Common Factors in Group Counselling for Borderline Personality Disorder

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Abstract

Borderline personality disorder dynamics are challenging to treat as an individual counsellor. Clients with BPD often have co-morbidities, are over medicated and are stigmatized in medical and psychotherapeutic settings. BPD clients may engage in self-harm, suicidal ideation and may express strong, fast-cycling emotions. Specialized approaches to treating BPD include group counselling. This literature review investigates the common factors in group counselling for BPD. The common factors of validation, normalization and psychoeducation are essential for a client with BPD to establish hope. Group cohesion, mentalization and relational skills establish and maintain trust in the process and in the client's own self. Other-focus, resilience and directness support the client's sense of purpose in the world. Peer workers, community-based longer-term groups and strong therapeutic alliance are important ingredients in successful group counselling for clients with BPD dynamics.

Keywords: borderline personality disorder, group counselling, common factors

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Chapter 1

This paper will explore common factors in group counselling for clients with borderline personality disorder (BPD) dynamics.

Group counselling is more cost effective than individual counselling for non-profits who are delivering services on tight budgets (Fraser, 2014). Clients with BPD have better outcomes from longer term therapy than short term therapy (Feinstein, 2022). Community counselling organizations may have numerous BPD clients who don't have access to specialized, longer-term counselling. Rather than cycling through short term therapies that can exacerbate fear of abandonment (Feinstein, 2022), community counselling organizations can offer support groups for clients with BPD dynamics. Common factors in group counselling for BPD can provide some basic guidelines for this type of program.

Overview of Topic

Clients with BPD dynamics are seen as challenging patients within the medical system (Feinstein, 2022). Clients with BPD dynamics can also be difficult clients for counsellors (Tedesco, 2023; Puder, 2022). The risk of suicide and self-harm behaviours are often present. Professionals in both systems are concerned about liability and may avoid accepting clients with BPD (Feinstein, 2020; Day et al, 2018). Additionally, clients with BPD dynamics may become very attached to individual counsellors, but also may engage in disruptive behaviours which challenge the therapeutic alliance (Tedesco, 2023; Mulder & Tyrer, 2023).

One of the approaches which has been effective with BPD clients is group counselling (Lothstein, 2023; Hutsebaut et al, 2020; Grenyer, 2022; Goldstein 2020; Gec 2021). This may include psychoeducation, peer support and practicing interpersonal communication. What are the common factors that make group counselling with BPD clients effective? On the surface, it

seems that a regular gathering of folks who have challenges with interpersonal relationships would be doomed to fail. Yet clients report (Ditlefsen, 2021) improved interpersonal functioning and show marked improvement over time (Aafjes-van Doorn & Horne, 2022) with a combination of group and individual counselling (Buono et al, 2021). Modalities used to treat BPD, such as dialectical behavioural therapy (DBT), mentalization based therapy (MBT) and schema therapy (ST) all include group counselling. What are the common factors that make group counselling effective for clients with BPD?

Common factors is a term used to identify similarities between different theoretical approaches to counselling. Similarities that are found to contribute to positive outcomes across different theoretical approaches are referred to as common factors. The promotion of specialized techniques, modalities and trainings has blossomed in capitalist culture; Feinstein (2022) states that specialized trainings "are offered not only to train clinicians to treat patients, but also to disseminate their approaches, preserve their brand, and for monetary gain" (p. 149). In this climate of specialization, common factors may be overlooked. Additionally, counsellors learning common factors is associated with improved client outcomes (Sprenkle, 2009; Spedding et al, 2022; Pickard et al, 2021).

Group counselling is a group process facilitated by a counsellor or counsellors with a therapeutic focus. Groups may be open or closed, for a fixed period or ongoing. The therapeutic process may involve feedback and other facilitated exchanges between group members. This can be beneficial for clients for whom interpersonal relationships are a challenge.

Borderline personality disorder is in the DSM-5 category of personality disorders. Borderline personality disorder symptoms include fear of abandonment, unstable sense of self, a

risk of self-harm and of suicide, fast cycling of strong emotions, impulsivity, and unstable relationships.

Estimates of the percentage of people with BPD in the general population varies from 2.8% in New Zealand (Newton-Howes, 2021) to 0.7 to 2.7% in the US (Tedesco et al, 2023). Patients with BPD visit hospital more frequently compared to patients with other diagnoses (Newton-Howe, 2021; Ditelefsen, 2021; Tedesco et al, 2023). Patients with BPD dynamics may have lifelong social issues (Hutsebaut et al., 2020) due to relational instability.

Individual therapy and medication are less useful for BPD (Feinstein, 2022) than individual therapy plus group therapy over longer periods of time, usually 18 to 24 months (Gardner, 2022; Ditlefsen, 2021).

Purpose Statement

The purpose of this capstone is to identify common factors in group counselling for clients with borderline personality disorder. This research will be useful for organizations who want to offer group counselling for clients with BPD dynamics and who want criteria for choosing a trans-theoretical approach to design and fund a low or no-cost group counselling program. It will also be useful for new counsellors who are learning to recognize BPD dynamics and to consider working with clients with BPD dynamics.

Clients with BPD dynamics elicit many complicated feelings, especially in new counsellors who are less familiar with countertransference. New counsellors who are encountering clients with BPD dynamics will need additional supervision to manage the countertransference and they will need to establish and hold very strong boundaries around what they will and won't accept from clients (Merced, 2018). The urge to save or rescue clients with

BPD dynamics can be strong- stronger boundaries and thorough supervision are essential (Merced, 2018).

Theoretical Approach

I am taking a social justice approach to researching common factors in this paper, along with a feminist lens. In the absence of formal, specialized training, how can community organizations offer supportive, low, or no-cost group counselling services for clients with BPD dynamics? Evidence-based therapies suggest that trauma, genetics and adverse childhood experiences or environments are the roots of personality disorders (Feinstein, 2022, p. 137). Clients who have had traumatic early-life experiences deserve access to care and support through the mental health system. Unfortunately, clients with BPD dynamics often have comorbidities and interpersonal challenges that limit their access to services (Feinstein, 2022). It is important to offer effective, accessible, inexpensive, or free services to those who need them.

Empathy, validation and developing a strong therapeutic alliance are the primary interventions with BPD (Feinstein, 2022, p. 147). Building on the common factors between DBT, ST and MBT we can ascertain which aspects of group counselling are most significant for clients with BPD dynamics.

Research Questions

This paper is intended to support a charitable organization to hold regular group counselling sessions for clients with BPD. Community services for BPD clients are limited, with many clients coming for no-cost, short term individual counselling at the charitable organization in question. What are the common factors that create a supportive group environment for BPD clients? This paper is also intended to introduce BPD dynamics to new counsellors. What are key

indications of BPD dynamics? How might a new counsellor support themselves in working with a client with BPD dynamics?

Reflexivity and Positionality Statement

I approach this paper as a white, middle class, cis gender, heterosexual, early 50s, Master of Counselling Psychology student, working as a contract facilitator and counsellor for charitable organizations for the past 10 years. In my experience, clients with BPD dynamics are often referred to free counselling services offered by charitable social service organizations. Individual counselling is somewhat useful for borderline clients. However, they may become emotionally attached to their counsellor and devastated by the short-term nature of the service. Ongoing group counselling provides a container to practice interpersonal skills, receive feedback and to have other people in their social landscape (Barr et al, 2020; Ditlefsen et al, 2021; Gillard et al, 2015). Group counselling can also provide validation, affirmation, peer support and peer learning.

I have an interest in group counselling and this research is partly for my own learning about the theories and approaches to group counselling for clients with BPD dynamics. I have worked with numerous clients with BPD dynamics in individual counselling and find the work challenging and rewarding. I was not aware of BPD when I began working with clients and was flummoxed by the intense countertransference responses that I had towards some clients. I hope that other counsellors will find useful information about BPD dynamics in this paper.

This research is also intended to de-mystify group counselling for new counsellors and to encourage charitable community service providers to offer group counselling for clients with BPD dynamics.

Definition of Terms

Borderline personality disorder (BPD) is made up of five groups of symptoms: unstable behaviour, unstable emotions, unstable relationships, unstable sense of identity and awareness problems (Canadian Mental Health Association, n.d.). Borderline personality disorder affects the way a person relates to other people and to themselves. They might not have a good sense of who they are as a person. Their moods might be extreme and change quickly and often, and they might have strong impulses. They could have a hard time trusting others and they could have a fear of being abandoned. In life, this can look like strong, sometimes aggressive emotions combined with a fear of abandonment (Canadian Mental Health Association, n.d.). Suicidal ideation and/or self-harm as strategies to manage strong feelings may be present.

In this paper I will refer to “clients with BPD dynamics”. This term is intended to include clients with a diagnosis and clients who self-identify as having BPD dynamics. As counsellors we do not diagnose clients. Some clients will have done research and will ask if you think they have BPD. It is important to neither confirm nor deny a client’s own research, but rather to ask what they’ve learned, how it fits or not for them and how they are relating to this knowledge. At the same time, if a counsellor is aware that BPD dynamics are present in a session (such as splitting, strong countertransference, boundary violations, etc) it is important for the counsellor to seek extra supervision and support, no matter whether the client has a diagnosis, self-identifies as having BPD dynamics or not. BPD dynamics can be challenging to work with, especially for new counsellors. Supervision, personal counselling and strong boundaries around your work with the client are important (Merced, 2018).

