participants. This may also be an important factor if the interviews were taken over the span of several weeks or months because this might increase variability in the data if multiple researchers collected data from therapists over a longer period of time. This would further negatively impact the trustworthiness and dependability as well as credibility of the research.

Lastly, the way data is recorded from semi-structured interviews is an important consideration in qualitative studies. Conducting semi-structured interviews allows for researchers to record each unique response through audio and video recording and have a verbatim account to reference for thematic analysis. This increases the level of rigor, trustworthiness and dependability of the data in terms of how it was collected. Data which is recorded verbatim is much less likely to be altered, distorted, misinterpreted, or otherwise missed. It increases the

rigor of the study if researchers, the analysis team, and independent auditors used in this study have access to the same data recordings rather than relying on interview notes from the various researchers.

The interviews conducted in the Putrino et al. (2019) study were audio recorded and not video recorded, which could have some limitation. It may have been more beneficial to do video recordings of the interviews since the researchers were examining responses about physical sensations and bodily reactions. Video recordings may have added to the richness of the results in being able to see and record therapists' non-verbal responses to questions about their work with clients with BPD. This may have also increased the level of rigor, trustworthiness and credibility of the data by making non-verbal data visible and accounted for by the research team. Researchers could go back over the recordings multiple times to observe certain CTr reactions and responses more carefully, further improving the rigor of study. It would be interesting to observe through video whether therapists differed in posture, physical gestures signaling defensiveness or aggression, and facial reactions, etc., when recalling their work with clients with BPD, as opposed to talking about clients diagnosed with other psychopathologies. They may subsequently learn more about how CTr could present physically or appear in the therapeutic relationship to a client, or whether therapists demonstrated attempts at physically avoiding or diverting from certain topics or questions. Certain CTr reactions from therapists may be more notable for clients with BPD. They may be more sensitive to, or perceptive of, changes in the relationship or subtle attempts from others at disengagement from the relationship. This method of data collection may be important for investigating sensitive issues which invites more nuance and self-disclosure. Therefore, using audio or video recordings for researchers to refer to

can improve trustworthiness, credibility and dependability of the data, which could otherwise be difficult to collect.

While having audio and video recordings can increase the credibility and dependability of the data, there are additional considerations in using this technology in studies with human participants. Storing data electronically leaves an extra measure of data encryption and protection for researchers to consider. Additionally, using video recordings would be even more resource consuming and expensive. Participants may also not be as willing to provide consent for privacy and confidentiality reasons, which may potentially reduce the number of participants in an already small sample of therapists with experience providing psychotherapeutic treatment for BPD such as in the study by Putrino et al. (2019). Participants may also decide to withdraw their participation after completion of a video recording in which they shared information they did not expect to share, for instance. Which may further impact the credibility, dependability and rigor of the study.

Ultimately, the use of the semi-structured interview method in this qualitative study established that there was a difference in the perceptions and CTr experiences for therapists working with BPD clients versus clients diagnosed with MDD. With the use of audio transcribed interviews with experienced therapist participants, researchers and independent auditors, this study provided trustworthy, credible and dependable data. Accounting for some limitations due to small sample size, timing of interviews, data collected retrospectively by multiple researchers and several inherent biases in using semi-structured interviews such as confirmation, social desirability and defensiveness biases, the results based on this data could be transferred to other clinical setting.

Conclusion

The way data is collected directly informs what the researchers can know about their studies and the inferences they can make based on that data. In the studies under consideration, data was collected via 21 instruments using either the cross-sectional or longitudinal data collection methods. Data collection instruments used throughout these studies all had sufficient reliability and validity, making it easier for researchers to generalize their results. One qualitative study used a cross-sectional method and conducted semi-structured interviews which provided this investigation with trustworthy, credible and dependable data about CTr in the therapeutic relationship with clients diagnosed with BPD. Altogether, these data collection methods allowed researchers to make reliable inferences and interpretations about factors which influence the therapeutic relationship in the treatment of BPD.

Data Analysis

Data analysis is the method of sorting and making sense of, or interpreting, empirical evidence. The way in which data is analyzed is important to how we understand what influences the therapeutic relationship with clients diagnosed with BPD. In this section quantitative and qualitative data analysis will be evaluated separately and include a discussion of assumptions, strengths and limitations of the data analysis methods used across the 10 studies.

Nine of the studies were analyzed using only quantitative data analysis methods (Colli et al., 2014; Fatter and Hayes, 2013; Liebman & Burnette, 2013; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Rosenberger and Hayes, 2002; Rossberg et al., 2007; Spinhoven et al., 2007; Westerling et al., 2019). These studies used either correlational or quasi-experimental study designs. Researchers applied various data analysis techniques such as descriptive statistics and sequential and regression analysis to organize and make sense of the data provided by both

therapist and client participants about BPD, the therapeutic relationship, and CTr. In quantitative studies, the aim is to use rigorous data analysis methods in order to make reliable inferences about the data. Furthermore, how data is analyzed can also increase the validity of the results and help to decrease bias, which improves generalizability of the results.

Qualitative data analysis is inductive, exploratory and descriptive. This is a common method in studies analyzing psychotherapeutic practice It helps us to understand complex phenomena more deeply, such as the therapeutic relationship. It is a method which allows for more subjectivity in the analytical method in order to gain a comprehensive and nuanced understanding of the research topic, which may not be practical to do in large quantitative studies. The one qualitative study in this review by Putrino et al. (2019) used a modified consensual qualitative research approach (CQR-M) to analyze their interview data through a thematic analysis. Considering influential factors in the therapeutic relationship with clients who have BPD through a qualitative approach added depth to the investigation. Additionally, the use of triangulation and independent auditors during their thematic analysis enhanced the rigor of qualitative data analysis and helped increase trustworthiness and dependability of results. The aim in qualitative studies is transferability of results, so other researchers and clinicians could transfer what was learned and apply it to their psychotherapeutic treatment of BPD.

Quantitative Data Analysis

Data in all nine quantitative studies was analyzed numerically, specifically using SPSS 20 software. SPSS and other statistical analysis software require that researchers display data in variables, attributes, and numerical representations of responses from participants (Kirby et al., 2006). From this data, researchers can make inferences about what the data means, a process referred to as inferential statistics. Inferential statistics formally test hypothesis and permit

inferences to be made from a sample about a population, and test whether results are more likely due to random factors or to a real relationship between variables (Neuman and Robson, 2009). In other words, researchers use descriptive statistics to hypothesize that certain variables covary, or are associated, and are not independent of each other (Neuman and Robson, 2009). Higher levels of significance between two or more variables leads to results that can be relied on with a higher degree of confidence. The level of statistical significance among the analyzed data variables such as the severity of BPD symptoms and CTr will either support the research hypothesis, or not. Inferential statistics use a variety of regression analyses which are discussed throughout the section. These included bivariate regression (Colli et al., 2014; Lingiardi et al., 2015; Rossberg et al., 2007), standard multiple regression (Fatter & Hayes, 2013), logical and multivariate regression (Liebman & Burnette, 2013), hierarchical multiple regression (Lingiardi et al., 2015; Nissen-Lie et al., 2020; Spinhoven et al., 2007; Westerling et al., 2019), and sequential analysis (Rosenberger & Hayes, 2002). For instance, Rossberg et al. (2007) used bivariate regression analysis to examine if therapists CTr varied more with different PD diagnoses.

Assumptions

There are several assumptions underlying inferential statistical analysis. One of which is equality or homogeneity of variance across the data. This assumes that the variance is equal across data samples or that samples are normally distributed among the population. In the case of a significant difference found within a group of clients with BPD in terms of severity of diagnosis for instance, this would impact the validity of the results making it difficult for the researchers to generalize their findings. An example of how researchers tested for this assumption was done in the study by Westerling et al. (2019). They conducted a correlational analysis for skewed variable analysis, testing for equality of variance across their data. If

variance was found, this would impact the studies' internal validity and limit the researcher's ability to draw inferences about the results.

There is also the issue of variability within the data that one individual participant provides throughout the study. This is the assumption that data is independent of variability within the data samples over time. Nissen-Lie et al. (2020), for instance, studied within-person effects of therapist CTr by using person-mean centering. They wanted to establish within-person effects and whether therapists' CTr reactions were differently predicted by patient variables over the course of the study. Changes to a data sample may take place over time; however, if the within-person effect is not measured, then these changes may be minimally attributed to variables, if at all. For example, data about CTr reactions of inadequacy may change for a therapist participant due to the development of the therapeutic relationship over months and/or years. However, if this effect is not measured, CTr might appear to be related to other variables, such as severity of BPD symptoms or type of intervention used. Establishing whether this effect is taking place within the data further improves internal validity.

Another common assumption is independence in observations about the data. Researchers can miss correlations or confounding variables, assuming observations in the data are independent of one another when they may actually be connected. The variables analyzed among these studies include: Tr and CTr, PD and BPD diagnosis, client age and gender, clinician's years of experience, and therapy modalities used. Data sets in seven of the studies were analyzed separately for client and therapist participants to determine if correlations exist between them (Colli et al., 2014; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Rosenberger & Hayes, 2002; Rossberg et al., 2007; Spinhoven et al., 2007; Westerling et al., 2019). In other words, if two variables are actually independent, cases with certain values on one variable do not

have value on other variables. For instance, clients' BPD diagnosis and therapists' years of experience may be independent variables, where no correlation is found. Researchers need to be cautious of assuming independence between variables; however, as they may miss associations in the data that could be relevant for their results. In the case of some studies, if responses between two groups of participants do influence each other, such as in the case of CTr and the severity of BPD symptoms, a researcher can account for this covariation in their data analysis through multivariate statistical analysis.

Control Variables

Controlling for alternative explanations to a hypothesis in non-experimental quantitative studies is done by measuring for these alternatives with control variables. Multivariate statistical analysis introduces a third variable to test bivariate relationships between variables to see whether they remain statistically significant or become spurious (Neuman & Robson, 2009). Furthermore, this type of analysis is used when researchers want to test their hypothesis to see whether results from a sample hold true for a population and then decide whether any differences are substantial enough to indicate if a real relationship exists (Neuman & Robson, 2009). They are cautious when interpreting bivariate relationships until control variables have been applied (Neuman & Robson, 2009). For example, Rosenberger and Hayes (2002), used sequential analyses to examine the relationship between clients' material related to the therapist's unresolved conflicts, and therapist avoidance. Descriptive statistics were then used to characterize other relationships among the variables of interest. What researchers are concerned about is the internal validity of their studies. Validity answers whether the analysis of the data accurately accounts for the social phenomenon it refers to (Kirby et al., 2006). It is the ability to eliminate alternative explanations of the dependent variable and rule out variables other than the

treatment by controlling conditions of the study and establish salience (Kirby et al., 2006; Robson and Neuman, 2009). Internal validity was established in the study by Rosenberger and Hayes (2002) through triangulation of analysis between raters. This was done to minimize the effects of bias such as experimenter expectancy where researchers can hold onto a hypothesis thus indirectly communicating desired findings to participants (Neuman & Robson, 2009).

Validity

Independent raters and data coders were used in two of the quantitative studies (Rosenberger & Hayes, 2002; Spinhoven et al., 2007). Raters are used by the researchers in the process of data analysis to help establish a level of rigor. The therapist and researcher in the study by Rosenberger and Hayes (2002) were aware of and involved in all aspects of the study and could not therefore analyze these therapeutic sessions with the same level of objectivity as the independent raters could. Therefore, they used two teams of three raters. Similarly, in the study by Spinhoven et al. (2007), researchers randomly selected audio tapes of therapy sessions and had one rater listen to one randomly selected tape of each patient. Twenty-one contract phases in the transference focused group were rated on the Contract Rating Scale. None of the raters in either study were informed of the purpose of the research until the study was completed, all raters were debriefed following their participation in the rating procedures and all were compensated for their time (Spinhoven et al., 2007).

The use of independent raters and coders can strengthen the internal and external validity or generalizability of results, especially in studies where there is regular and close interaction between study participants and researchers. Generalizability is the extent to which results can be applied to other settings and populations. Moreover, studies can improve generalizability when the research outcome or theory is also supported by other research (Kirby et al., 2006). Overall,

data analysis methods in these studies allowed researchers to make conclusions about factors which influence the therapeutic relationship which could be generalized to psychotherapeutic work with clients diagnosed with PD, including BPD, in various clinical settings.

Data analysis in Correlational Studies

Six studies, (Colli et al., 2014; Fatter & Hayes, 2013; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Rosenberger & Hayes, 2002; Westerling et al., 2019) used a correlational design for their studies. Correlational studies measure and analyze the relationships between variables in the data to test hypothesis. For instance, the relationship between severity of BPD symptoms and CTr, as explored in the study by Colli et al. (2014). Correlation does not mean causality, however. Researchers conducting correlational studies depend on the statistical measures that indicate the amount of association, or significance of a correlation, between two or more variables. Descriptive statistics are a method used to measure these correlations and describe numerical data, categorizing them by the number of variables involved: univariate, bivariate, or multivariate (Neuman & Robson, 2009). Bivariate statistics, for instance, let the researcher consider two variables together and describe their relationship. Colli et al. (2014) investigated their hypotheses using bivariate correlations. They wanted to know whether specific personality disorders evoked distinct CTr responses in therapists. This analysis found that there is a relationship between BPD and therapists' CTr emotional responses. Which direction that relationship goes (positive or negative) is also a matter of how data is analyzed and therefore what can be inferred from the data.

Multivariate statistical analysis allows researchers to consider three or more (multiple) variables and describe significant relationships between them. Lingiardi et al. (2015) first used bivariate statistical analysis to investigate the relationship between patients' symptom severity

and clinicians' emotional responses. Afterwards, multivariate statistical analysis were used to verify if this relationship was accounted for by several therapists' variables (i.e. theoretical orientation, gender, age, profession, and experience; Lingiardi et al., 2015). Furthermore, a series of hierarchical (block) multiple regression analyses were done as well, which is another statistical method of exploring the relationship between a dependent variable and several independent variables. This type of analysis allows for variables to be measured in stages and tells the researchers whether change occurred from baseline data. In the case of this investigation, it can point to specific variables which may significantly influence changes for clients with BPD undergoing psychotherapeutic treatment. Westerling et al. (2019) analyzed patterns of the relationship between CTr and attachment in therapist-client dyads using hierarchical regression analysis. This analysis showed changes to CTr over time as the therapeutic relationship with clients developed.

Results inferred and based on correlational data, even though not casual, can indicate significant relationships between variables as well as the strength of these associations. Since there is more control in studies which use quantitative data analysis through the use of control variable, there is less variability in the data, thus increasing reliability of the studies.

Data analysis in Quasi – Experimental Studies

Three studies used the quasi-experimental study design (Nissen-Lie et al., 2020; Rossberg et al., 2007; Spinhoven et al., 2007). The quasi-experimental design makes identifying a causal relationship more certain than do correlational designs for instance (Neuman and Robson, 2009). In quasi-experimental designs, data analysis usually requires less control over independent variables then would otherwise be required in classic experimental designs. Yet, it still helps researchers test for casual relationships in settings where the classical design is

difficult or inappropriate (Robson & Neuman, 2009). Such is the case when studying highly vulnerable groups of people undergoing psychotherapeutic treatment for BPD. It would not be appropriate, for instance, to study client diagnosed with BPD in experimental conditions where the researchers manipulate factors within the therapeutic relationship, potentially compromising the wellbeing of the participants in order to test their hypothesis. However, researchers can still analyze their data with more rigor by using various techniques in their study design, such as random allocation to treatment conditions. They can show a strong association between the dependent variable and independent variables, without having to subject their data to the same level of rigor or control in their analysis (Neuman & Robson, 2009) in order to demonstrate causality as they would in classical experiments.

Spinhoven et al. (2007) used a quasi-experimental method to examine the therapeutic relationship between two intervention groups for clients with BPD, schema-focused therapy (SFT) and transference-focused therapy (TFP). The researchers "hypothesized that the quality of the therapeutic relationship would be rated higher in SFT than in TFP." (Spinhoven et al., 2007, p. 112) Additionally, these researchers also hypothesized that a dissimilarity in pathological personality characteristics or "personality organization between therapists and patients over the first year of intervention would facilitate the development of therapeutic relationship and affect therapy outcomes." (Spinhoven et al., 2007, p. 112) They did a two-group post-test only study design and randomly assigned client participants into the two groups which reduced the chance that the groups differed before the treatment (Spinhoven et al., 2007). Without a pretest, however, the researchers cannot be as certain that the groups started the same on dependent variables (Neuman and Robson, 2009) making this study quasi-experimental. "Differences in the quality and development of the therapeutic alliance was analyzed with a 2 (group) X 3 (time)

mixed factorial design to determine whether early to mid-treatment changes predicted mid to late treatment changes in outcome." (Spinhoven et al., 2007, p.108)

Multiple regression analysis is used in quasi-experimental studies to determine how well a set of variables explains a dependent variable and also measure the direction and effects of each variable on the dependent variable (Neuman & Robson, 2009). It is especially important for testing theories that state that multiple independent variables cause one dependent variable (Neuman & Robson, 2009) such as in this study by Spinhoven et al. (2007) which measures 2 independent variables, SFT or TFP, with 3 categories each, early, mid or late treatment. Spinhoven et al. (2007) assessed BPD as a baseline and then every 3 months for 3 years. The measurements for the quality of the therapeutic alliance were collected only after 3 months (i.e., early treatment), after 15 months (i.e., mid treatment), and after 33 months (i.e., late treatment). In longitudinal data analysis when a correlation between early process changes and later outcome changes was statistically significant, hierarchical regression analyses can be performed to test whether early process changes still predicted later outcome changes after controlling for autocorrelations and synchronous correlations (Spinhoven et al., 2007, p.108). Differences between SFT and TFP groups remained statistically significant (Spinhoven et al., 2007). According to the multiple regression data analysis used in this study, BPD symptoms reduced as the therapeutic relationship developed over the first year of treatment (Spinhoven et al., 2007). From this study, inferences can therefore be made about how the modality and length of treatment may influence the development of the therapeutic relationship with BPD clients over time. These results can also be generalized to other clinical settings as a result.

Qualitative Data Analysis

The purpose of data analysis in qualitative studies is to gain a deep understanding of a topic like how a diagnosis of BPD impacts CTr in psychotherapy, such as in the study by Putrino et al. (2019). In order to understand CTr in depth, researchers in this study transcribed interviews verbatim for their team and the auditors. They used a modified consensual qualitative research (CQR) approach to systematically code and thematically analyze 43 transcribed interviews. The participants' responses were first ordered by thematic areas or domains. The primary team then identified the domains and core ideas through open discussion (Putrino et al., 2019). This was done with an auditor who reviewed the team's work and provided feedback to ensure balance and organization of the core ideas and themes among all team members (Putrino et al., 2019). This added a level of rigor through consensus and coherence via the process of triangulation, creating more credibility and dependability in the results. In qualitative studies, triangulation is an important method in establishing trustworthiness and dependability and assumes that if you get similar outcomes by using different methodological approaches, then both the data and research outcomes are dependable (Kirby et al., 2006). In qualitative research, generalizability is not the goal (Kirby et al., 2006). Knowing who is completing the data analysis and how it is being analyzed provides a level of transparency in qualitative research and therefore transferable to working with clients diagnosed with BPD.

There are limitations to using qualitative analysis methods, however. Data analysis of open-ended interviews which may deviate in unexpected or unanticipated ways from the interview questions is time and resource consuming. Moreover, there are inherent limits to semi-structured interviews such as defensive bias or not recognizing information or processes that an outside observer might otherwise identify. Confirmation bias and social desirability bias may

also be an issue with therapists' responses in semi-structured interview data. The use of auditors in combination with the systematic CQR data analysis approach were ways to mitigate the risks of these biases.

Another limitation in the study by Putrino et al. (2019) is that the researchers analyzed retrospective interview data. The more time that passes after therapeutic work with clients, the more distorted the accounts of this relationship could become. There are risks of a therapist confusing one client for another, as well as over or understating qualities about past clients, further distorting the data. Analyzing retrospective data can negatively impact the trustworthiness and dependability of results, therefore, researchers need to account for this risk. Putrino et al. (2019) analyzed interview data of therapists' work that was no older than a year.

The data analysis approach of the Putrino et al. (2019) study showed that there is nuance to CTr when working with clients with BPD which may go unrecognized using quantitative approaches alone. The depth of analysis revealed that CTr is not only a psychological and emotional phenomenon but also experienced physically. The CQR method of data analysis about CTr reactions in the therapeutic relationship with clients diagnosed with BPD, uniquely informed the investigation through triangulation and independent auditors.

Conclusion

Several data analysis methods were used between the quantitative and qualitative studies. Six of the quantitative studies used correlational data analysis techniques and three used a quasi-experimental approach in measuring quantitative data. Relationships among different variables across 9 quantitative studies were evaluated using descriptive statistics. Data analysis in these studies mainly focused on associations between the diagnosis and severity of BPD and Tr/CTr in the therapeutic relationship. Data analysis methods established reliability and validity in the

studies which allowed researchers to confidently make inferences about the data and generalize to other clinical contexts. Validity, reliability and generalizability are evaluated using different standards in quantitative and qualitative studies. In data analysis, how well a study generalizes to the population is more a concern in quantitative studies; whereas, dependability and transferability of results is the goal in qualitative studies. With most of the data analysis being quantitative, reliability and generalizability were emphasized. The qualitative study added an in-depth analysis of CTr with BPD specifically, further supplementing and complementing the quantitative data analysis. Overall, the data analysis throughout these studies established that there were various factors, which influenced the Tr/CTr dynamics of the therapeutic relationship with clients diagnosed with BPD.

Research Findings

The purpose of this study is to identify and better understand factors, which influence the Tr/CTr dynamics of the therapeutic relationship with clients diagnosed with BPD. In this, section, I will discuss the findings of the study after synthesizing the results of 10 research studies. I used content analysis as my method to analyze these studies. Content analysis is a technique for examining multiple sources of research, such as articles, revealing themes that may be difficult to see; researchers can then compare the content across many articles and analyze themes in the context of their own research questions (Neuman, & Robson, 2009). I used a summary table to organize the methods and results of each study and make the information more visually accessible for analysis and synthesis into patterns and meaningful themes.

Therapist, client and treatment factors emerged as important themes across the studies. Therapist factors included heightened CTr and self-reflection, which influenced the way therapists established and maintained the therapeutic relationship with clients diagnosed with

BPD. Client factors included severity of BPD symptoms, level of motivation and engagement in psychotherapy, and personality dissimilarity with the therapist. These factors influenced CTr and the Tr/CTr dynamics between the client and the therapist. Therapist and client factors were primarily studied in terms of internal qualities. These are factors intrinsic to the client or therapists' personality and internal relational processes. Treatment factors, on the other hand, were external to the individual personalities or qualities of the client and therapist. These included level of training and length of treatment, which were important for maintaining the therapeutic relationship with clients diagnosed with BPD and in terms of treatment outcomes.