Dialectical behavioural therapy (DBT) "is a third-wave CBT treatment, primarily focused on behavioural change" (Feinstein, 2022, p. 138). Dialectical behavioural therapy emphasizes

acceptance and change through a non-judgemental coaching stance (Feinstein, 2022). DBT emphasizes distress tolerance, mindfulness, emotional regulation, and interpersonal work (Feinstein, 2022, p. 138).

Evidence based practice (EPB) are well-researched, specialized modes of therapy. Extensive training is required for certification as a therapist using each mode.

Mentalization based therapy (MBT) "integrates ideas from psychoanalytic and attachment theory and the neurosciences" (Feinstein, 2022, p. 137). The therapist adopts a stance of not-knowing and explores the client's attachment style, mentalizing and interpersonal functioning (Feinstein, 2022). Treatment involves psychoeducation about the personality disorder and encourages the client to effectively mentalize themselves and others, thus improving attachment, stabilizing emotions, and interpersonal relationships (Feinstein, 2022).

Schema therapy (ST) uses several aspects of cognitive, behavioural, and psychodynamic theory. ST focuses on early maladaptive coping strategies, schemas, and behaviours (Feinstein, 2022). Schema therapy includes psychoeducation, takes a limited reparenting stance and uses countertransference to explore interpersonal relationships (Feinstein, 2022).

Splitting is the process that clients with BPD dynamics may engage in with others. It includes putting the person up on a pedestal, then tearing them down. Splitting can be a significant impediment to relational stability for clients with BPD dynamics.

Chapter 2

This literature review will consider the common factors in group counselling for BPD. Qualitative studies which highlight first person responses of clients with BPD dynamics will be emphasized. Qualitative research is a more effective way to understand what matters to clients or consumers of mental health care (Goldstein, 2020; Grenyer, 2022; Ditlefsen et al, 2021; Gillard et al, 2015). Quantitative studies of BPD are often focussed on reduction of self-harm and suicidal ideation (Feinstein, 2022) rather than the long-term qualities of recovery for clients with BPD dynamics. This literature review will include long-term qualities of recovery, such as "survival, resilience and self-management" (Ng et al, 2019a, p 4) or "living well" (Gillard et al, 2015, p 1). Lothstein (2023) describes "intimacy and connectedness" as desirable outcomes for clients with personality disorders (p 251). Ng et al (2019a) share the importance of "meaningful activities and relationships" (p 5) as part of recovery. Qualitative studies are more effective at determining which therapeutic factors matter most to clients (Tedesco et al, 2023). Additionally, qualitative research, rather than quantitative, is better at capturing the subjective experiences of clients with BPD dynamics (Goldstein, 2020). Identification of client strengths and capacities is an important part of building hope, especially for clients who have regularly been stigmatized and invalidated due to their diagnosis (Day et al, 2018; Barr et al, 2020).

From the qualitative research Ng et al (2019a) identifies three phases of recovery: "being stuck, diagnosis and improving experience" (p 4). The 'being stuck' stage involves overwhelming emotions, lack of understanding and insight and self-harm or suicide attempts, often with misdiagnoses and lack of guidance from health care (Ng et al, 2019a). This is the most raw and painful phase for clients with BPD dynamics. The 'diagnosis' phase involves validation, normalization, psychoeducation and greater understanding and insight, though discrimination

and stigma may still occur (Ng et al, 2019a). The 'improving experience' phase involves clients being aware of their own thoughts and feelings, strengthening their sense of self and understanding the perspectives of others (Ng et al, 2019a). The phases are non-linear, and setbacks can cause clients to move to a different phase, which is why supports for cultivating hope and re-engaging with treatment need to be readily available (Ng et al, 2019a).

Studies which promote low cost, community delivery of services will be highlighted (Hutsebaut et al, 2020; Spedding et al, 2022; Gec et al, 2021; Barr et al, 2020). These studies reflect the feminist, social justice lens that I align with in my work. Accessibility of psychosocial interventions is a major issue for clients with BPD (Feinstein, 2022; Gec et al, 2021). Low cost, community-based services are well positioned to address this gap, though funding from the medical system would not be amiss. Gillard et al (2015) researched a program in which participants could be diagnosed or self-identified with the thoughts, feelings and behaviours associated with personality disorders. This is an important improvement in accessibility to care.

Consumer perspective, quality of life and recovery-oriented care (Grenyer et al, 2022; Goldstein, 2020; Ng et al, 2019a; Pickard et al, 202; Gillard et al, 2015) are emerging themes in the literature. This represents a shift from the medicalized, top-down perspective of the DSM. This shift is essential for clients to engage effectively with treatment, especially when the cycle of stigmatization and discrimination of clients with BPD dynamics has been present in the medical system for many years (Day et al, 2018).

History of Common Factors Research

Discussion of common factors in therapy goes back to the 1930s (Duncan, 2002). Sprenkle et al (2009) describe two paradigms of change in therapy; "model-driven change" and "common-factors-driven change" (p 4). Models are seen as vehicles for common factor change,

useful for structuring therapy but ultimately not the source of change (Sprenkle et al, 2009). This reflects a shift from the western medical model which views therapies as medications used to address specific conditions. Instead, we see that that common factors such as therapeutic alliance and a sense of hope are necessary for any model to work (Sprenkle et al, 2009). An example of this would be the ways that different theories, such as DBT or MBT bring about the common factor called "change of perspective" (Sprenkle et al, 2009, p 55).

Group cohesion in group therapy could be viewed as the equivalent of therapeutic alliance in individual therapy (Cuijpers et al, 2019). Therapeutic alliance can be defined as the trusting alliance between the client and therapist on therapeutic goals and tasks (Vincente et al, 2021). One of the components of group cohesion is connections between individual group members and between members and the therapist that are trusting and cooperative (Vincente et al, 2021). In this way, the conditions of 'hope for change' and 'trust in others' can be seen to underpin the common factor of therapeutic alliance or group cohesion. Vincente et al (2021) investigate group cohesion and therapeutic alliance as common factors in group therapy. Their findings indicate that higher levels of therapeutic alliance between the therapists and the group members are correlated with higher levels of group cohesion.

History of Borderline Personality Diagnosis

Borderline Personality Disorder is in the DSM-5 category of personality disorders. Symptoms include fear of abandonment, unstable sense of self, a risk of self-harm and of suicide, fast cycling of strong emotions, impulsivity, and unstable relationships (CMHA, 2014; Newton-Howes et al, 2021; Puder, 2022).

The ICD-11 personality disorder classification provides a more nuanced spectrum assessment than a list of BPD criteria (Mulder & Tyrer, 2023). Mulder & Tyrer (2023) go on to

discuss the significance of the spectrum model for choosing appropriate interventions for each client. For example, more trauma-focused treatment for those with identity disturbance, more structured, boundaried treatment for those with disinhibition and group work for those with a primarily negative affect (Mulder & Tyrer, 2023). This prescriptive approach extends the diagnostic model without considering where a client might be in the phases of their personal recovery.

Mulder & Tyrer (2023) are strongly opposed to the BPD diagnosis. They state that BPD symptoms overlap largely with other personality disorders and that a BPD label is not helpful. Furthermore, Mulder & Tyrer (2023) say that psychological treatments for BPD are indistinguishable from treatments for other forms of distress or disfunction, that no medications are beneficial and that the diagnosis itself is a major stigma for clients. Tedesco et al (2023) and Ng et al (2019b) describe that compassionate diagnosis with psychoeducation is useful for clients with BPD. The diagnosis, while potentially stigmatizing within the medical system, does help clients to better understand their behaviour and it validates their experiences (Ng et al, 2019a; Tedesco et al, 2023).

Tedesco et al (2023) explore the idea that it would be more appropriate to reclassify BPD as a trauma disorder, rather than a personality disorder. This reflects the 70% of clients with BPD dynamics who report childhood trauma. However, the 30% of clients with BPD dynamics who do not report trauma would indicate that while BPD and trauma are related, they are distinct diagnoses (Tedesco et al, 2023). Porter et al (2020) state that clients with BPD dynamics report childhood adversity 13 times more than non-clinical controls (p 8). It is useful to hold trauma as a frequently co-occurring aspect of BPD.

Tedesco et al (2023) report the following themes related to BPD diagnoses; those problems began in adolescence, but diagnosis was delayed by an average of 18 years, that clients identified a variety of sociobiological and psychological factors that affected their development of BPD, that being diagnosed was a mix of positive and negative experiences and that accessing treatment was difficult. This leads us to consider the purpose of diagnosis. How does it serve the client? Is the reluctance to diagnose BPD a well-intentioned but misguided attempt to avoid stigmatizing the client? Are clients with the diagnosis able to access resources and supports? Clients emphasized that earlier diagnosis would have helped them to feel less isolated and to have a better understanding of themselves (Tedesco et al, 2023).

Tedesco et al (2023) further identified that the most important positive aspects of diagnosis were psychoeducation, treatment recommendations and follow-up. These aspects were often delayed or missed altogether. Clients identified early, compassionate diagnosis with a clear description of symptoms in everyday life and provision of non-stigmatizing treatment options as very important (Tedesco et al, 2023). This offers a structure from which to review clients' individual experiences and to understand their current openness or disinclination to engage with treatment.

Diagnosis of BPD is statistically very gendered (Tedesco et al, 2023; Goldstein, 2020) Most studies include more women participants than men, with Woodbridge et al (2021) reporting a mean proportion of 88.67% female participants across 28 studies. Further research to understand whether BPD is less often diagnosed or less prevalent in men would be useful.