Therapist Factors

Therapist CTr was examined in all of the studies. Six of these studies, however, looked at CTr specifically with clients who were diagnosed with PD's or BPD (Colli et al., 2014; Nissen-Lie et al., 2020; Lingiardi et al., 2015; Putrino et al., 2019; Rosenberger & Hayes, 2002; Spinhoven et al., 2007; Westerling et al., 2019). These studies looked at CTr as an emotional, psychological and physical phenomenon experienced by the therapist during psychotherapy with clients diagnosed with BPD. The therapists' level of self-awareness and self-reflection about CTr was an important factor in terms maintaining the therapeutic relationship. Since results from these studies pointed to CTr that was predictable and consistently experienced with clients undergoing treatment for BPD, therapists who were more aware and self-reflective of CTr with these clients were less avoidant and better equipped at managing CTr in the therapeutic relationship.

Heightened CTr

Heightened CTr refers to an increase in the intensity and frequency of CTr reactions. Heightened CTr could be both negative or positive when working with clients with BPD.

Therapists' heightened CTr, particularly negative CTr, was found to negatively influence the therapeutic relationship. Negative thoughts, attitudes, assumptions, and emotions towards clients with BPD were common CTr for therapists throughout the studies. Various CTr reactions were identified, these included: helpless, inadequate, overwhelmed, special, overinvolved, contradictory, confused, distrustful, disorganized, avoidant and/or inconsistent CTr patterns (Colli et al., 2014; Liebman & Burnette, 2013; Lingiardi et al., 2015; Nissen-Lie et al., 2020). Therapists in the study by Liebman and Burnette (2013), for instance, measured therapists' attitudes towards clients diagnosed with BPD. They felt that clients with BPD were distrustful and dangerous to Self and others yet also likeable at the same time and disagreed that client with BPD were simply displaying a behavior problem or would never get better. Furthermore, heightened and negative CTr adversely influenced the therapist and how they worked with their clients with BPD. Putrino et al. (2019) reported that 68% of therapists "expressed having an emotional charge with a negative impact" when working with a client with BPD (p. 916). According to Lingiardi et al. (2015) and Spinhoven et al. (2007) therapists' predominantly negative CTr towards clients with BPD can be problematic in terms of perpetuating old relational dynamics within the Tr/CTr dynamics, like resentment and anger, eventually interfering with establishing a more positive and constructive therapeutic relationship.

It was also common for therapists to experience heightened CTr in the form of bodily reactions when working with clients with BPD. Putrino et al. (2019) found that "psychotherapists perceived different bodily reactions during the treatment of different psychopathologies" (p. 916). Specifically, they found that therapists experienced heightened CTr with clients diagnosed with BPD more frequently then with clients with other disorders, such as depression. In the treatment of BPD, therapists reported increased drowsiness (27.5%), exhaustion (27.5%),

muscular tension (25%), increased heart rate (11.6%) and headache or stomach-ache (10%). Therapists' physical CTr, is an influential factor in the therapeutic relationship with BPD clients because this can in turn heighten the level of emotional and psychological CTr, and overall stress experienced in therapeutic interactions.

The study by Rossberg et al. (2007) found that CTr was not always subjectively negative. Improvement of BPD symptoms correlated negatively with CTr feelings of rejection, boredom, guardedness, overwhelm, and inadequacy among therapists, and correlated positively with CTr feelings of importance and confidence for therapists (Rossberg et al., 2007). A heightening of CTr in general may be because psychotherapists become more attuned to clients heightened psychological, emotional and physical states, or level of dysregulation, and therefore experience similar affect to that exhibited by the client (Putrino et al., 2019). As such, an increase in attunement to clients' Tr, therefore, may increase awareness of CTr, which may in turn increase positive CTr through the acknowledgement and expression of heightened CTr.

Level of Awareness and Self-Reflection

Therapists' level of awareness and self-reflection about how CTr influences the therapeutic relationship with clients diagnosed with BPD. Fatter and Hayes (2013), Liebman and Burnette, (2013), and Putrino et al. (2019) studied therapists' CTr by asking them to retrospect, recall and reflect upon CTr through the use of vignettes, interviews and self-report surveys about clients with BPD. Awareness and reflection in the context of this study refers to a therapists' capacity to differentiate, be mindful of, and have insight about their thoughts, emotions, and bodily reactions while engaged in the therapeutic alliance with clients with BDP. Clients with BPD symptoms can evoke more intense CTr, therefore the dynamic can demand a certain level of awareness and self-reflection from the therapist.

When a therapist avoided talking about certain issues with clients, and did not address CTr, the therapist perceived herself to be less of an expert, and less capable, competent and attractive (Rosenberger & Hayes, 2002). Therapists' who avoided or resisted addressing CTr could further heighten CTr, and heighten Tr for the client, making it more likely for the client to discuss material related to the therapist's unresolved conflicts (Rosenberger & Hayes, 2002). Westerling et al. (2019) found that decreases in a clients' avoidance was related to decreases in avoidance among therapists as well. Therefore, less avoidance or resistance of CTr and more awareness and acknowledgement of it, influenced the therapeutic relationship by decreasing the impact of negative CTr and better managing Tr/CTr dynamics between the client and therapist. These findings suggest that regardless of CTr being conscious or not, the avoidance or resistance of such material could nonetheless heighten the Tr/CTr dynamics within the therapeutic relationship with clients with BPD. The intensity of the interactions may signal the therapist to become increasingly aware and self-reflective, and consequently urge the therapist to address the CTr in the therapeutic relationship.

Heightened CTr towards clients may allow therapists to become more aware of Tr/CTr dynamics, and engage in deeper self-reflection about CTr, thus influencing the therapeutic relationship towards more constructive and positive outcomes for their clients. Studies suggest that therapists' ability to remain present and mindful, and to reflect about CTr during BPD treatment, regardless of the intensity of CTr in the moment, may influence the therapeutic alliance positively. Therapists' personal characteristic of non-reactivity was predictive of improved anxiety management and qualities such as self-insight, self-integration, and empathy, which may have interpersonal benefits for the therapeutic relationship in terms of CTr management (Fatter & Hayes, 2013). Reflecting upon and 'metabolizing' therapists' (particularly

negative) CTr reactions is important because it helps to manage clients' Tr (Rossberg et al., 2007). This means that the therapist takes on clients' Tr by reacting to CTr in an unconscious way. The more aware the therapist becomes of CTr, the more the client's material can be processed or worked through more constructively, thus 'metabolized' with the therapist in the therapeutic relationship. The more therapists engaged in self-reflection, the more they were "able to preserve a neutral part of their mind that was able to accurately monitor and analyze CTr provoked by…projective identification." (Spinhoven et al., 2007, p. 113) Therefore, therapists were more able to stay present with the client in the here-and-now of the therapeutic relationship (Spinhoven et al., 2007). In this way, therapists' CTr can be used as an important clinical tool in the psychotherapeutic relationship with BPD clients (Rossberg et al., 2007).

Client Factors

Clients with BPD tend to experience more volatility and hostility in their relationships. This instability in personal relationships gets transferred into the therapeutic relationship as Tr and enacted through the Tr/CTr dynamic between the therapist and client. Heightening the experiential intensity of the Tr/CTr dynamic may be an unconscious attempt from the client to re-enact and engage the therapist in a familiar relationship. For this reason, treatment can be difficult because establishing a therapeutic relationship can be destabilizing for both therapist and client. Therefore, the more intense and severe the symptoms of BPD, the more heightened the CTr becomes, which in turn negatively influence the therapeutic relationship. The level to which a client is motivated to participate in psychotherapy and to which the therapist engages with the client with BPD were important factors in decreasing negative CTr and maintaining the therapeutic relationship. Furthermore, the level of engagement in the alliance is influenced by the clients and therapists' perception about the therapeutic relationship. The level of dissimilarity in

personality structures between a therapist and client with BPD impacted the therapist and the client differently in terms of their perceptions about the therapeutic relationship.

Severity of BPD Symptoms

The severity of BPD symptoms was a client factor which influenced the therapeutic relationship by heightening negative CTr. Therapist's reported intense emotional reactions such as being on guard, rejection, apprehension, dread, anxiety, inadequacy and difficulties experiencing positive and nurturing feelings towards clients distressed by severe symptomatology, regardless of therapeutic approaches used (Lingiardi et al., 2015; Niessen-Lie et al., 2020; Rossberg et al., 2007). According to several of the studies, the BPD diagnosis specifically, symptom severity and lower levels of psychological functioning, elicited more negative CTr (Colli et al., 2014; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Westerling et al., 2019). Consequently, this heightening of negative CTr provoked several problems to managing the clinical relationship, triggering therapists to feel like they are not doing enough for their clients and experiencing more feelings of frustration, urgency and stress during therapeutic interactions (Lingiardi et al., 2015). In other words, these patterns of CTr are mostly elicited by higher levels of patients' symptom severity, or the level of personality dysfunction, rather than by their personality structure (i.e. crisis; Lingiardi et al., 2013). This influences the Tr/CTr dynamic insofar as how CTr is managed in order to engage the client in more positive Tr towards a more constructive therapeutic relationship.

Level of Motivation and Engagement in Psychotherapy

Studies indicated that higher levels of engagement in therapy sessions from both clients and therapists, particularly at the beginning of treatment, indicated more positive Tr and CTr, such as motivation, and increased positive outcomes for clients with BPD. Rossberg et al. (2007)

noted that therapists' negative CTr was significantly different at the start of the treatment with patients who dropped out of treatment, compared with those who completed treatment. Negative CTr at early treatment was predictive of dropout, whereas positive Tr and CTr in the 1st half of treatment predicted subsequent symptom reduction and overall improvement (Rossberg et al., 2007). However, there was a strong positive relationship found between positive CTr and improvement, and a strong negative relationship between the negative CTr and improvement (Rossberg et al., 2007; Spinhoven et al., 2007). Perhaps because clients with BPD tend to engage in more volatile relational dynamics, they may perceive heightened Tr/CTr as an increase in engagement from the therapist in the therapeutic relationship. Niessen-Lie et al. (2020) found a significant interaction between client's motivation and feelings of disengagement; if the client felt less motivated to engage in therapy, then the therapist was more disengaged. Therefore, therapists who engaged in the Tr/CTr dynamics with their clients regardless of how intense, or whether it was positive or negative; treated their clients with BPD for longer periods of time. Which, in turn, influenced the development of the therapeutic alliance, and a more positive therapeutic relationship over time.

Personality Dissimilarity from Therapist

In the studies, divergence in the personality structures between a client with BPD and the therapist influenced both the client and therapist in the therapeutic relationship, but in different ways. This dissimilarity appeared to heighten CTr for therapists, yet did not negatively impact Tr for clients; thereby influencing clients to more positively perceive the therapist and the therapeutic relationship. For therapists, Lingiardi et al. (2015) attributed heightened CTr of over-involvement or sense of specialness in the treatment of BPD to issues of personality in the therapeutic alliance. In other words, the more severe the personality disorder, the more clients

engaged in the therapeutic relationship, and consequently the more heighted the CTr became. Spinhoven et al. (2007) indicated that a "higher degree of dissimilarity in personality organization between client and therapist was associated with the development of a better therapeutic alliance from the clients', but not the therapists', point of view." (p. 112) Therefore, the more dissimilar a clients' personality was from the therapists, the bigger the difference in perception about the therapeutic relationship between the client and the therapist. Personality dissimilarity was a factor which heightened positive Tr for clients with BPD and CTr for therapists, no matter positive or negative.

Treatment Factors

Two treatment factors were found to influence the therapeutic relationship with clients diagnosed with BPD. The majority of therapists in these studies who treated BPD, tended to have a higher level of education and training than therapists who did not have experience with this client population. Their level of training and experience with this disorder positively influenced how long clients tended to stay in or complete treatment for BPD.

Level of Training with BPD Clients

Higher levels of exposure, training and overall experience a therapist had working with clients with BPD indicated more positive CTr for therapists, regardless of the theoretical approach used. Studies by Fatter and Hayes (2013), Putrino et al. (2019), Rosenberger and Hayes (2002), and Westerling et al. (2019) included therapist participants with less than 3 years of experience in their studies. More specifically, Rosenberger and Hayes (2002), and Westerling et al. (2019) included supervised therapist participants working with clients who were not diagnosed with PD's or BPD. Therefore, the majority of therapists across most of the studies had a higher level of clinical training in psychotherapy and experience working with clients,

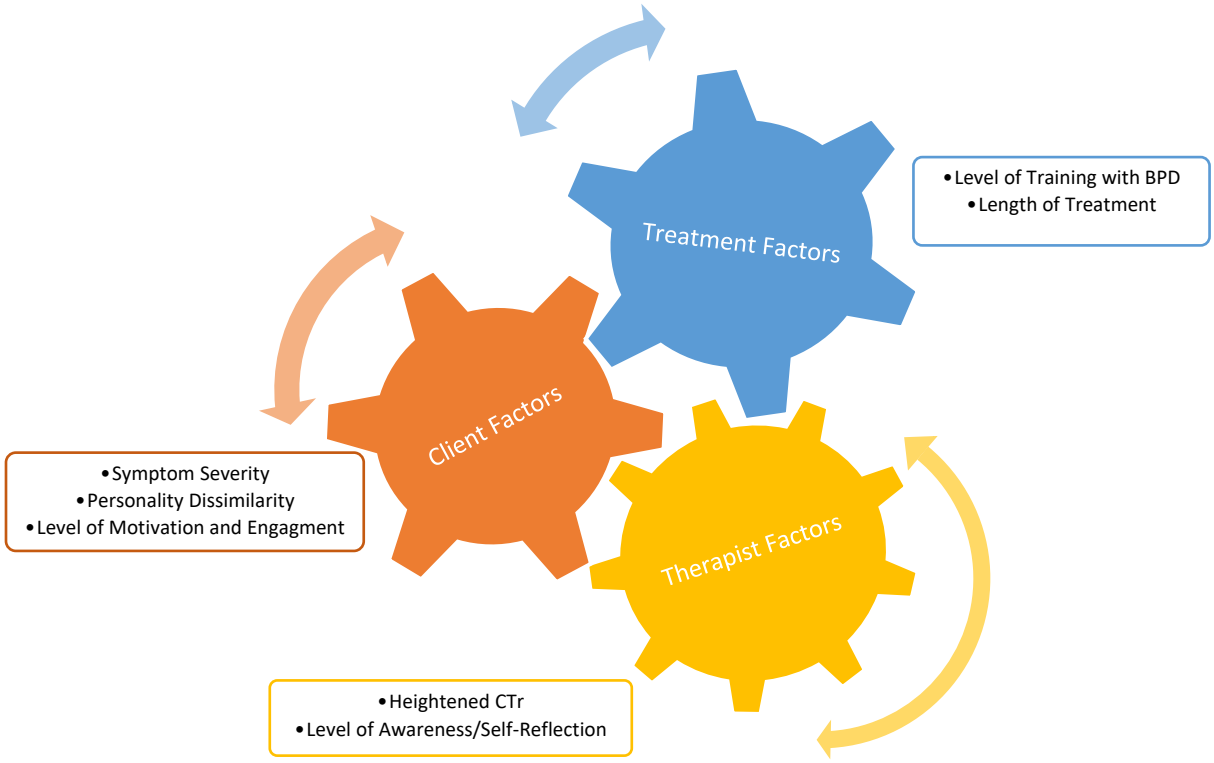
including those diagnosed with BPD. Liebman and Burnette (2013) found that therapists with special education and training for BPD rated clients with the disorder as less dangerous, felt that the condition was less chronic than those without such experience or training, and had more empathy and trust toward clients with BPD. Therapists with more direct exposure and training with clients with BPD were thus more familiar and comfortable with the BPD diagnosis. Therefore, these therapists had enhanced positive CTr of competence and improved reflexive functioning in the therapeutic relationship. This may improve the Tr/CTr dynamics and outcomes of the therapeutic relationship overall for clients undergoing treatment for BPD.

Length of Treatment

It may take longer to resolve heightened and particularly negative CTr working in the here-and-now dynamics with a client with BPD. Five longitudinal studies examined psychotherapeutic treatment lasting between 1-3 years (Colli et al., 2014; Lingiardi et al., 2015; Nissen-Lie et al., 2020; Spinhoven et al., 2007; Westerling et al., 2019) and established that the quality of the therapeutic relationship improves over time. These studies usually account for at least one year of treatment for BPD, and in many cases, clients attempt treatment several times. Therefore, longer-term psychotherapeutic treatment is conducive to establishing a more positive and constructive Tr/ CTr dynamics with clients diagnosed with BPD. Spinhoven et al. (2007) reported that "growth of the therapeutic alliance during the first year of therapy represented an important therapeutic mechanism by which a later reduction of BPD pathology was facilitated." (p. 112) As clients' anxiety in the relational dynamic decreased, therapists became increasingly aware of the emotional burden of working with clients with attachment disorders, like BPD, over extended periods (Westerling et al., 2019, p. 78). However, over time therapists also experienced a decrease in reactivity between early and late treatment phases, and less negative CTr such as

inadequacy, anxiety, and overinvolvement (Spinhoven et al., 2007; Westerling et al., 2019). The resolution of old relational patterns through the Tr/CTr dynamics of the therapeutic relationship, and experiencing more stable and constructive relationships in general, may take a longer-term approach, but is ultimately the goal for both clients and therapists when treating BPD.

Diagram 1: Therapist, Client and Treatment Factors which Influence the Therapeutic Relationship with BPD Clients



Conclusion

Results from the collective 10 studies were analyzed to find therapist, client and treatment factors which influenced the therapeutic relationship. Therapist factors included heightened CTr, and awareness and self-reflection. Client factors included severity of BPD symptoms, level of motivation and engagement in psychotherapy and level of personality dissimilarity between client and therapist. Treatment factors comprised of level of training with BPD and length of treatment for BPD. These factors influenced the therapeutic relationship by

facilitating the resolution of heightened Tr/CTr dynamics within the therapeutic relationship with clients diagnosed with BPD over the long term. Ultimately improving the Tr and CTr dynamic within the therapeutic relationship can reduce BPD symptom severity, increases levels of motivation and engagement with clients, and improves therapeutic outcomes.

Application to Clinical Practice

Several factors influence the therapeutic relationship with BPD clients, including therapist factors such as awareness of heightened CTr reactions, and self-reflection. Client factors included severity of BPD symptoms and follow through with treatment. Since the therapeutic relationship with BPD is unique, it requires clinical considerations beyond the typical psychotherapeutic interventions. Applications to clinical practice include CTr management and higher levels of professional experience, training and supervision for therapists in order to positively influence the therapeutic relationship, reduce symptom severity and increase treatment follow through with clients diagnosed with BPD.

CTr Management

Heightened, and particularly negative CTr about clients with BPD were found to be common for therapists. BPD was significantly related to inadequate, overwhelmed, and overinvolved CTr patterns (Colli et al., 2014; Lingiardi et al., 2015; Nissen-Lie et al., 2020). CTr can be further exacerbated by symptom severity, dropout rates, and lack of follow-through by clients. Therefore, it is important that therapists are able to effectively manage CTr.

Reflexive Practice

Fatter and Hayes (2013) found that self-reflective practices which facilitate self-awareness are significantly correlated to self-insight, self-integration, and CTr feelings of empathy. The ability for the therapist to maintain reflexivity is one way to manage heightened

CTr reactions during therapeutic sessions with clients who exhibit severe symptomology, and are at a higher risk for dropout. Reflexivity in the psychotherapeutic context refers to the therapists' ability to reflect upon and examine one's 'Self' (i.e. beliefs, judgments, biases and practices), how this may simultaneously impact clients, and the therapeutic relationship. In clinical practice with BPD clients, however, even if a therapist is aware and accepts the realities of Tr/CTr dynamics, (i.e. projections, defenses, and enactments), they can continue to impact the therapeutic relationship and treatment progress. Therefore, managing CTr through reflexivity is an important clinical application of this study.

Several clinical practices help define the Tr/CTr for the therapist to be mindful of. These include having a consistent observational and witnessing role, reflecting back, clarifying and simply accepting the client's experience of the therapist in the "here and now" with the therapist engaged and available in a stable therapeutic stance (Diamond & Meehan, 2013; Holmes, 2017; Kernberg, 2019). In psychodynamic psychotherapy, clients "carry out free association around the problems that brought them to treatment" (Ganzer, 2018, p. 19) identifying defenses and behavior patterns. The therapist needs to restrict their role to careful observation of the activation of Tr and CTr, helping to identify: "Who am I in the patient's object world…and who are they in mine?" (Ganzer, 2018, p. 19; Kernberg et al., 2008). The intensity of the CTr evoked by clients with severe character pathology requires an ongoing transparency, awareness and alertness to CTr developments that the therapist has to tolerate (Kernberg et al., 2008; Ngo-Smith, 2018). A reflexive practice demands this intensive work in the here-and-now interactions between a client and the therapist that is the vehicle for change (Diamond & Meehan, 2013, p. 1157). Therefore, the therapists' own self-regulatory needs are important to consider (Silverman, 2017; Westerling et al., 2019) because reflexivity about one's own affect in the Tr/CTr dynamic may provide

answers if the therapist can let him/herself be influenced by the total situation in which he is now engaged with the client (Kernberg et al., 2008).

According to Yalom (2005) it is impossible to work with the hardest to treat clients unless the therapist is able to recognize personal distortions and blind spots. Until their own CTr reactions are extremely well sorted-out and conscious, effective therapeutic work will be severely limited (Ngo-Smith, 2018; Yalom, 2005). CTr management requires therapists engage this mutual reflexive function within the therapeutic relationship. Otherwise, it can lead to the therapists' dysregulation, which inhibits creative listening, thinking and self-reflective functions (Westerling et al., 2019), further exacerbating negative Tr/CTr dynamics within the relationship. A therapy based on a true alliance between therapist and client reflects a greater respect for the capacities of the client and, with it, a greater reliance of self-awareness (Yalom, 2005, p. 560). The absence of integrity in relationships, which is acting in accordance with well-ingrained ethical values, is manifested in hypocrisy or insincerity at best, and betrayal or exploitation at worst. While it is easy to appreciate how vain, lustful, greedy, or angry motives can be damaging and harmful; dual relationships can also result from virtuous motives such as compassion and justice (Truscott & Crook, 2013). Reflexive practice is about consistent reflection upon the clients' Tr as well as reflecting on one's own CTr at the same time. As a result, with greater attunement and management on behalf of the therapist, highly vulnerable clients such as those with BPD, may subsequently experience improved therapeutic outcomes (Westerling et al., 2019).