Recommended treatment for BPD and the reality that most clients are medicated

Many clients with BPD dynamics interact with the medical system due to a crisis related to suicide or self-harm (Monk-Cunliffe et al, 2022; Feinstein, 2022). Clients who are medicated

to address a crisis often have little to no follow-up with the medical system (Day, 2018; Gunderson, 2011). There are many gaps in service on the route between crisis intervention in the medical system and longer-term psychological supports (Feinstein, 2022; Gunderson, 2011). This is reflected in Tedesco et al's (2023) findings that clients had difficulty accessing counselling due to availability, cost, and distance from services. The medical system is only able to offer medications in response to crisis, while clients have limited access to longer term supports such as group or individual therapy (Shay, 2021; Hutsebaut et al, 2020; Spedding et al, 2022). This gap in service is a significant obstacle for clients in their BPD recovery process.

Clients with BPD dynamics are over-represented in mental health care systems (Grenyer et al, 2022) and have higher mortality rates. Clients with BPD dynamics may be experienced as difficult to treat and evoke frustration in medical staff (Gunderson, 2011; Goldstein, 2020). Clients may misinterpret interpersonal cues or show aggression when strong feelings come up. Education about BPD for medical staff may help to address this issue.

Most therapists experience higher levels of countertransference with clients with BPD dynamics than other clients (Feinstein, 2022, p 486). The interpersonal difficulties of clients with BPD dynamics make it more challenging to establish therapeutic alliance; once therapeutic alliance is established the pressure on the relationship can lead to splitting, aggression, or other issues. Increased supervision for therapists is useful in addressing these BPD client challenges (Goldstein, 2020; Feinstein, 2022).

In the US, health insurance coverage is often insufficient for extended psychosocial treatments as recommended for BPD (Gunderson, 2011). In Canada, psychological treatments are often costly or, if publicly funded, may only be offered in larger centres or for clients with single diagnoses. Many programs moved online during the covid pandemic and in person

services may not have been restored. There can be special challenges for clients with BPD dynamics accessing online services (Wurman et al, 2020). Many clients with BPD dynamics have co-morbidities, as a result they may be excluded from BPD groups or research (Buono et al, 2021). The experience of being excluded from a group due to co-morbidities can be very damaging to a client's trust and willingness to access resources. It is important as new counsellors that we consider best practices and existing barriers to treatment, such as cost, co-morbidities and accessibility of services.

Therapists are often unwilling or reluctant to work with clients with BPD (Goldstein, 2020). This unwillingness can be read as dismissal or rejection by clients already sensitized to abandonment (Goldstein, 2020; Merced, 2018). This paper is intended to encourage therapists to recognize BPD dynamics, to consider ways to work with clients with BPD dynamics and to raise awareness of the need for therapeutic services for clients with BPD dynamics. Clients with BPD dynamics face significant obstacles in relationships and in accessing the medical system. Consellors need to be aware of these challenges and not subscribe to the stigmatized medical perception of clients with BPD dynamics.

Woodbridge et al (2021) describe the most common medications prescribed to clients with a BPD diagnosis being benzodiazepines, mood stabilisers, antidepressants, and antipsychotics. 80% of clients with BPD are taking 3 or more medications (Feinstein, 2022), despite significant research showing counselling is the first line treatment and medications are not recommended (Goldstein, 2020; Gec, 2021; Day, 2018). Medications and engagement with the medical system can interfere with clients' participation in long term recovery. For example, clients may develop an external locus of control and reduced agency around managing their strong feelings and behaviours and a related frustration that their doctor is not able to cure them

(Feinstein, 2022). Clients' sense of self may suffer due to psychological impairment or side effects caused by medications, especially long-term use of medications.

Group therapy and the reasons it's especially useful for clients with BPD dynamics

Yalom & Leszcz (2005) identify that group therapy can provide a sense of commonality and connection among group members. Additionally, groups offer the opportunity to support others (therapeutic altruism) and to receive support, and to learn directly or through modelling and practice (Yalom & Leszcz, 2005). These common factors in group therapy can occur within any model of therapy, offering a venue to try out new behaviours and receive peer feedback (Woodbridge et al, 2021). However, the experience of connection between people is often fraught with peril for clients with BPD dynamics. How can clients for whom connection and belonging has been problematic view group therapy as potentially beneficial?

In a broad review of group research, group psychotherapy is defined as treatment of emotional or psychological difficulties in a group format, with an emphasis on behaviour, interpersonal relationships, and intrapersonal change in the participants (Burlingame et al, 2017).

Holmes & Kivlighan (2000) identify the important benefits of group therapy as clients forming social networks with group members and leaders, which creates a better balance of relational safety and challenge, offers validation and noramlization and puts less relational strain on an individual therapist. The group cohesion or therapeutic alliance supports challenge, encouragement, and reflection on each other's situations. Group therapy provides an opportunity to balance focus on self and focus on others, which improved emotional awareness and interpersonal skills. It also deepens participants' understanding of their personal feelings, thoughts, and behaviours.

The elements described above are part of the group therapy process generally. These also occur in BPD groups, which we will now examine more specifically. Ng et al (2019a) found that 88% of clients with BPD wanted to function better from a psychosocial perspective. This included workplace relationships, personal relationships, and relationship with self. Having a group setting for relationship practice offers multiple perspectives and moments of challenge and of support. Having an intentional group in which to practice relating to others and to self is beneficial for clients with BPD dynamics.

The processes of sharing, reducing shame and learning from each other's experiences were identified as significant factors in a BPD psychoeducation group as part of MT (Ditlefsen et al, 2021). These processes reflect normalization and validation in action. For some clients, it was their first time being in a group with others who used self-harming to regulate emotions; "it makes you fell less alone, it relieves the shame a little" (Ditlefsen et al, 2021, p 262).

Grenyer et al (2022) identified isolation as an issue for some study participants. These participants had only one support person or identified the treating clinician or their pets as their only support. A state of isolation puts additional pressure on any new relationships in the client's life. This pressure may be too much for a successful therapeutic alliance with an individual counsellor, however a psychoeducational group could offer multiple points of connection, thus reducing the pressure on individual connections. This speaks to the question of how clients with BPD dynamics are best able to build and trust therapeutic alliance. Yalom & Leszcz (2005) state that the groups are a better container for clients with BPD dynamics to practice trusting others, to experience relational challenges and be present for their grief, fear and anger triggered by the absence or loss of group members or therapists. Group therapy offers multiple people so that interpersonal challenges are spread out, rather than focussed on an individual therapist (Yalom &

Leszcz, 2005). This significantly increases the potential that a client will be able to weather relational challenges.

A significant effect on clients' openness to joining a group is their experience of relational instability (Holmes & Kivlighan, 2000; Grenyer et al, 2022; Ditlefsen et al, 2021). Exploring a client's experience of groups, what groups represent to them and what stages or processes, as described by Ng et al (2019a) they are in, as well as their personal motivation, helps address reasons a client may not want to engage with group treatment.

Many clients with BPD dynamics have co-morbidities, such as substance abuse, depression, anxiety and eating disorders which can be challenging to treat in addition to the relational difficulties of BPD (Gunderson, 2011). Groups for BPD can include participants with co-morbidities, as described by Morken et al (2019). Helping a client to stabilize their sense of self and improve their interpersonal skills will be useful as they engage with treatments for other diagnoses.

Woodbridge et al (2021) explore BPD clients' non-response to psychotherapeutic treatment, including individual and group treatments. Woodbridge et al (2021) reviewed 28 studies of psychotherapy for BPD and found a mean of 48.80% of participants who did not respond to treatment, as determined by reduced symptoms. Further, the specialized BPD models produced similar results to the generalist models. There are several limitations in this review, including that reduction in symptoms may not capture improved social and occupational functioning and having a sense of purpose in life (Woodbridge et al, 2021). However, the issue of non-response to treatment is significant and requires further study (Woodbridge et al, 2021).

Wibbelink et al (2022) reported a 30% dropout rate of clients with BPD from DBT and ST programs. Hummelen et al (2007) interviewed clients with BPD who dropped out of group.

Client participation in a group may tax already limited relational skills. Early psychoeducation groups allow clients to access a group with less interpersonal pressure, which is the model used in Mentalization Therapy (Ditlefsen et al, 2021).

Pickard et al (2021) describe the stepped-care model, which uses the principles of "least restrictive" and "self-correcting" approaches to treatment (p 2). This means providing the minimum specialist treatment required and the flexibility to shift, increase or decrease treatment depending on the client's individual needs (Pickard et al, 2021). This approach seems suited to shifts along the stages and processes of recovery described by Ng et al (2019a).

Hummelen et al, 2007 conduct a qualitative study of clients with BPD who dropped out of group. Their research showed that between 17 and 67% of clients with BPD drop out of group (Hummelen et al, 2007). Their primary findings were that clients had negative feelings about the switch from regular daily treatment to weekly psychotherapy groups (Hummelen et al, 2007). Hummelen et al (2007) describe the difficulties that clients had making this transition and the relational attachment wounds around the ending of daily treatment. They also described that negative feelings were not satisfactorily contained or regulated in the group (Hummelen et al, 2007). The disconnect between patients who felt anxiety but were perceived by therapists as "difficult" or "problematic" and the aggression expressed by clients but not perceived by therapists was significant (Hummelen et al, 2007). The containment and regulation of negative feelings is an important factor in BPD groups (Hummelen et al, 2007). Mulder & Tyrer (2023) state that group counselling is most effective for clients with negative affect.

Further research could look at how group facilitators support clients to contain and regulate negative feelings. How does therapists' insensitivity to negative affect support them to lead BPD groups? Yet also leave clients feeling unheard, misunderstood, or unsafe, potentially leading to

them dropping out of the group? Group facilitators need a level of sensitivity to group members' affect without taking negative affect personally, along with strong boundaries and therapeutic abilities to lead BPD groups. Client perspectives enhance our understanding of this dynamic (Hummelen et al, 2007; Ng et al, 2019b).

Hummelen et al (2007) found that clients felt responsible towards other group members, limiting their sharing in order not to take time from others or protecting others who they perceived as vulnerable, which meant the group sessions felt short and rushed. Clients described that the weekly sessions left too much time for rumination on their behaviour or what they'd shared and the potential negative consequences of same (Hummelen et al, 2007). This level of self-consciousness in interpersonal behaviour highlights one of the relational difficulties experienced by clients with BPD dynamics, who can be very sensitive to and protective of fellow group members. Ng et al (2019b) convey the resentment that can follow when group members have difficulty separating their sense of themselves from their sense of others. The process of building self-awareness in group is challenging, yet group offers opportunities for immediacy and feedback that are not available in other settings (Ng et al, 2019b).

Other challenges with group therapy include clients perceiving the group as the cause of their difficulties (rage, frustration, difficulty making themselves heard) rather than considering that their own difficulties in relationships may be at play (Hummelen et al, 2007, p 80). Having hope for recovery and trust in others is essential in the face of relational challenges like this.

Stephanatou (2022) describes parallel therapy for young adult clients and their parents. In this way families are supported to support their person, with the group providing a safe space for unexpressed and very challenging emotions to be heard and validated. Many older clients with BPD dynamics may be isolated from family or friends, but supporting families who are

supporting younger clients with BPD dynamics is an important intervention on behalf of the client and on behalf of the stability and mental health of clients' families, who may not have a clear understanding of their child's behaviour.

Issues limiting client access to group therapy

Limited access to treatment can be caused by a lack of groups, cost of groups or by physical distance to in-person groups. Trauma, in the form of lack of epistemic trust and prevalence of triggers can make joining a group feel impossible. A history of interpersonal challenges, the presence of anxiety (social and otherwise) plus a lack of therapists willing to offer groups all affect clients' access to group therapy.

Clients identified physical distance, cost, long waitlists, and lack of access to specialized treatments as barriers to psychotherapeutic treatment (Shay, 2021; Spedding et al, 2022; Duggan & Tyrer, 2021; Tedesco et al, 2023). The option of remote services was studied by Wurman et al (2020) who researched the effects of Covid-19 on treatment delivery especially for clients with BPD. Attachment challenges and feelings of abandonment were significantly triggered by the switch from in-person to remote service delivery (Wurman et al, 2020).

Role of Developmental Trauma

Emotional regulation issues may be linked to childhood emotional invalidation, in that children don't learn how to identify, feel, and work with different emotional states (Porter et al, 2020). BPD and CPTSD co-occur, with clients with BPD dynamics 13 times more likely to describe childhood adversity (Porter et al, 2020). Jowett et al (2020) describe higher levels of perceived threat, reduced coping skills and intense emotional responses of BPD and CPTSD. Clients' interpersonal sensitivity and low epistemic trust may prevent them from accessing group therapy (Ditlefsen et al, 2021; Goldstein, 2020).

The fear of shame and humiliation prevents clients from joining groups and therapists from leading groups (Shay, 2021). Many clients and counsellors prefer the perceived safety and privacy of individual therapy, which may reflect the idealized maternal connection (Shay, 2021). There is an element of public challenge in group therapy; counsellors risk experiencing shame, humiliation or being unmasked as inadequate or incompetent in the process of leading a group (Shay, 2021, p 73). The idea of group therapy may trigger discomfort, fear, and social anxiety for both clients and therapists (Shay, 2021). This universal fear of shame and humiliation can prevent clients from joining groups and therapists from leading groups (Shay, 2021). For a client, the group has the potential to hold their shame in a shared space, validating and normalizing it, which can be an antidote to shame (Shay, 2021, p 74). From a therapist's perspective, it can be very engaging to risk "the possibility of exposure and the possibility of self-knowledge and growth" (Shay, 2021, p 74). Group counselling is a riskier proposition for counsellors and clients in terms of social anxiety and the potential for experiencing shame in front of others. The element of risk can add to the value of being witnessed in these potentially turbulent dynamics.

The point of this paper is to help counsellors understand BPD dynamics and identify ways that group counselling may be appropriate for their clients with BPD dynamics. It is also intended to encourage counsellors to offer group counselling, which counsellors seem to be universally afraid of (Shay, 2021). Therapists' stigma and caution around BPD may prevent them from offering treatment, group or individual, to clients with the diagnosis (Goldstein, 2020). Further research about therapist perceptions of group counselling, especially with clients with BPD dynamics and how to train, recruit and support group counsellors would be useful.

Selecting clients for group therapy

Feinstein (2022) notes that the client's current level of functioning and response to treatment should be taken as information in making treatment decisions. Informed by qualitative research, Ng et al (2019a) identifies three phases of recovery: "being stuck, diagnosis and improving experience" (p 4). Contextualizing a client's experience within this non-linear continuum helps to identify the approaches that will be most useful (Ng et al, 2019a). Clients who are in the 'being stuck' phase benefit from stabilization, normalization, and establishment or re-establishment of hope (Ng et al, 2019a). Clients in the 'diagnosis' stage benefit from normalization, validation and establishing or re-establishing trust in treatment and in other people (Ng et al, 2019a). Clients in the 'improving experience' stage are better able to integrate feedback, challenge, and interpersonal experiences (Ng et al, 2019a). Consideration of common factors from this perspective builds groups that are more appealing and effective for clients and makes the possibility of recovery more accessible (Tedesco et al, 2023; Ng et al, 2007).

Ditlefsen et al (2021) states that there should always be at least 2 of a kind in a group, so that no one is without someone they can feel kinship with. This is reflected in the comments of a lone male participant in a therapy group described by Ditlefsen et al (2021). The client left the group because he felt he couldn't speak openly (Ditlefsen et al, 2021).

Corey et al (2018) advise against including group members who are hostile or aggressive, as the energy required to contain these members can be detrimental to the functioning of the group. Yalom & Leszcz (2005) suggest that hostile group members can experience important reality checks from other members (p 419). The most important selection criteria is the client's own motivation (Yalom & Leszcz, 2005; Baumer et al, 2022). Further, if a client has had a positive experience of therapy and expects group therapy to be useful, it likely will be (Yalom &

Leszcz, 2005, p 251). Thus, assessing clients' motivation, experience and expectations is an important part of the selection process. Starting with a psychoeducation group (Ditlefsen et al, 2021; Fisher, 2009) is an effective way to build clients' hope and trust in the therapy process, which can carry over into a group therapy experience.

Client context is an important factor in selection criteria. Gec et al (2021) note that for their IGP research, study participants need to have access to supports in the community. Considering client context is an important way to ensure that clients are not betting everything on group therapy. This situation may cause too much tension and pressure, such that an interpersonal issue or other situation in the group can be overwhelming and lead to dropping out (Hummelen et al, 2007).

Common factors in group counselling

The Group Counseling Helpful Impacts Scale (GCHIS) was developed by Kivlighan et al (1996). I have selected it as an important foundation for understanding common factors in group counselling because it uses clients' own assessments of the factors that were most significant in their experience. Factor analysis revealed four components of effectiveness: "emotional awareness – insight, relationship – climate, other versus self- focus, and problem definition – change" (Holmes & Kivlighan, 2000, p 479). These factors reveal that self-knowledge, group cohesion, role flexibility and psychoeducation are significant components in effective group therapy for BPD (Holmes & Kivlighan, 2000; Ditlefsen et al, 2021; Ng et al, 2019a).

"Therapeutic factors associated with group psychotherapy involved vicarious learning (client improvement in response to the observation of another group member's experience), role flexibility (client as both help seeker and help provider), universality (group member's realization that other members are struggling with similar problems), altruism (client's offering

of support and encouragement to other group members), family re-enactment (resemblance of group to one's family of origin), and interpersonal learning (learning from interpersonal interaction with other clients)" (in Holmes & Kivlighan, 2000, p 479). These factors are reflected in the findings of Ditlefsen et al (2021) and Ng et al (2019a).

Common Factors- Hope category

The process of instilling hope regarding recovery helps clients to open themselves to the group therapy process. This process can include offering psychoeducation about BPD to clients (Tedesco et al, 2023) and their families (Stephanotou, 2022), fostering curiosity about the experiences of others (Ng et al, 2019) and fostering a process of self-inquiry (Bond et al, 2019).

Psychoeducation. Ng et al (2019) described an average 15-year gap between emergence of BPD symptoms and diagnosis. Tedesco et al (2023) describe an average 18-year gap between emergence of BPD symptoms and diagnosis. Clients who are given a diagnosis with compassion and provided with information and support are more likely to experience hope and to pursue recovery (Gillard et al, 2015).

Ditlefsen et al (2021) describe the psychoeducation component of an MBT program. Psychoeducation was found to foster hope, to encourage further engagement with therapy and to provide important tools and approaches to self-management. It made clients feel less alone through the realization that others also use self-harm to regulate emotions (Ditlefsen et al, 2021). It was important for group members to not feel too different from others in the group, similarity reduces isolation. The content of the psychoeducation program helped clients build their knowledge, perspective, and vocabulary to describe their experiences, which led to increased self-understanding and acceptance (Ditlefsen et al, 2021). Learning new perspectives on thinking

and feeling increased the possibilities of new behaviours and new forms of self-expression (Ditlefsen et al, 2021).