Professional Experience with BPD

Most of the studies in this investigation included therapists with substantially more education and experience such as clinical psychologists or psychiatrists. Studies by Fatter and

Hayes (2013), Putrino et al. (2019), Rosenberger and Hayes (2002), and Westerling et al. (2019), included therapist participants with less than 3 years' experience working with clients. Though they were the minority among these therapist participants such as trainees or new therapists who were completing their education or training and required supervision. The complexity of treating BPD requires that therapists have higher levels of clinical experience with BPD clients in order to better understand the therapeutic challenges inherent in working with BPD clients, effectively manage CTr, and improve the therapeutic relationship with highly vulnerable clients.

Training in Psychodynamic Psychotherapy

Liebman and Burnette (2013) reported that therapists who had more special training and had treated more clients with BPD felt that the client's condition was less chronic and dangerous, and had more empathy towards clients with BPD as compared to those without such training. Clients with BPD may be particularly resistant to the resolution of loss and trauma, even with intensive interventions (Levy et al., 2006, p. 488). Understanding the clinical presentation and impact of trauma, as well as tolerating the feelings of being targeted and exposed by the client is experienced as a tension in the CTr (Ngo-Smith, 2018). Therefore, most of the therapist participants in these studies had a level of clinical training in psychotherapy and experience working with clients diagnosed with PD's. Higher levels of exposure and training a therapist had with PD's and BPD indicated more positive, and therefore better CTr management in the therapeutic relationship.

Psychodynamic approaches are well-suited to hold this intense affect and to provide deeper way of working in the context of the impossible binds (Ngo-Smith, 2018, p. 29; Yalom, 2005). Various trauma informed approaches are usually highly manualized and require years of extra training and supervision for clinicians, many of whom in the literature are psychiatrists or

clinicians with over 20 years' experience with clients with PD's. Psychoanalytic/psychodynamic interventions include Traditional Psychoanalysis (PA), Transference-Focused Psychotherapy (TFP), Supportive Psychodynamic Psychotherapy (SPP), and Long-Term Psychodynamic Psychotherapy (LTPP). Therapists delivering transference-focused psychotherapy (TFP), such as in the study by Spinhoven et al. (2007) had prior therapy experience in the associated therapeutic orientation and had clinical experience in treating clients with BPD (p. 107). According to Doering et al. (2010) therapists who practiced TFP were usually experienced clinical psychologists, most of whom were psychodynamic psychotherapists who had an average of 9.4 years of experience after completion of their psychoanalytic or psychodynamic training.

Inherent in working from the psychodynamic perspective is the therapist having the experience of doing this work personally before fully acquiring the capacity to reach the client at this level clinically. It is widely accepted in modern psychotherapy practice that ultimately "it is the therapist more than the model that produces benefits." (Yalom, 2005, p. 562) This further provides support developing more capacity in CTr management and reflexivity through specialized training in psychodynamic interventions with emphasis on the understanding, application and management of Tr/CTr dynamics in the therapeutic relationship.

Supervision & Consultation

As levels of education and training increase, supervision and consultation become a necessary and ongoing standard of practice for psychologists, which in turn supports the development of therapists' reflexivity and CTr management through professional relationships and support. Kernberg et al. (2008) found that ongoing supervision and "the mutual supervisory process of senior clinicians stimulated more junior colleagues to openly ask for help and be able to accept it." (p. 613) Furthermore, supervision and consultation when using psychodynamic

therapy can be useful for enhancing the therapists' confidence in the therapy format (Jones et al., 2020). Experiencing more positive CTr like confidence shifts relational dynamics with BPD clients towards more constructive Tr and CTr, thereby decreasing severity of BPD symptoms and increasing likelihood of follow through for BPD clients. Supervision and consultation set up a system of support for new therapists to seek help from more experienced and seasoned therapists.

As therapists gain more direct exposure and hands on experience with BPD clients, they become more familiar and comfortable, and develop positive CTr of competence and improved reflexive functioning in the therapeutic relationship. A therapist with more experience increases the comfort level that the client with BPD may experience in the interaction which might consequently disarm or placate certain defences as they play themselves out in the Tr/CTr matrix (Bateman & Fonagy, 2013). However, even therapists who have experience require more clinical experience with clients diagnosed with BPD specifically. The task for therapists through increased experience with BPD may partly be in reframing Tr/CTr behaviors as a way to help understand and guide education, training and interventions to treat relational trauma. This is an important clinical application which helps to ensure that therapists receive the required training and support in developing their capacity to effectively manage CTr and practice reflexively in the therapeutic relationship with clients diagnosed with BPD.

Conclusion

Through CTr management and increased professional experience, therapists can help BPD to decrease the severity of BPD symptoms, increase follow through with treatment, mitigate risks of heightened Tr/CTr reactions in the therapeutic relationship and improve treatment outcomes overall. In compliance with the Canadian Code of Ethics for psychologists

(CPA, 2017), psychologists have a duty to respect the dignity of clients, maintain safe and responsible caring, and ensure the integrity of the therapeutic relationship, regardless of the diagnosis. In order to stay in professional integrity, a psychologist is expected to participate in the here-and-now psychodynamics with their client, even when the Tr/CTr dynamics of the therapeutic relationship become difficult to manage.

Ethical Considerations

There are several ethical issues, due to an increased level of vulnerability through the mutual engagement of Tr/CTr dynamics of the therapeutic relationship, which are especially pertinent when conducting research and psychotherapy with clients diagnosed with BPD. Ethical standards directly impact research and psychotherapeutic practice with clients. Researchers and practitioners need to consider and maintain ethical principles and standards to respect, protect, and uphold integrity with their participants (Canadian Institutes of Health Research et al., [CIHR], 2018; Canadian Psychological Association, [CPA], 2017). However, since heightened CTr and intense dynamics characterize this alliance, this discussion focuses on the need to uphold practice standards and core ethical principles above and beyond those of typical psychotherapeutic practice. Clients undergoing treatment for BPD are at increased risk for experiencing more severe symptomology, such as emotional volatility, self-harm and suicidality, through the destabilizing effects of psychotherapy. Therapists who work with clients with BPD are also at a higher risk in terms of compromising ethical standards and principles when engaged in particularly challenging Tr and CTr enactments within the therapeutic relationship. Additionally, ethical issues are not just about the individual client or therapist, but also about protecting and maintaining the therapeutic relationship. The demands of psychotherapeutic work as well as participation in research studies requires an added level of ethical consideration for

clients with BPD and their therapists in terms of ensuring safety and integrity within the complex dynamics of the therapeutic alliance.

Ethical standards are based in three core principles in research involving human participants. These include justice, respect for persons, and concern for welfare (TRI-Council Policy Statement: Ethical Conduct for Research Involving Humans, [TCPS 2], 2018). Researchers need to uphold these ethical standards through their study design and how they conduct their research. For particularly vulnerable participants, such as those with BPD and their therapists, this involves the consideration and maintenance of ethical principles such as fair and equitable participation, including decisions making capacity for both client and therapist participants, as well as informed consent, privacy and confidentiality, and therapists' professional competency.

Justice for Vulnerable Persons

Justice is a core ethical principle and refers to the obligation to treat all people fairly and equitably, with equal respect and concern (TCPS 2, 2018, p. 8). One important difference that must be considered for fairness and equity is vulnerability, which is often caused by limited decision-making capacity (TCPS 2, 2018, p. 8). Individuals whose circumstances may make them vulnerable in the context of research and psychotherapy include those with mental health issues and those with diminished capacity for self-determination (TCPS 2, 2018). Clients with BPD are particularly vulnerable because of their diagnosis, especially in the case of severe symptomology. Therapists who treat clients for BPD would also be considered vulnerable in their participation in a power-over relationship with highly volatile, suicidal and self-harming clients. Once engaged in the intense dynamics of the Tr/CTr dynamics of the therapeutic

relationship, both client and therapist may become limited in their self-determination and ability to make decisions about their own welfare.

Decision-Making Capacity

"Decision-making capacity refers to the ability of participants to understand relevant information presented about a research project and to appreciate the potential consequences of their decision to participate or not participate." (TCPS 2, 2018, p. 44) Clients with severe symptoms of BPD may not always be fully aware of their level of risk once their Tr is triggered within the therapeutic relationship, or between sessions. There can be extra safety considerations in terms of helping these clients advocate for themselves and make decisions concerning their own welfare not only during treatment but outside of it as well. According to the Canadian Code of Ethics for Psychologists (2017) responsible caring recognizes and respects the "ability of individuals and groups to make decisions for themselves and to care for themselves and each other." (p. 18) However, this ability is compromised in the therapeutic relationship with clients with BPD when Tr patterns of self-harm or drop-out, for example, may be re-enacted with the therapist.

One way in which researchers of these studies upheld fairness and equity with vulnerable participants is through inclusion and exclusion criteria. Due to high levels of risk and vulnerability for clients with BPD, Spinhoven et al. (2007), made the decision to exclude from their study, client participants whose primary diagnosis were psychotic disorders, bipolar disorder, dissociative identity disorder, antisocial personality disorder, attention deficit/ hyperactivity disorder, addiction, and mental retardation (p. 107). These criteria may inadvertently infringe on the core principle of justice and the ethical standard of responsible caring. Spinhoven et al. (2007) admitted that their study may have benefited by expanding its

inclusion criteria to reduce attrition, and many people who could have received the option of ongoing treatment for BPD, but did not. According to TCPS 2 (2018) those who lack the capacity to decide on their own behalf must neither be unfairly excluded from the potential benefits of research participation, nor may their lack of decision-making capacity be used to inappropriately include them in research (p.44). It is important to recognize that these measures could stand as barriers to treatment and participation in research the with clients who may be comorbidly diagnosed with BPD. However, researchers need to be able to determine how to fairly and equitably allow highly vulnerable participants to partake in their research. For instance, in the case of clients diagnosed with BPD who were actively self-harming or suicidal. They have to consider this ethical principle of justice also in terms of not including those where it would be inappropriate or unsafe to do so.

Therapist participants are also more vulnerable when participating in research studies and treating clients with BPD. Therapists have to maintain standards of practice with clients regardless of the requirement of research. "One may therefore have diminished capacity in some respects but still be able to decide whether to participate in certain types of research." (TCPS 2, 2018, p. 44) Researchers must be sensitive and responsive to these issues for both clients and therapists as the therapeutic relationship progresses. One way this issue was addressed in the studies by Niessen-Lie et al. (2020) and Rosenberger and Hayes (2002) was in the study design in that the therapists were also the researchers. There was a variety of disciplines included across these studies; not all therapists were licensed psychologists, as some were psychiatrists, social workers or psychoanalysts. Even in their participation in research, therapists' decision-making power and autonomy as licensed and competent therapists must be protected in terms of upholding their own professional ethics, obligations and standards of practice.

Respect for Persons

A major consideration for this investigation is the respect for the dignity of the person, which requires that research be conducted in a manner that is sensitive to the inherent worth of all human beings (TCPS 2, 2018, p. 6; CIHR, 2018). Clients with BPD are at high risk for harm to their sense of self-worth in the therapeutic relationship due to unconscious re-enactment of traumatic relational patterns through Tr/CTr dynamics with the therapist. All of the studies in this review include human participants, either therapists or clients; however, three studies by Lingiardi et al. (2015), Putrino et al. (2019), and Westerling et al. (2019) highlighted respect for the dignity of persons, emphasizing inherent worth, non-discrimination, protection and moral rights of the individual (CPA, 2017). In these studies, respect for clients with BPD was upheld through informed consent and maintaining privacy and confidentiality of information throughout the research and therapeutic processes.