Fisher (2009) states that clients with trauma "may interpret our interventions to prevent or reduce suicidality as our not caring about how they feel" (p 2). Fisher (2009) describes a dynamic in which the therapist speaks in favour of safety and the client speaks in favour of self-harm (p 2). This dynamic is not productive and weakens the therapeutic alliance. Fisher (2009) states that investigating the client's experience with the understanding that self-harm is a comfort (perhaps the only comfort) will strengthen the therapeutic alliance. Finding alternatives to self-harm is the most important therapeutic task. In times of crisis, reaching out to the therapist or seeking medical help goes against the client's belief that others cannot be trusted (Fisher, 2009). The client prioritizes self-directed means of seeking relief, such as "cutting or starving or risk-taking" (Fisher, 2009, p 4). Fisher (2009) states that the client "needs our concern and commitment to pain relief more than our actual availability because the only ways she knows to 'ask for support' are to ask indirectly through action or provocative behaviour or to just throw up her hands and give up any attempt to help herself" (p 4). The core task for the therapist is to keep their own anxiety from interfering with their ally-ship with the client, whose experience is that relationships are not a source of comfort or safety (Fisher, 2009, p 4). This dynamic is probably best addressed in individual therapy, as the stress of a client's provocative behaviour may be too much for the group to contain.

Fisher (2009) states that "the sense of safety in the therapy does not come from just the absence of criticism or blame but also from the therapist's making sense of the patient's chaos and providing psychoeducational tools and a clear path into the future" (p 8). This reflects the necessity of providing psychoeducation at an early stage. Group therapy places relational

demands on the client that they may not have the capacity to sustain without a psychoeducational understanding of the dynamics at play.

Ditlefsen et al, 2021 described the early psychoeducation group of a MT program. The process instills hope, normalizes strong feelings and enhances the client's trust in the process (Ditlefsen et al, 2021). Having a positive experience in a group is predictive of success in group therapy (Yalom & Leszcz, 2005). A psychoeducation group is a good first step for a BPD client.

Validation and Normalization. Clients in Ng et al (2019b) reported wanting better psychosocial function, which included personal relationships, work relationships and relationship with self (p 148). For clients with BPD dynamics who have often experienced feeling as though they are abnormal or defective (Goldstein, 2020) and unlike those around them, having their feelings validated and normalized is a key step. Goldstein (2020) discusses the ways that having one's emotional experience mirrored by a caring adult is important for a child to develop "a coherent sense of self and trust in one's emotional life" (p 141). The process of validation and normalization addresses this missed developmental thread for clients with BPD dynamics.

Goldstein (2020) explored in more detail what clients with BPD dynamics were looking for from their therapists. The qualitative nature of this study allowed for more complexity than simple symptom reduction. For example, Goldstein (2020) found that clients were wanting a feeling of the therapist "being with me" (p 137). The emotional signposts that are most significant for clients may be related to histories of invalidation or rejection. A client for whom being invalidated creates a sense of being "worthless, powerless, alone" (Goldstein, 2020, p 138) may naturally respond with anger and rejection. This could be framed as the healthy protest of a child in a similar situation. Goldstein (2020) goes on the explore the specific therapeutic stance of walking with a client in their experience, rather than analyzing the reasons for the experience

(p 139). Clients reported that having the attention and understanding of therapists was most significant (Goldstein, 2020). While joining others may feel accessible and normal for most people, clients in Goldstein's (2020) study described a sense of being "abnormally, even defectively, emotionally sensitive" (p 139) from a young age. This sensitivity had typically been met with rejection or invalidation from parents, siblings, friends, and health professionals (Goldstein, 2020). Clients are describing a need for attention that has not been met in other areas of their lives (Goldstein, 2020). The tension around the experience of not being seen or being misunderstood is high (Goldstein, 2020). The question of how facilitators respond to this tension, combined with the client's capacity for distress tolerance is one measure of the success or failure of group therapy (Hummelen et al, 2007; Goldstein, 2020).

Clients with BPD dynamics may "severely tax the resources of the group" with their "demands and primitive anger" (Yalom & Leszcz, 2005, p 418). A client with BPD dynamics may act out their anger in the form of tardiness, missing sessions, substance use or self-harm (Yalom & Leszcz, 2005). Another way to frame these acts is provided by Fisher (2009); "Children who have experienced neglect or abuse have learned to avoid connection, rather than to seek it, and to rely almost exclusively on their own resources" (p 1). Fisher (2009) goes on to describe the ways that trauma survivors have difficulty trusting others or using relationships as a source of support (p 1). If we see tardiness, absence, substances or self-harm as ways to disconnect from the group and from relationship we can see that addressing these directly in group has the potential to create new options for the group member. These behaviours would reflect the hope stage of treatment when trust has not yet developed and psychoeducation and hope for change needs to be instilled and sustained. Clients at this stage may not be ready for the

emotional intimacy of group therapy and may be better served by compassionate diagnosis, psychoeducation, and validation. Once these are in place then trust can be developed.

Stephanotou (2022) discussed support groups for parents of clients with BPD dynamics. The group provides an important outlet for parents to express frustration, rage and helplessness related to their child's behaviour. The intense and potentially confusing behaviours of clients with BPD dynamics ripple out in families, workplaces, and the health care system. Providing psychoeducation, normalization and validation is important for clients and for the families and other systems where they hold relationships. Without this, health systems may write-off clients and continue the pattern of client invalidation followed by rage, to the detriment of both clients and health systems.

Common Factors- Trust Category

Trust between group members and between members and the therapist is a necessary ingredient for group cohesion and therapeutic alliance (Levay et al, 2021; Ditlefsen et al, 2021; Jowett et al, 2020; Porter et al, 2020).

Group cohesion / Therapeutic alliance. Group cohesion is based on therapeutic alliance. Yalom & Leszcz (2005) describe "group cohesiveness" as the quality of therapeutic alliance between the therapist and each group member as well as between group members. Psychosocial belonging is a major determinant of mental and physical health (Tucker et al, 2020). Group cohesion reflects this need for belonging and is ranked as the most important factor in group counselling by participants in Tucker et al, (2020). Corey et al (2018) notes the importance of group cohesion and describes is as a climate in which group members support one another, share, bond, and experience mutuality, belonging, warmth and closeness (p 300). However, group cohesion may feel threatening to clients with BPD dynamics, who have

experienced conflict, anxiety, and other issues in relationships. The sense of belonging and trust that clients struggle with seems very close at hand in group settings; however, we need to proceed slowly in order not to exceed the clients' capacity to trust themselves, the group, and the facilitators.

A lack of containment and regulation of negative affect is a significant barrier to clients with BPD dynamics feeling a sense of group cohesion more strongly than a sense of threat (Hummelen et al, 2007). A heightened sense of threat and lower levels of epistemic trust can be features of BPD and of PTSD (Hummelen et al, 2007). Yalom & Lesczc (2005) state that helping clients to share strong affect safely can enhance relationship. Although they are not addressing clients with BPD dynamics specifically, this approach may facilitate group cohesiveness. Yalom & Lesczc (2005) discuss the importance of the facilitator managing negative affect by addressing the issue directly, setting strong boundaries and modelling non-judgement, curiosity, and empathy.

Yalom & Leszcz (2005) articulate the importance of the group as a container for clients' negative transference – group members can offer alternate perspectives and the co-leaders of the group can be visible objects of positive and negative transference (p 420). A therapy group offers feedback from multiple members and at least 2 objects of transference, making it a useful container for a BPD client to explore their perspective. The intensity of feelings and the negative transference would likely be too much for individual therapeutic alliance to survive. Yalom & Leszcz (2005) also point out that a client can temporarily participate at a lower level in a group, resting until they are ready to re-engage (p 420). These sorts of breaks are not typically available in individual therapy.

Challenges to trust (Hummelen et al, 2007) include clients' negative affect and the misperception of this negative affect by group leaders. Group leaders' and clients' perceptions of experiences in groups varied significantly (Hummelen et al, 2007), presenting a challenge to group cohesion. Folmo et al (2019) compare 2 groups, one with high ratings and one with low ratings. Facilitators who were able to use strategy to call out, identify and investigate problematic patterns and generally bring clients "out of their comfort zone" were more highly rated than the facilitators who were themselves brought out of their own comfort zone and attempted to address this by being supportive towards clients (Folmo et al, 2019, p 141). Facilitators need to be able to regulate themselves in the face of client challenges in group, to be able to name and explore those challenges and not be thrown off by this process (Folmo et al, 2019). Folmo et al (2019) explore specific in-session dynamics between clients and therapists using transcripts. These exchanges highlight the perils of group therapy including how feelings of "not being liked, being useless, feeling judged or criticized" might lead a therapist to avoid challenging a client (Folmo et al, 2019, p 148). For clients with BPD dynamics, a therapist's ability to be transparent about countertransference, to tolerate clients' negative affect and to remain curious and committed to exploring the alliance is helpful (Folmo et al, 2019).