Informed Consent

One of the most pertinent issues with high-risk and vulnerable populations, such as those with mental health diagnoses like BPD, is that they often lack the capacity to ethically provide consent to participate in research and in treatment. Participants provide highly personal and specific demographic data and diagnostic information, and they need to know how that information is going to be used and disseminated by researchers. “Individuals who participate in research should do so voluntarily, understanding the purpose of the research and its risks and potential benefits as fully as reasonably possible.” (TCPS 2, 2018, p. 27). Furthermore, consent shall be given voluntarily, can be withdrawn at any time, and if a participant withdraws consent, the participant can also request the withdrawal of their data (TCPS 2, 2018, p. 28). This is an especially important in this study because clients with BPD may be highly dysregulated and

experiencing severe symptoms at the initial stages of research and the therapeutic relationship. Since the therapeutic relationship can take longer to establish with clients with BPD, clients may not fully understand what the expectations are in terms of treatment; for more longitudinal research studies, for instance. They may otherwise not be fully prepared to engage in treatment for BPD. Westerling et al. (2019) attended to this issue by only including data from client participants who consented to follow up once they were already recruited and undergoing treatment. These participants were informed that their therapists would see their initial packets but would not see their follow-up responses (Westerling et al., 2019). This way, researchers and therapists can uphold respect for the dignity of persons by ensuring that clients are informed to the best of their ability, emphasizing the need to protect and maintain the moral rights of vulnerable participants.

Privacy and Confidentiality

There was a high level of disclosure of personal information in these studies such as detailed demographics, health and diagnostic information, and session recordings throughout these studies; especially in the studies by Colli et al. (2014), Fatter and Hayes (2013), Lingiardi et al. (2015), Rosenberger and Hayes (2002), Spinhoven et al. (2007), and Westerling et al. (2019). Privacy refers to an individual's right to be free from intrusion or interference by others, and the ethical duty of confidentiality refers to the obligation of an individual or organization to safeguard entrusted information (TCPS2, 2018, pp. 57-58). The study by Westerling et al. (2019), for instance, did not include identifiable demographic information (e.g., age, race, ethnicity, religion, gender identity, sexual orientation) from therapist participants (p. 79). "The ethical duty of confidentiality includes obligations to protect information from unauthorized access, use, disclosure, modification, loss, or theft." (TCPS 2, 2018, p. 58). Three studies used

only therapist participants and electronically collected their information, such as email and online questionnaires. This can add to the risk of lost, misplaced or improperly stored information and data since electronic submissions require an added level of protection and security. Researchers have a responsibility to all participants in keeping their data private and confidential. Therefore, information provided through online data collection procedures risk non-compliance of privacy and confidentiality standards which could pose a threat to the therapists' professional practice.

Concern for Welfare

Concern for welfare consists of the impact on the quality of life for individuals such as their physical, mental and spiritual health, as well as their physical, economic and social circumstances (TCPS 2, 2018, p. 7), and can vary in severity from minor to substantial (CPA, 2017). Most studies in this review considered responsible caring and integrity in relationships as a priority ethical standard in their studies, and risks were addressed by the researchers in various ways to mitigate harm and negative effects on the welfare of both client and therapist participants. Lingiardi et al. (2015) and Rosenberger and Hayes (2002) specifically promoted exploring whether the therapist adequately attended to their biases and addressed them appropriately. According to the Canadian Code of Ethics for Psychologists (2017), personal values and self-interest can affect therapeutic practice such as assumptions, questions asked, selection methods, what they observe or not, and how they interpret data. Therapists are engaged in therapeutic relationships with highly vulnerable, and mentally and emotionally unstable clients, therefore the risk of bias and compromising the welfare of clients and themselves is increased. Researchers across these studies, therefore, used well-validated instruments such as diagnostic interviews and questionnaires, and provided regular consultation, a collaborative team

approach and follow up to minimize the negative impact for clients and therapists. These ethical standards ensured that therapists adhered to the core principle of concern for welfare for themselves as well as their clients.

Professional Competency

Researchers and therapists alike have a responsibility to adhere to the standard of integrity in relationships which the Canadian Code of Ethics for Psychologists (2017) defines as an expectation of psychologists to commit to truthfulness, accuracy and honesty; straightforwardness and openness; maximizing objectivity and minimizing bias; and avoidance of conflict of interest (p. 25). Therapists are at increased risk of compromising their welfare and wellbeing when treating clients for BPD in terms of psychological, emotional, physical or economic consequences. Several of the studies are retrospective, mitigating some of these risks. However, in five of the studies which included client participants, therapist participants treated more than one client with BPD (Colli et al., 2014; Nissen-Lie et al., 2020; Rossberg et al., 2007; Spinhoven et al., 2007; Westerling et al., 2019). Additionally, therapists with less training and experience in BPD can be more affected by their pre-conceptions and biases with clients who invoke heightened CTr. Consequently, treatment planning may differ depending on their own perception of chronicity of BPD (Colli et al., 2014). Therefore, "psychologists need to be willing to work in partnership and collaboration with others, be self-reflective, and open to external suggestions and criticism about their work." (Canadian Code of Ethics for Psychologists, 2017, p. 31) Furthermore, psychologists need to consider the importance of engaging in self-reflection regarding their own values, attitudes, experiences and social contexts in an effort to provide competent care (Canadian Code of Ethics for Psychologists, 2017). Meeting these expectations of competency and integrity in the therapeutic relationship with clients diagnosed with BPD is

enhanced by self-knowledge, training and regular supervision and/or consultation. Otherwise, therapists are at an increased risk for compromising their professional competency and ethical standards of practice in providing psychotherapeutic services for clients with BPD.

Conclusion

There were several important ethical considerations to consider for vulnerable participants throughout these 10 studies, for therapists and clients with BPD engaged in the complex and often volatile Tr/CTr dynamics of the therapeutic relationship. The ethical issues of decision-making capacity, informed consent, privacy and confidentiality, and therapists' competency were discussed according to the core principles of TCPS 2 (2018), the CPA (2017), and the ethical standards of the Canadian Code of Ethics for Psychologists (2017). Core principles of justice for vulnerable persons, respect for the dignity of persons, and concern for welfare were important to consider and maintain in the context of research as well as the therapeutic relationship between clients diagnosed with BPD and therapists. Ethically responsible research and psychotherapeutic treatment are ongoing practices. Ultimately, actively and sensitively addressing ethical concerns can mitigate risks for both clients with BPD and therapists alike.

Future Research

The purpose of this study was to identify and better understand factors, which influence the Tr/CTr dynamics of the therapeutic relationship with clients diagnosed with BPD. In this, section, I will discuss the recommendations for future research based on the results of this study.

Recommendations for Mixed Method and Qualitative Research

Given that no mixed method studies and only one qualitative study were included in this investigation, I recommend more mixed method and qualitative studies be done on this topic. For

example, the study by Westerling et al. (2019) relied solely on quantitative data to draw conclusions about therapist CTr, patient attachment, and process dynamics (p. 79). However, these researchers also recommended that mixed methodology or qualitative research be conducted on the topic of CTr in psychodynamic psychotherapy, as it might be able to provide greater breadth and understanding of the therapeutic relationship. Having a deeper understanding of which factors influence the Tr and CTr dynamics of the therapeutic relationship can also have benefits for understanding how the relationship with clients diagnosed with BPD develops differently than with clients without BPD, or perhaps personality dysfunction in general.

Qualitative or mixed methodology research could also help to define how therapists can be best supported in the therapeutic relationship with personality disordered clients. Training, supervision and consultation are applications of this study; however, the logistics of this application warrant further examination. For instance, it would be beneficial to know the frequency of supervision or consultation that therapists find most helpful. Additionally, it could help researchers better understand the risks and ethical issues that may come up in the therapeutic relationship with personality disordered clients, especially if therapists do not have as much training and/or support. There is an emphasis in the literature for the need for a clear and articulated treatment structure, and the need for ongoing supervision groups (Kernberg et al., 2016). One research question could be: How does a clients' history and level of suicidality impact the therapists CTr and subsequent CTr management with that client?

This study made me increasingly curious about the fact that several studies have investigated working with highly unstructured personalities (i.e. BPD) in highly structured environments (i.e. hospitals and specialized treatment centres). Conventional treatment for PD's and BPD currently takes place in highly structured and formalized environments, therefore, I

would recommend that qualitative research be done around the therapeutic setting to help us better understand how treatment settings impact the therapeutic relationship and treatment outcomes with BPD clients. We may investigate issues such as accessibility, reliance on technology, privacy, use of security, and health measures in hospitals, private clinics and/or rehabilitation centers, for instance. These elements of the therapeutic environment impact both client and therapist. Therefore, it may be helpful to delve into issues such as how therapeutic milieu affects the Tr/CTr dynamic, feelings of safety in the therapeutic relationship, access to professional supports for therapists, dropout rates, and follow through with treatment in a more or less structured environment.

Qualitative research provided this study with a deeper understanding about CTr with the BDP client. I recommend that more qualitative research, as well as mixed method studies, be done with clients to better understand insights and perceptions of the therapeutic relationship, from the clients' perspective. As Quatman (2015) asserts, psychotherapy is intensely two-person focused, and Tr and CTr is an inevitable part of our relationships across various contexts, including professional ones. Therefore, qualitative and mixed method studies about clients' Tr experiences within the therapeutic relationship would add the clients' voice to current literature about personality disorders such as BPD.

Recommendations to Study Psychodynamic Psychotherapy

The capacity for therapists to Self-reflect and therefore practice reflexively with clients could be examined through the theoretical orientation of relational psychodynamics. It would be beneficial to study whether therapists improve in their reflexivity through the use of the psychodynamic modality. Lingiardi et al. (2015) argued that future research investigates more complex and holistic models of the therapeutic relationship, assuming the reciprocal interactions

and influences of client and therapist characteristics. A model which sees therapist responses as part of a relational matrix, and a valuable source of information about CTr responses (Lingiardi et al., 2015). Investigating this would also help to better understand whether using this approach, in contrast to conventional treatment for PD's and BPD, are more useful in reducing negative CTr reactions, reducing the severity of BPD symptoms, and/or in increasing positive Tr/CTr dynamics of the therapeutic relationship. Additionally, Kernberg (1984) postulated that the client also develops the capacity to think more reflectively and coherently. This integration in psychological structure is hypothesized to allow for increased modulation of affect and coherence of identity, a greater capacity for intimacy in relationships, a reduction in self-destructive behaviors, and general improvement in functioning (Levy et al., 2006, p. 484). More research into psychodynamic psychotherapy may therefore benefit BPD clients in having better treatment outcomes as well as help therapists in using an approach which facilitates the development of CTr awareness and reflexive capacity.

There is benefit to studying the psychodynamic model longitudinally as this study has recognized that the therapeutic relationship with BPD clients takes longer to develop and maintain then treating clients without BPD. There is evidence that the effect of psychodynamic therapy increases over time and sets in motion psychological processes that lead to ongoing changes, even after therapy has ended (Khademi et al., 2019, p. 47). Conducting longitudinal research on this topic would be valuable in getting a thorough understanding of how Tr and CTr dynamics evolve and change over time, and in generating further research questions about the development and maintenance of the therapeutic relationship with clients with PD's, and BPD specifically. It would also be worthwhile to do research with personality disordered clients after the completion of psychodynamic treatment, and/or at follow up, to determine if psychodynamic

psychotherapy is more effective with BPD clients in the long term as compared to other more conventional treatment interventions.