Mentalization- awareness of self and other. Ng et al, 2019a describe development of awareness of self and emotions. Further stages of this include (p 4) increasing awareness of thoughts and emotions, stronger sense of self and understanding perspectives of others (Ng et al, 2019a). Juul et al (2021) describe the experience of a client in a short term MBT program who was fearful of joining the group. She identified that in an interaction with heightened emotions she felt by turns "confused, anxious and angry and would ultimately conclude that she was somehow 'damaged goods'" (p 1572). As part of the case formulation the client and therapist

agreed to focus on heightened emotional states and to develop goals related to this challenge (Juul et al, 2021). The client in this situation would benefit from psychoeducation before experiencing the reality testing aspects of group therapy. On the other hand, a sense of belonging in a group can support a client to work through their self-critical feelings. Group cohesiveness is very important for a BPD client to accept the reality testing perspectives offered by members (Yalom & Leszcz, 2005). Belongingness is a key quality of cohesiveness and is the very quality that clients with BPD dynamics struggle with (Yalom & Leszcz, 2005). Yet clients with BPD dynamics have much to offer in a therapy group. They are sensitive to affect, will often be transparent about needs, beliefs and fears and can be attentive to other group members. They may encourage emotional expression in other members who are less expressive (Yalom & Leszcz, 2005).

Relational skills. Rutan (2021) describes the process of rupture through therapist error and repair and the effects these processes can have on group cohesion. “It is not unusual for the alliance to be tested, doubted, broken and rewon” (Rutan, 2021, p 312). Rutan (2021) describes some possible ruptures as microaggressions, empathic failures, memory failures, timing errors, overlooking group issues, countertransference and not maintaining boundaries. He goes on to list the 4 steps to address ruptures, which include recognition of rupture, owning responsibility for the rupture, understanding with the group what led to the rupture and the therapist risking transparency about their contribution to the rupture along with encouraging full expression by group members of their reactions and feelings (Rutan, 2021, p 316). This process is thoroughly described, and examples are provided. Rutan (2021) also states that it is better as a group therapist “to be respected and trusted than liked or admired” (p 326). This is especially true for a

group therapist in a BPD group; being liked or admired risks that a client will engage in splitting and a rapid descent will follow.

LoCoco et al (2019) describe ruptures of withdrawal or confrontation that can occur in group therapy along with suggestions and examples of repair. The key role of the facilitator is to notice that a rupture has happened and present it to the group for repair right away (LoCoco et al, 2019). Further, repair is seen as restoring trust in others and strengthening group cohesion (LoCoco et al, 2019).

Watching group facilitators or members model curiosity, non-judgement and empathy can open the possibility of connection through emotionally challenging situations. A corrective relational experience may occur because of a rupture and repair in a group therapy setting (Rutan, 2021). A therapist or group member modelling a skillful repair can help clients to integrate new relational possibilities (Rutan, 2021). Yalom & Lesczc (2005) suggest that ruptures and repair in a group can echo early family experiences and offer emotional resolution.

Common Factors- Purpose category

Other-focus, rather than self-focus. It is important that group members experience receiving and giving support and listening (Holmes & Kivlighan, 2000). This is described by Fuhriman & Burlingame (1990) as "role flexibility" in that the client can both offer help and seek help within the group. The process of changing roles helps a client to develop perspective and to identify similarities and differences between themselves and other group participants, thus enhancing mentalizing (Ng et al, 2019b).

Chen (2003) describes the ways that "self-disclosure and interpersonal feedback" can reduce bias and anxiety in group members (p 461). In particular, the disclosure of historical, outside of group, content can provide opportunities for other group members to recognize their

social position in relation to their fellow participant (Chen, 2003). These types of self-disclosures can help group members better understand how these experiences have shaped their personal identities (Chen, 2003). Yalom & Leszcz (2005) also discuss the disclosure of in-the-moment feelings and how this combination of historical and in-the-moment disclosures can build perspective. In particular, the shift from content to experience and back helps group members to create shared realities that are more nuanced and less black and white (Chen, 2003). Group members require a level of hope and trust to risk personal disclosures (Goldstein, 2020).

Role modelling by peer workers or peer facilitators is significant in building both hope and purpose for clients with BPD dynamics (Bond et al, 2019; Barr et al, 2020). Role models increase clients' sense of possibility and represent one route to helping others. Helping others counteracts the narrative of deficiency and burden and builds a client's sense of purpose.

Resilience. Clients with BPD dynamics may be embedded in stories of relational failure and deep shame (Ng et al, 2019a). Finding the exceptions to these stories and encouraging sharing stories of success can begin to build up the client's sense of themselves beyond their shortcomings and failures. Clients who are developing skills to identify and tolerate emotions are in a place to begin to reframe their understanding and perception of themselves (Ng et al, 2019a). Ng et al (2019a) offer the following perspective from a client experiencing their own resilience as "responsibility to learn the skills and do it yourself" (p 5). This requires an increased sense of self and a positive sense of capacity, both of which can be enhanced in group therapy.

Ng et al (2019b) noted an important element of therapy for clients with BPD dynamics- the recovery literature identifies a reformulation of self as part of the process. Clients with BPD dynamics experience a lack of identity from a young age, so building or rebuilding a sense of self is a significant aspect of therapy.

Bond et al (2019) describe the importance of "humour, praise and experiential knowledge" in a self-help group setting (p 640). Humour can break the tension of an interpersonal challenge. Praise, especially from someone with experiential knowledge of BPD can effectively challenge clients' negative scripts or schemas (Bond et al, 2019). Positive feedback can be difficult for clients with BPD dynamics because it goes against their primarily negative self-concept (Bond et al, 2019). A peer facilitator who praises clients' persistence, courage and coping skills encourages competence, self-efficacy and empowerment (Bond et al, 2019, p 642). However it can take time and therapeutic alliance for a client to accept this type of feedback. A peer facilitator who shares her own negative self-perceptions and coping strategies can role model mentalization for the group members (Bond et al, 2019, p 643).

Directness. Morken et al (2019) describe the importance of addressing the elephant in the room in groups. The facilitators' ability to address strong feelings in the room was a significant factor for clients to feel safe enough in group. Rutan (2021) describes the 2 main forms of rupture as withdrawal or confrontation. These are likely responses by clients to unaddressed emotional tension in the group. For clients who struggle to tolerate their own strong feelings, being in a group with the strong feelings of others can be overwhelming (Goldstein, 2020). A facilitator needs to be able to identify and address tension or ruptures to build and sustain clients' trust in the group process. Goldstein (2020) describes the challenge for facilitators working with a group of clients known for sensitivity and emotional neediness to validate the feelings of group members while maintaining firm boundaries for the group to function. This tension can take an emotional toll on group members and on facilitators (Goldstein, 2020). Folmo et al (2019) describe the necessity for facilitators not to be triggered by clients' negative affect, but rather to remain committed to the therapeutic tasks of investigating the alliance and being transparent

about countertransference. This supports emotional safety for clients. The interpersonal stressors of group work directly challenge the interpersonal sensitivities of clients with BPD dynamics. (Rutan, 2021; Goldstein, 2020; Hummelen et al, 2007). Directness may be extra challenging for clients with BPD dynamics to learn to use, as many have experienced losing it on people with negative consequences. Learning to be direct through modelling by facilitators and practice can enhance a client's communication skills and trust in themselves. Hope, trust, and purpose must be established and revisited regularly through strong boundaries and commitment to therapeutic goals for clients to meet these challenges and build sense of capacity and resilience through recovery.

Methodological Analysis

Quantitative studies focus on symptom reduction while qualitative studies focus on the perceptions and perspectives of clients. Goldstein (2020) points out that the shifting needs of clients with BPD dynamics make quantitative analysis less effective. Exploring the foundations of strong therapeutic relationships with clients with BPD dynamics are better done through qualitative means, which can express the nuance and paradoxes of clients who experience a shifting sense self and whose capacity is subject to change (Goldstein, 2020).

Burlingame et al (2018) is a meta-analysis of 55 articles with a focus on group cohesion as a factor affecting group client outcomes. Many relationships develop simultaneously- group to member, member to leader and member to member. SUD and in and out patient studies are included (Burlingame et al, 2018).

Tedesco et al (2023) conducted qualitative interviews with clients with lived experience of BPD. The focus was on the diagnosis gap (symptoms at average age 12 and diagnosis at average age 30) and the benefits of therapy, such as fostering insight, aiding treatment planning

and reducing isolation, and the challenges of therapy, such as stigma and limited treatment availability (Tedesco et al, 2023).

Wibbelink et al (2022) explored selection criteria and mechanisms of change for schema and DBT approaches to therapy for clients with BPD dynamics. This study relied on questionnaires to sort client feedback. A more qualitative and recovery-based approach would have been beneficial in understanding client experiences directly.

Ditlefsen et al (2021) conducted qualitative interviews with clients with BPD dynamics who had just completed the psychoeducation component of an MT program. The psychoeducational group was described as instilling hope offering normalization and increasing trust of participants in leader, each other, and self (Ditlefsen et al, 2021). The scope of this research was narrow enough that it offered important client perspectives on this stage of recovery.

Morken et al, 2019 used qualitative, semi-structured interviews after MBT weekly group and individual sessions. Themes identified were: “I am not alone” or identifying with other participants, “taking blinders off” or hearing different perspectives from other participants, “just say it” on the importance of addressing the elephant in the room (Morken et al, 2019, p 1). These themes are useful in formulating which common factors will support clients with BPD dynamics in group therapy.

Grenyer et al (2022) used qualitative analysis and found 3 themes: self-love and love of others, feeling a sense of purpose in work and study and a stable daily life. Grenyer et al (2022) concluded that approaches to group psychotherapy for BPD need to focus on these factors, as they most significantly affect improvement or non-improvement of clients.