Conclusion

I have discussed the research that informed which factors which influence the therapeutic relationship with clients diagnosed with BPD. I used the relational psychodynamic model to frame my study and discussions about the therapeutic relationship. I started by providing a literature review which focused on Tr, CTr, and the diagnosis of BPD. I then outlined the purpose of the study and research question, as well as the research problem and significance of the study. After reviewing the literature for gaps around the therapeutic relationship with BPD clients, I presented my own position and biases.

I analyzed the methods in 10 studies which covered the topics of Tr and CTr, the therapeutic relationship and the diagnosis of PD's and BPD specifically. Nine of the studies were quantitative and one was qualitative. I discussed my methods next, which included an overview of three research paradigms, positivist, post-positivist and constructionist, and also considered the roles of the researchers. My methodology sections included an overview of data sampling and recruitment, data collection and analysis. This also covered each studies' strengths and limitations.

Analysis and synthesis of results from the 10 studies was completed via content analysis. Two therapist factors, three client factors, and two treatment factors were found to influence the therapeutic relationship with BPD clients. Therapist factors included heightened CTr and self-reflection. Client factors included severity of BPD symptoms, level of motivation and engagement in psychotherapy, and level of personality dissimilarity between client and therapist. Treatment factors comprised of level of training with BPD and length of treatment for BPD.

Applications to clinical practice included CTr management, reflexivity, and higher levels of professional experience and training for therapists in order to positively influence the therapeutic relationship, reduce symptom severity and increase treatment follow through with clients diagnosed with BPD.

A discussion of the ethical considerations for working with vulnerable and high-risk clients was included in accordance with the Canadian code of ethics for psychologists (CPA, 2017) and the TRI-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2, 2018). Two main recommendations for future research were suggested. First, a recommendation for more mixed method and qualitative research studies investigating these factors more deeply, as well as looking at how the therapeutic environment impacts the therapeutic relationship with BPD client. Secondly, I recommended to study the use of psychodynamic psychotherapy with clients with BPD more closely by gaining insight about the therapeutic relationship from the client's perspective, and examining whether this approach is more effective at follow up then other approaches.

The therapeutic relationship is important for success with any counselling client, however, the considerations when working with clients diagnosed with BPD, are distinct. This is due to the activation of particularly heightened Tr/CTr dynamics with BPD clients. Clients with severe BPD symptomology struggle with perspective taking and connecting at the level of mutually beneficial dynamics in relationships. Tr/CTr is captured within the therapeutic space and can be applied intentionally, whether it be negative or positive (Jones, 2020). "Subsequent improvements in attachment status may reflect a meaningful reorganization of a patient's relationships to self and other, which could lead to stable, self-perpetuating gains in functioning." (Keefe & Derubeis, 2019, p. 756) The purpose is for the client to make sustainable

improvements in relational patterns and work on the latent effects of trauma and abuse, with the therapist. The hope is that clients with BPD can begin to exhibit more relationally adaptive and flexible behavior, and experience healthier interpersonal patterns of attachment through the therapeutic relationship with a regulated, reflective, and experienced therapist.

This investigation lends its contribution in terms of the various factors which influence the therapeutic relationship with a vulnerable and unique population, clients diagnosed with BPD. Therapists need to feel safe in the therapeutic environment, and with their clients. CTr feelings of inadequacy, for instance, may point to the reality that therapists' might actually lack the competency or level of training to effectively acknowledge and manage CTr. The emergence of personal discomfort, such as feelings of self-doubt and humility, however, is also an opportunity for greater tolerance, self-exploration and reflection into CTr that will ultimately make therapists better therapists (Jones et al., 2020; Yalom, 2005). Ultimately, the therapeutic relationship requires the therapists' authenticity, engagement, and attunement to the client's emotional and subjective experiences (Yalom, 2005). Therefore, the therapists' ability to take an empathic, nonjudgmental approach is important to building genuineness, honesty, flexibility, acceptance, and a willingness to be impacted in the therapeutic relationship (Diamond & Meehan, 2013; Ganzer, 2018; Jones et al., 2020; Ngo-Smith, 2018). With increased self-reflection, better management of heightened CTr, and reflexivity, therapists may indeed feel increased relational safety with clients who challenge the relationship alliance. Through the therapeutic relationship, mature therapists continually evolve, regarding each client as a learning experience (Yalom, 2005).

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Appendix A

Table 1

Article Summary

Title	Authors	Year	Sample Pop.	Appr.	Hypothesis/research question
Patient personality and therapist response: An empirical investigation	Colli et al.	2014	71 adult patients (79% female; M. age 34) 11 therapists (2 males, 9 females; M. age 41; Yrs. Exp. at least 3 years, avg. 10 yrs.)	QN Corr.	Purpose: To examine the relationship between therapists' emotional responses and patients' personality disorders and level of psychological functioning. H 1: Specific personality disorders evoke distinct CTr responses H 2: CTr responses cannot be accounted for by therapist theoretical orientation. H 3: Globally lower-functioning patients evoke the most intense negative emotional responses in therapists.
What facilitates counter-transference management? the roles of therapist meditation, mindfulness, and self-differentiation.	Fatter & Hayes	2013	100 Therapist Trainees (68 female, 30 males, 2 transgender; 0-16 yrs. of exp.) 78 Supervisors (Avg. 11 yrs. exp.)	QN Corr.	Purpose: To examine the potential roles of therapist trainees' meditation experience, mindfulness, and self-differentiation in facilitating CTr management. H 1: Meditation experience would be positively related to CTr management qualities. H 2: Therapist was directly related to CT management qualities. H 3: Differentiation of self would be positively related to therapist trainees' CTr management qualities.

Title	Authors	Year	Sample Pop.	Appr.	Hypothesis/research question
It's not you, it's me: An examination of clinician- and client-level influences on counter-transference toward borderline personality disorder	Liebman & Burnette	2013	560 Clinicians (407 Female, 147, males; /490/87% Caucasian; M. age 50; Yrs. exp. ranged from <5 - 20)	QN Quasi-Exp.	Purpose: To examine clinician reactions toward individuals with BPD across client- (age/gender) and clinician factors (demographics/clinical experience). H 1: Clinicians would diagnose BPD more often for a female than a male client and more often for an adult than an adolescent client. H 2: Clinicians with more experience and specialized training would be more likely to accurately diagnose BPD than those without. H 3: Clinician CTr reactions would be more negative toward clients with BPD compared with other disorders. H 4: Clinician reactions would be more negative toward adults versus children and women versus men with BPD. H 5: Older clinicians and with more clinical experience would have more positive CTr reactions toward clients with BPD than do younger or less experienced clinicians.

Title	Authors	Year	Sample Pop.	Appr.	Hypothesis/research question
Does the severity of psychopathological symptoms mediate the relationship between patient personality and therapist response?	Lingiardi, et al.	2015	203 Psychiatrists and Clinical Psychologists (>3 years clinical experience, avg. 10 yrs.) (100% Cauc.; 111 females, M. age 43) 203 adult patients (Diagnosis of PD's, 118 females; M age 34)	QN Corr.	Purpose 1: To investigate the relationship between patients' symptom severity and clinicians' emotional responses. Purpose 2: To explore mediated effect of symptom severity on the relationship between patients' personality pathology and CTr responses. Purpose 3: To examine if severe symptomatology acts as a mediator on the relationship between different types of PD's and patterns of CTr reactions. H 1: Patients with higher levels of symptom severity tend to evoke stronger degrees of clinicians' negative emotional responses that cannot be accounted for by their theoretical orientation and other variables, such as gender, age, profession, and experience. H 2: Symptom severity mediates the association between patients' personality pathology and therapists' responses.

Title	Authors	Year	Sample Pop.	Appr.	Hypothesis/research question
Patient factors predict therapists' emotional counter-transference differently depending on whether therapists use transference work in psychodynamic therapy	Nissen-Lie, et al.	2020	7 Therapists (2 female, 5 males; 10–25 years of exp. in psychodynamic psychotherapy) 100 adult patients (51/57% females; M. Age 37; 72 with Axis I diagnosis, 41/47% personality disorder diagnosis.	QN Descr.	Purpose: To investigate whether therapist CTr was related to patients' pre-treatment interpersonal problems, degree of personality pathology and motivation for psychodynamic therapy. Purpose 2: To explore if these relationships depended on whether the therapists used Tr Work or not in sessions. Test 1: Investigated if three patient variables: 1) level of PD pathology, 2) interpersonal problems, and (3) motivation for psychodynamic psychotherapy, predicted therapist CTr responses, differently. Test 2: Tested if these relationships were moderated by the use of Tr work in sessions.
Psychotherapist emotional and physiological reactions toward patients with either borderline personality disorder or depression.	Putrino, et al.	2019	43 clinical psychologists with different theoretical orientations (28 females, 15 males; M. age 41.3; M. years of exp. 14.3)	QL Explor. & Descr.	Purpose: To examine therapists' reactions to patients diagnosed with MDD and BPD.

Title	Authors	Year	Sample Pop.	Appr.	Hypothesis/research question
Origins, consequences, and management of counter transference: A case study.	Rosenberger, and Hayes	2002	1 female client (Cauc. 21 yrs.) 1 female Psychologist (Cauc., 34-yr. 3 yrs. exp.) 6 Raters	QN Case Study/ Corr.	H 1: That client speaking turns containing material related to the therapist's unresolved conflicts would tend to be followed immediately by therapist speaking turns that were avoidant. H 2: A direct relationship would be detected between the frequency of client speaking turns related to the therapist's conflicts and the amount of avoidance behavior by the therapist.
An empirical study of counter-transference reactions toward patients with personality disorders.	Rossberg, et al.	2007	71 adult patients (79% females, M. age 34) 11 therapists (2 men, 9 women; M. age 41)	QN Quasi-Exp.	Purpose 1: Examine therapists' CTr reactions in a day treatment program for patients with PDs. Purpose 2: Examine to what extent cluster A+B PDs evoked other CTr reactions compared with patients with cluster C PDs. Purpose 3: Examine relationship between CTr and outcome. T 1: Examine whether patients with BPD would elicit different CTr than patients with APD, and whether the staff varied more in their reported CTr T 2: Examine whether patients who dropped out of treatment evoked different CTr 2 wks after start of treatment than patients who completed treatment. T 3: Examine the relationship between different CTr feelings and improvement during treatment.

Title	Authors	Year	Sample Pop.	Appr.	Hypothesis/research question
The therapeutic alliance in schema-focused therapy and transference-focused psychotherapy for borderline personality disorder.	Spinhoven, et al.	2007	86 patients analyzed. 78 assig. to SFT and TFP groups. SFT: 40 (90%) females, 4 males; M. age 31.7 TFP: 32 (94%) females, 2 males; M. age 29.4 44 therapists (21 in TFP, 23 in SFT) 1:1 ratio of male to female	QN Quasi-Exp.	H 1: The quality of the therapeutic alliance would be rated higher in SFT than in TFP. H 2: A lower quality of the therapeutic alliance at early treatment would predict premature treatment termination and outcome. H 3: Growth of the therapeutic alliance during the first year of therapy represents an important therapeutic mechanism by which a later reduction of BPD pathology is facilitated. H 4: Dissimilarity in pathological personality characteristics between therapists and patients would facilitate the development of therapeutic alliance and indirectly affect therapy outcome.
Patient attachment and therapist counter-transference in psychodynamic psychotherapy.	Westerling, et al.	2019	19 Therapists 335 adult patients (63% female, 37% male; Age range 18-69 yrs.)	QN Corr.	Purpose: To provide a greater understanding of how therapists can attend to patient attachment and their own CTr to improve treatment outcomes. H 1: Higher levels of attachment anxiety among patients will be related to higher levels of parental/protective and special/overinvolved CTr among therapists. H 2: Higher levels of attachment avoidance in patients will be related to higher disengaged CTr among therapists. H 3: Longitudinally, decreases in attachment anxiety in patients will be related to decreases in parental/protective CTr. H 4: Decreases in attachment avoidance in patients will be related to decreases in disengaged CTr in therapists.