Gec (2021) study participants showed no improvement in social functioning after 10-week Intensive Group Program (IGP). IGP focuses on psychoeducation, skills, DBT, ACT, assertiveness, mindfulness, and self-compassion. It appears that there was less emphasis on relational learning, such as that described by Ditlefsen et al (2021) and Grenyer et al (2022). Gec et al (2021) state that although well-being was improved, the lack of social functioning improvement is likely due to brevity of the program.

Ethical Considerations

Research with clients with BPD dynamics needs to "be mindful of the perspective of the participant" (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2012, article 3.8 C). Clients with BPD dynamics have experienced stigma in the medical system and have good reason not to want to engage with treatment or research. Qualitative data that directly expresses the perspective of the participant is less likely to reproduce stigma than quantitative data that seeks to generalise participant responses.

There is a risk that a bad experience in a research group could prevent a BPD client from pursuing recovery. This risk should be clear to participants, following the principle of Respect for Persons, so that participants can make an informed decision (Canadian Institutes of Health Research et al., 2022, article 4.7).

Gec et al (2021) describe the financial limitations of providing specialist therapy for clients with BPD dynamics. They assessed a 10 week, 2 sessions per week group and found a high level of client satisfaction (Gec et al, 2021). Many clients cannot afford to access private treatment, attention to the cost and barriers to accessibility is a necessary part of research into BPD group therapy.

LMIC, or low- and middle-income country studies demonstrate ways that mental health services can be provided in the community at lower costs (Spedding et al, 2022). Private health care has a profit motive, which means clients of a lower socio-economic status will not be able to access treatment. In offering services, we must be clear about whether we are part of the community, public or private systems and how this affects clients' ability to access services.

Spedding et al (2022) explored the use of common factors to organize psychological help for clients in LMIC. Evidence supports the provision of mental health programs by community health workers and trained peer providers (Spedding et al, 2022; Gillard et al, 2015). This shift to common factors is significant, as most research focusses on specialized modalities with their associated higher costs and limited availability (Spedding et al, 2022). Tools such as ENACT may be useful to quantify the competencies of non-specialist workers (Spedding et al, 2022). Consumer peer workers and carer peer workers use experiential knowledge to support clients in recovery (Barr et al, 2020). The support that peer workers provide to consumers and to carers is significant (Barr et al, 2020) and highlights the utility of experiential knowledge.

Flynn et al (2021) discussed increasing the scale, accessibility and reach of DBT based programs through clinical and community-based settings. This has the potential to address some of the accessibility issues identified by clients (Shay, 2021; Duggan & Tyrer, 2021; Tedesco et al, 2023).

Juul et al (2021) describe a short term, 20-week version of MBT, which includes group and individual therapy facilitated by the same therapists (p 1569). The issue of alliance in group and individual therapies is addressed. Yalom & Leszcz (2005) feel that simultaneous group and individual therapy can impede client progress, however this requires further research with clients with BPD dynamics specifically.

Ribeiro (2020) discussed diversity issues in groups, in particular ways that oppression may show up in a group. These include exploitation, marginalization, powerlessness, cultural imperialism and violence (Reibeiro, 2020, p 8). Group therapists should be aware of these manifestations of oppression and be prepared to address ruptures and facilitate repair (Reibeiro, 2020).

Gender is a factor in groups (Ditlefsen et al, 2021). BPD symptoms may show up differently for men and for women. In a largely female group, men may not speak freely (Ditlefsen et al, 2021). In a largely male group, women may not speak freely. A balance of genders or a gender-homogenous group may be appropriate.

Wurman et al (2020) describe pandemic era issues with remote access to services for clients with BPD dynamics. The anxiety of the pandemic and the lack of access to in-person services was challenging for clients (Wurman et al, 2020). Wurman et al (2020) concludes that fostering mentalization and emphasizing resilience as part of the existing MBT treatment is effective as a remote access offering. This research may encourage organizations to offer remote services, especially for clients who have difficulty accessing in person treatment.

Critical Analysis

Research into specialized modalities has typically been focussed on symptom reduction. The shift to consumer perspective and qualitative research marks an important new opportunity to better address the needs and goals of clients with BPD dynamics. Research into specialized modalities most often has a profit motive at the core. From a community-based, consumer model of recovery, client experiences can be brought to the foreground and accessible programs that address client needs can be designed and funded. Client factors outside of therapy can be

included in the case formulation, building on clients' personal knowledge, strengths and resources.

Peer support in BPD recovery is covered in Barr et al (2020). Peer support offers hope, trust-building reciprocal connection and a sense of purpose which are all significant common factors in group therapy for BPD. (Barr et al, 2020). The peer workers approach is gaining ground in recovery focussed programs, an area in which further research is needed.

This literature review covered perspectives from within the medical system (Feinstein, 2022; Bohus et al, 2021) and from a consumer perspective (Bond et al, 2019; Ditlefsen et al, 2021; Barr et al, 2020). A variety of research into specialized therapies for BPD (Farrell & Shaw, 2022; Folmo, 2019) and more generally into the experience of consumers of BPD therapy (Goldstein, 2020; Grenyer et al, 2022) is included. Qualitative research offers more nuanced and client or consumer centred information. Further research and development of consumer programs with peer supporters is needed.

Chapter 3

Clients with BPD are routinely medicated and lack access to therapeutic treatment and recovery programs, despite therapy being the acknowledged best practice treatment for BPD (Feinstein, 2022). The purpose of this paper is to explore common factors in group therapy for clients with BPD dynamics. This paper is intended to encourage organizations to offer group therapy for clients with BPD dynamics. It is also intended to demystify BPD for therapists and to encourage them to consider training to provide individual and group therapy for clients with BPD dynamics.

Through this exploration of common factors, we can see the organizing principles of hope, trust, and purpose, which function as non-linear stages of recovery for clients with BPD dynamics. The stage of hope includes hope for recovery, diagnosis (official or self-identified) with psychoeducation, validation, and normalization. The stage of trust includes therapeutic alliance or group cohesion, mentalization or awareness of self and other and relational skills. The stage of purpose includes other-focus rather than self-focus, resilience and directness.

Themes of trauma informed practice (Fisher, 2009), recovery rather than treatment (Barr et al, 2020) and qualitative research rather than quantitative research (Bond et al, 2019; Ditlefsen et al 2021) emerged through this literature review. Trauma informed approaches are appropriate given that there is a high correlation between developmental trauma and BPD (Jowett et al, 2020; Porter et al, 2020). The concept of recovery shifts control from health professionals to clients themselves (Bond et al, 2019; Grenyer et al, 2022). A recovery-based program addresses the long-term nature of BPD dynamics, is holistic, person-centred and encourages clients to build their capacity and resilience (Grenyer et al, 2022). These themes represent a significant shift from the hierarchical medical perspective to the consumer experiential perspective.

The medical perspective locates the 'problem' of BPD dynamics in the patient. The consumer experiential perspective considers the ways that trauma, socialization, gender, stigma, race, and class affect a person's coping strategies. When we view BPD dynamics from a developmental trauma lens, we can see that a client is simply using strategies to try and get their needs met (Heller & LaPierre, 2012). This can help us as counsellors to be kind, firm, supportive, boundaried and clear in our work with clients with BPD dynamics (Merced, 2018).

The next section will be a discussion of the research, conclusions, and limitations of the literature review. This review covers a mix of quantitative and qualitative research. These studies cannot be directly compared, however the underlying approach to treating personality disorders or assisting in a client's recovery can inform our own work with personality disorders. While we cannot diagnose, we can be aware of BPD dynamics, of local resources and of our own capacity to work individually or in groups with clients with BPD dynamics. Recommendations for practice and for future research will follow.

Discussion

What are the common factors in group counselling for BPD? We can see that the qualities of hope, trust, and purpose, can function as phases of recovery for clients with BPD dynamics. We will review the common factors grouped according to these qualities of hope, trust, and purpose.

First the hope for recovery must be established. When clients are well-established in the dynamic of crisis, help-seeking, invalidation, anger, and isolation the external forces are strong and internal resources are negative or non-existent. Clients who are unable to locate themselves in the dynamic may be helped by trauma-informed psychoeducation (Fisher, 2009), validation, and normalization (Goldstein, 2020). Hearing about BPD from a peer worker or role model

(Gillard et al, 2015) may be more effective, especially if clients have been sensitized to invalidation and rejection by the medical system (Goldstein, 2020). Sometimes clients are too activated to take in new information, in which case supporting them primarily through validation may be necessary (Fisher, 2009). Clients may have a diagnosis or self-identify with BPD (Gillard et al, 2015). Psychoeducation about BPD can be clarifying, validating, and normalizing (Ditlefsen et al, 2021; Gillard et al, 2015). A client who is curious to know more is in a better place to take in new information.