Appendix B

Table 2

Summary of Psychometric Properties of Measurement Tools

References	Measurement tool	Norming sample	Reliability	Validity
Colli et al. (2014); Lingiardi et al. (2015); Westerling et al. (2019)	Therapist Response Questionnaire (TRQ). Designed to assess CTr patterns in psychotherapy via 79 items measuring a wide range of thoughts, feelings, and behaviors expressed by therapists toward their patients. The questionnaire contains eight CTr dimensions: overwhelmed/ disorganized, helpless/ inadequate, positive/satisfying, special/overinvolved, sexualized, disengaged, parental/protective, criticized/mistreated.	Psychiatrists (30%), clinical psychologists (70%) (N = 332), at least 3 yrs. exp., 10 hrs./wk. of direct client work. Avg. was 10 yrs. exp. Patients (N=332) with Axis I & II diagnosis, incl. PD's (Tanzilli et al, 2016). Westerling et al. (2019) normed it using a random US sample of 181 psychologists/ psychiatrists.	High reliability, and excellent internal consistencies of all 9 subscales and items, all coefficients between .78 - .84. (Betan et al., 2005; Colli et al., 2014; Tanzilli et al, 2016).	Robust and valid instrument with good construct validity: CTr patterns predictably and coherently related to specific personality disorders. Convergent validity showed very high intercorrelations between all the factors, $.78 \leq r \leq .98$. (Betan et al., 2005; Colli et al., 2014).
Rosenberger and Hayes (2002); Spinhoven et al. (2007)	Working Alliance Inventory (WAI) assesses the quality of the working relationship between therapist and client. Contains 36 items, composed of three 12-item subscales which measure across three domains: Task, Goal, Bond. (Horvath & Greenberg, 1989; Horvath, 1989). The Spinhoven et al. (2007). study Patient's completed the WAI-P, measuring the contribution of the therapist to the alliance as perceived by the patient. Therapists	Normed on two samples: 1) 231 adult clients and their therapists in ongoing therapy. 83 males, 148 females. 18 - 65 yrs. 2) 235 adult clients from several outpatient facilities. 56 males 167 females	The samples demonstrated adequate person and measure reliability, S1=.92; S2=.88; measure reliabilities S1=.92; S2=.88. (Hatcher et al., 2006) The internal consistency of the WAI-P is excellent at .94; WAI-T at .95.	The WAI moderately predicts therapy outcomes, r=0.24 (Martin et al., 2000; Horvath, 1994; Busseri & Tyler, 2003). A commonly used and extensively validated measures of the therapeutic alliance. Horvath and Greenberg (1989) and

	completed WAI-T, rating the contribution of the patient to the alliance. i.e. Working towards mutually agreed upon goals, agreement on treatment plan, feelings of mutual respect, acceptance and understanding.	18 - 63 yrs. (Hatcher et al., 2006).	(Kokotovic & Tracey, 1990; Rosenberger & Hayes, 2002; Spinhoven et al., 2007).	Horvath (1989) found excellent construct and convergent validity r = .76. (Rosenberger & Hayes, 2002).
Fatter and Hayes (2013); Rosenberger and Hayes (2002)	The Countertransference Inventory – Revised (CFI–R) is a 40-item measure of CTr management designed to reflect five qualities that have been theorized and found to facilitate CTr management: self-insight, self-integration, empathy, anxiety management, and conceptualizing ability (Latts, 1996).	Construct validity established via experienced therapists (N = 122) Evidence of content validity was gathered via 33 expert therapists (mean yrs. of exp.=21) Convergent validity was normed on experienced therapists N=345 (Latts, 1996; Van Wagoner et al., 1991; Hayes et al., 2011).	High internal consistency estimates for each subscale have been found at .91 - .92. In the current study, the instrument had acceptable overall internal consistency (.94) Subscale were rated between .75 - .87 internal reliability (Hayes et al., 1991) Rated at .79-.90 by Latts, (1996).	Rated highly for content validity by Hayes et al., (2011). Limited construct validity (measures all subscales altogether) Convergent validity for negative CTr management with effectiveness = -.52, (e.g. punitive, avoidant, aggressive) Demonstrates sufficient face validity, 3.55 - 4.82 (Friedman & Gelso, 2000).
Colli et al. (2014); Lingiardi et al. (2015)	Shedler-Western Assessment Procedure 200 (SWAP-200). Provides a comprehensive assessment of patient personality and psychological functioning through structured clinical interviews. Based on 200 items, clinician's rate and sort their patients on a likert scale. The instrument provides a personality diagnosis expressed as the	Tested in different patient samples, comparing diagnosis by treating clinicians and independent assessors. Clinicians/Psychiatrists/Psychologists N=530 reporting on	A reliable instrument in assessment of personality pathology. (Tanzilli, et al, 2016). Blagov et al., (2012), report moderate to high test-retest reliability coefficients, .64 - .94.	A well validated instrument with strong construct validity at .80; convergent validity .66; small to moderate median discriminant validity coefficients, -.06, between interviewers and

	matching of the patient assessment on 12 personality disorder scales, as described in the DSM-IV axis II disorders i.e. Avoidant, dependent, histrionic, borderline, etc. (Westen & Shedler, 1999).	patients N=267. Clinician retest sample N=94.	High Interrater reliability, .82 (Westen et al., 2006). Good internal consistency, .73. Mean reliability coefficient for scales of DSM-IV PD's, .90. (Blagov et. al., 2012).	clinicians. (Westen et al., 2006, 2007; Tanzilli et al, 2016).
Spinhoven et al. (2007)	Borderline Personality Disorder Severity Index (4th version; BPDSI-IV). DSM-IV BPD is a criteria-based semi-structured 3 mo. interview which index's current severity and frequency of specific BPD symptoms. (The BPDSI is not a diagnostic instrument)	64 BPD patients, (23 Cluster C PD; 20 non-psychiatric controls; all between 18 & 65 yrs.) Clinical norms derived from a sample of 28 BPD patients, showing improvement during 6 months of psychotherapy (Arntz et al., 2003).	Excellent interrater reliability and sensitivity to change during treatment. Excellent reliability coefficients, .93; ICC .97. 0 to 6 mo. test-retest correlation, .72. (Arntz et al., 2003) Moderately strong internal consistency, .83.	The BPDSI-IV shows excellent validity. Concurrent and construct validity indices are good. The correlation between BPDSI and number of BPD criteria in the BPD patients is .47, explaining 22% of variance. Suitable as a treatment outcome measure. (Arntz et al., 2003).

Appendix C

Table 3

Summary of all Measurement Tools

Reference	Measurement Tool
Fatter and Hayes (2013)	The Five Facet Mindfulness Questionnaire. A 39-item self-report instrument that was used to measure therapist trainees' self-perceived mindfulness along five dimensions: 1) Non-reactivity to inner experience; 2) Observing and noticing sensations, perceptions, thoughts, and feelings; 3) Acting with awareness, concentration, and non-distraction; 4) Describing and labeling experience with words; and 5) Non-judging of experience.
Fatter and Hayes (2013)	The Differentiation of Self Inventory-Revised (DSI-R). A 46-item self-report measure of therapists' perceived differentiation in current relationships with their families of origin. Contains 4 subscales: Emotional Reactivity, Emotional Cut-off, Fusion with Others, and I Position.
Lingiardi et al. (2015)	The Symptom Checklist-90-Revised. The SCL-90-R. A self-report psychotherapy change measure of 90 psychiatric symptoms assessing the personal discomfort of physical status as well as the psychiatric symptoms and mental health status.
Lingiardi et al. (2015)	The Global Severity Index (GSI). A mean rating across all 90 items of the SCL-90-R. Summarizes clients' general psychiatric symptom severity.
Nissen-Lie et al. (2020)	Inventory of interpersonal problems- circumplex version (IIP-64). The IIP-64 is a self-report instrument designed to assess interpersonal problems in eight domains: Domineering, Vindictive, Cold, Avoidant, Non-assertive, Exploitable, Overly nurturant and Intrusive.
Putrino et al. (2019); Nissen-Lie et al. 2020; Rossberg et al. (2007)	The Structured Clinical Interview for DSM-III-R diagnosis (SCID-II). Assesses personality disorders or Axis II diagnoses. PD is associated with a set of items in SCID-II that assesses different manifestations of a given PD The dimensional sum scores are used to represent degree of PD pathology.
Nissen-Lie et al. (2020); Rossberg et al. (2007)	Feeling Word Checklist-58 (FWC-58). A 58 item self-report measure used to assess therapists' countertransference. Therapists rate their degree of emotional responses toward a patient on 5-point Likert scales.
Rosenberger and Hayes (2002)	The Brief Symptom Inventory (BSI). Descriptively assesses client symptomatology pre- and posttreatment. Contains 53 items rated on a 5-point scale of distress. The instrument is intended to yield nine primary symptom dimensions and three global indices of distress.

Rosenberger and Hayes (2002)	Session Evaluation Questionnaire (SEQ) assesses session impact. Consists of 24 bipolar adjective subscales that measure session depth and smoothness.
Rosenberger and Hayes (2002)	Counselor Rating Form—Short version (CRF–S). Measures the client's and therapist's perceptions of the therapist's social influence. Contains 12 items, 4 items for each of three subscales measure therapist attractiveness, expertness, and trustworthiness.
Rosenberger and Hayes (2002)	Adjective Check List (ACL). Assesses the therapist's blind spots/unresolved conflicts of which they are unaware. Contains 300 adjectives within 15 subscales based on need-press theory of personality that respondents endorse if they accurately describe Self or the person being rated.
Rossberg et al. (2007)	Mini International Neuropsychiatric Interview (MINI). Structured clinical interview tool to assess for axis I disorders.
Rossberg et al. (2007)	Global Assessment of Functioning (GAF) used to measure the severity of mental illnesses and how much symptoms affect daily life (0 to 100 scale).
Spinhoven et al. (2007)	Inventory of Personality Organization (IPO). The 90-item IPO consists of three primary clinical and two secondary interpersonal relations scales
Spinhoven et al. (2007)	Difficult Doctor–Patient Relationship Questionnaire -Ten Item Version (DDPRQ-10). A self-report questionnaire measuring the extent to which patients are experienced as difficult in the therapeutic relationship by their doctor or therapist, and as provoking levels of distress that transcend the expected and accepted level of difficulty. Patients characterized by often comorbidly presenting psychosomatic symptoms, personality disorder, and Axis I psychopathology.
Spinhoven et al. (2007)	Young Schema Questionnaire (YSQ). A 205-item self-report questionnaire developed to measure 16 core beliefs or early maladaptive schemas.
Westerling et al. (2019)	Experiences in Close Relationships-Short Form (ECR-S) measures patient attachment. A 12-item self-report measure developed from the original 36-item ECR.