Second, trust in others and in self must be open as a possibility. Trust includes experiences of relational connection, therapeutic alliance or group cohesion that are meaningful for the client (Ditlefsen et al, 2021). Clients might have a person or pet with whom they have a connection (Grenyer et al, 2022). Grenyer et al (2022) describes how clients with very limited social networks such as this were not doing well one year after psychological treatment for BPD. However, any experience of connection can be a starting point in working with clients with BPD dynamics. What are the qualities of trust that are present in those relationships? The difficulty comes when the relationship may be under strain, as clients try to get all their needs met by only one or two beings. Assessing the client's current social network and the ways that network is or isn't meeting their attachment needs is an important part of the recovery process. Clients who experienced relational or environmental failure as children may have had some attachment needs met in another relationship. The experiential quality of that connection can be useful in the therapeutic process, as a reference point for the felt sense of trust. How is trust present in the client's life at this time? What their experience of that trusted person or pet? The process of mentalization, or awareness of self and other, is part of building trust and relational connection. This stage can be fraught with setbacks, fear of abandonment and splitting. From a trauma

perspective, the client may test the connection very thoroughly before being able to trust. A therapist or facilitator needs to be able to be direct, transparent, able to set boundaries and not take the tests personally. This process helps the client to build their understanding of their own thoughts, feelings and behaviours and the thoughts feelings and behaviours of others. Moments of insight in this process can be very significant for clients and therapists (Gardner et al, 2022). As a client is more able to trust themselves and others, they can mentalize, explore and practice relational skills (Bond et al, 2019). Some treatments, such as the MBT psychoeducational treatment studied by Ditlefsen et al (2021) explicitly describe and discuss mentalization in the first session. Clients who engage with psychoeducation first are less likely to drop out of treatment (Ditlefsen et al, 2021). They are also more likely to recognize the process of mentalization, name feelings and emotions and identify attachment issues (Ditlefsen et al, 2021). At this stage they may ask for feedback or make observations about their own thoughts and behaviours (Ng et al, 2019a; Ditlefsen et al, 2021). They may be cautiously curious about the effects they have on others and more motivated to share their internal process (Goldstein, 2020). At this stage trust is well-established (though never permanent) and relational learning may be happening in all kinds of communications, even appointments with the medical system. Clients sometimes become great investigators of what's happening in interactions with others. Providing a safe place to explore these findings and offering praise for examples of courage, emotional intelligence, skills, and abilities is very useful at this stage (Bond et al, 2019). Clients are increasing their sense of agency and curiosity from a place of trust, rather than acting out their fears. Exploring the role of context can be helpful, for example big feelings might not be welcome at the bank but might be more welcome with a close friend. Boundaries around the

therapist's role in the client's life and the therapeutic process continue to be very important (Merced, 2018, p 246).

Third, the stage of purpose includes other focus rather than self-focus, resilience, and directness. As clients become more familiar with their own feelings, thoughts, and behaviours they may become more aware of and more attentive to others. At this stage exploring relational dynamics, such as 'what happened for you when…?' or 'how did you notice that the other person was sad?' becomes useful (Goldstein, 2020; Grenyer et al, 2022). Clients can explore how they might respond in different situations and make choices about how they would like to respond. Clients may want to check their responses with you, and you can encourage experimentation and transparency. Setbacks (inevitable) can be explored using past examples of coping strategies, and examples of resilience (Bond et al, 2019). Establishing resilience as part of recovery helps to normalize setbacks. As clients progress, we want to encourage resilience, so that setbacks are not as catastrophic. Relational difficulties happen and we can explore the coping strategies that helped, or didn't help, in the past, adding and practicing new ones as needed. This emergent, iterative process, exploring options with non-judgement and curiosity, will support long-term client resilience in recovery (Gillard et al, 2015). The factor of directness may not make the transition from group therapy into the client's life. Directness can feel too close to confrontation to be used on a regular basis. However, occasions that require assertiveness and boundary setting can be used to explore a client's capacity for directness. For example, 'what would it be like for you to say x?' and 'when you say x to me, I feel …'. Having established trust with a client we can use immediacy, transparency, and directness to work through more complex communications or relationships. A long-term therapist's familiarity with the client's history will be useful in exploring the feelings and stories that come up when relational tension arises in the client's life.

This could be seen as the 'maintenance' phase of recovery, when having a long-term person (therapist or peer supporter) to check in with is useful. This kind of longer-term support can help clients to avoid decompensating under stress.

My interpretation of this material was strongly influenced by the first-person quotations in the qualitative research. Many of these quotations resonated with statements I've heard directly from clients. Linking the research to my own experiences with clients helped me to articulate the common factors that are most significant in working with clients with BPD dynamics.

Limitations of the research

Limitations of the research include the specialized nature of much psychotherapeutic diagnosis and research. The DSM is literally a catalogue that quantifies and validates costs for treatments. Specialized trainings and approaches are profit driven. Health authorities spend money to provide specialized approaches and research is designed to prove the effectiveness of each approach. The circular nature of specialized approach programs, research and treatments means that client experiences are often left out of the picture. Clients that are perceived as difficult, that have stigmatized diagnoses are not part of the tidy funding cycle and are often blamed for dropping out of treatment. The experience of BPD is inherently complex and changeable (Merced, 2018). Recovery approaches need to respect and work with this complexity, not try to generalize, and minimize the nuances of each client context. In this late-stage capitalist context in which funding for medical care is increasingly profit-driven it is vital to explore community-based, peer worker led programs that are effective, and consumer focussed (Barr et al, 2020).

Clients with BPD dynamics are frequently medicated despite official recommendations to the contrary (Feinstein, 2022). Therapeutic options for treatment are not the priority when clients are in crisis and seeking help from the medical system. Once the crisis has resolved, it is important that clients with BPD dynamics are connected to a therapeutic program.

The length and strength of therapist / client relationships is explored. The research indicates that longer-term treatments produce stronger, more long-lasting effects (Gillard et al, 2015; Gec et al, 2021). Clients are better supported when therapists are familiar with their history, providing important opportunities for comparing past and present behaviours, strategies, and insights.

Recommendations for Practice

Counsellors can be aware of BPD dynamics; they can provide psychoeducation and validation to clients. Counsellors need to be aware of countertransference and seek extra supervision when working with clients with BPD dynamics (Yalom & Leszcz, 2005; Feinstein, 2022). It is important for counsellors not to work outside of their scope of practice (BCACC, 2023). Counsellors can explore suicidal ideation and self-harm with the informed consent of the client. BCACC (2023) states that there is no duty to report adult risk of suicide or self-harm, but you are protected if you decide to report. Ideally counsellors will have supervision and access their own counselling to build capacity to hold space for clients to discuss self-harm and suicidal ideation (Fisher, 2009; Gardner et al, 2022). The counsellor can also set and hold strong boundaries, perception checking the client's story, building agency, providing praise and encouragement (Merced, 2018). Counsellors can pursue additional training on BPD dynamics, developmental trauma and consider further training to facilitate group therapy.

Organizations can remember that longer programs and/or relationships are more effective for clients with BPD dynamics (Aafjes-van Doorn & Horne, 2022). This might look like ongoing sessions spaced further apart, or the client attends group, then comes back to individual therapist to discuss experiences in group (Buono et al, 2021). A client's route from crisis intervention in the medical system to a therapy program needs to be clarified and improved (Feinstein, 2022). Organizations can apply for funding from the medical system to offer the type of community-based group that is accessible for clients with BPD dynamics.

Recommendations for Future Research

Women are more likely to be diagnosed with BPD (Tedesco et al, 2023; Goldstein, 2020; Woodbridge et al, 2021). Further research on the prevalence of BPD dynamics in men would be useful. The causal role of trauma in BPD has not been verified, longitudinal research is required (Porter et al, p. 16). Developmental trauma research and approaches have proven to be useful in working with clients with BPD dyanamics (Heller & LaPierre, 2012).

Consumer perspective, quality of life and recovery-oriented care (Grenyer et al, 2022; Goldstein, 2020; Ng et al, 2019a; Pickard et al, 202; Gillard et al, 2015) are emerging themes in the literature on psychotherapy for BPD. Consumer perspective is more likely to offer useful information into what matters to clients. Clients are the only ones who can define what quality of life looks like and feels like to them (Ditlefsen et al, 2021). Recovery oriented care addresses the importance of long-term treatment and support for clients with BPD dynamics (Merced, 2018). Clients are more likely to experience hope and trust in relationships in a longer-term framework than a short-term one. Recovery-oriented care that includes peer support also offers a sense of purpose, as clients experience their own growth and healing, they can envision the possibility of helping others, with the peer workers as role models. Qualitative research into client centred,

recovery-based approaches is timely and appropriate given the issues with lack of accessibility to standard psychotherapeutic treatments and the high dropout rates in those programs. Qualitative research into the recovery process, including peer support (Bond et al, 2022) is highlighting significant changes in how BPD dynamics are addressed in treatment. These shifts may be related to the cost and accessibility issues with formal DBT, ST or MT therapies. The shift away from the medical perspective is likely to resonate with clients, especially when the cycle of stigmatization and discrimination against clients with BPD dynamics has been present in the medical system for many years (Day et al, 2018). Further research into consumer perspectives on therapy for BPD will yield more information on program design and hopefully increase accessibility and reduce drop-out rates among group participants. Funding for services is largely tied to success rates. Programs that have lower dropout rates are more likely to receive funding. This could potentially improve program accessibility in the long run.

Further research about therapists' perceptions of group counselling, especially with clients with BPD dynamics would be useful. Research into the training, recruitment and support of group counsellors would be useful (Goldstein, 2020). Further research into BPD recovery, into clients' experience of self-diagnosis and peer BPD group leadership would all be useful.

Conclusions

Clients with BPD dynamics benefit from group therapy. Yet clients with BPD dynamics are frequently medicated, face stigma in the medical systems and often have limited access to group therapy. Addressing the needs of these clients is important.

Common factors in group therapy are visible in both quantitative and qualitative research. Organizations can use common factors to formulate a community-based BPD support group.

Counsellors can support clients with BPD dynamics provided they have extra supervision and set strong boundaries with clients. Counsellors can consider referring clients with BPD to group therapy. They can also consider training to offer group therapy themselves. Though clients with BPD dynamics can be challenging to work with, counsellors who are optimistic, composed, adaptable and resilient (Merced, 2018) will find this work very rewarding.

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