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Clinician gender as a factor of countertransference in the treatment of clients diagnosed with borderline personality disorder

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ABSTRACT

This qualitative study explores the interplay between clinician gender and

experiences of countertransference (CT) in treatment of clients diagnosed with Borderline

Personality Disorder (BPD). The central hypothesis of this study is that constructions of

gender will influence experiences of CT in the treatment of BPD clients, therefore having

a meaningful effect on the therapeutic relationship and clinical treatment. Utilizing

twelve qualitative individual interviews with clinicians who have treated clients

diagnosed with BPD, this study examined clinicians' perceptions of treatment, including

experiences and management of psychodynamic phenomena. The study also explored

clinicians' use of different theoretical and treatment models, their views on the

importance of therapist gender and the need for supervision when working with this

population.

Major findings reveal that gender identity is meaningful in the

countertransference experiences of clinicians treating BPD clients due to the pervading

assumptions and stereotypes held by both clinicians and clients. Findings point to the

need for clinicians to be more aware of transference and countertransference scenarios

that do and do not align with their manifest or traditional gender roles, especially due to

the relationship and identity issues common of BPD clients. Additional findings suggest

that erotic countertransference appears especially difficult for women clinicians treating

BPD clients, whereas men clinicians may need to explore pre-oedipal transference and

countertransference in working with BPD clients.

CLINICIAN GENDER AS A FACTOR OF COUNTERTRANSFERENCE IN THE

TREATMENT OF CLIENTS DIAGNOSED WITH

BORDERLINE PERSONALITY DISORDER

A project based upon an independent investigation,
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CHAPTER I

INTRODUCTION

This qualitative study explores the interplay between clinician gender and

experiences of countertransference (CT) in treatment of clients diagnosed with Borderline

Personality Disorder (BPD). Clinical interviews were conducted to capture the

complicated dynamics influencing treatment through discussion of the following themes:

- Understanding and treatment of BPD clients

- Experiences treating BPD clients including examples of transference, defensive splitting and projective identification, and boundary concerns.

- Feelings or reactions typically experienced when working with BPD clients and how to manage them in and out of session.

- Largest concerns in treating BPD clients

- Clinician gender as it relates to treatment of BPD clients

Psychodynamic literature examines countertransference phenomena to reveal a

clinician's unconscious internal schemas and anxieties in response to their clients.

Attention to countertransference reactions allows clinicians insight into the complicated

dynamics of the therapeutic relationship between clinicians and BPD clients. These

dynamics have been shown to be highly influenced by one's gender identity development

(Kernberg, 2000; Kernberg, Selzer, Koenigsburg, Carr, & Applebaum, 1989).

Literature has revealed gender to be significant in the experiences of clinical

countertransference reporting that women clinicians pay closer attention to pre-oedipal

CT, while men clinicians focus more often on erotic CT (Bernardez, 2004). Clinician gender in regards to transference and countertransference has been found to serve as a significant organizer of a client's response to the therapeutic situation due to the client's ongoing projections of transference paradigms onto the clinician (Kulish, 1993).

Gender differences have also been identified as significant in the treatment of clients diagnosed with BPD (Booth-Butterfield & Booth-Butterfield, 1990; Hoffman, 1977; Jacobs & Warner, 1981; Johnson & Stone, 1989; Maguire, 2004; Narud, Mykletun, & Dahl, 2003). Women clinicians have been found to display more empathetic warmth towards their BPD clients than male clinicians (Hoffman, 1977), which has been associated with deterioration or lack of improvement in PBD clients (Jacobs & Warner, 1981).

The central hypothesis of this exploratory study is that constructions of gender will influence experiences of CT in the treatment of BPD clients, therefore having a meaningful effect on the therapeutic relationship and clinical treatment. Utilizing twelve qualitative individual interviews with clinicians who have treated clients diagnosed with BP, this study examined clinicians' perceptions of treatment, including experiences and management of psychodymanic phenomena. The study also explored clinicians' use of different theoretical and treatment models, their views on the importance of therapist gender and the need for supervision when working with this population.

The results of this study provide qualitative data regarding clinical experiences in the treatment of clients diagnosed with BPD. By being aware of gender, a clinician is better able to understand how his or her beliefs, values and socially constructed attitudes are influencing treatment (Seem & Johnson, 1998). There is no currently published

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literature examining clinician gender as a factor of CT specifically in treatment of BPD clients. Therefore this study hopes to expand current knowledge with exploration of the interactions between clinician gender, CT, and the clinical treatment of clients diagnosed with BPD.

CHAPTER II

LITERATURE REVIEW

This chapter reviews the existing empirical and theoretical literature underlying

the investigation of gender as a factor of clinician countertransference in the treatment of

clients diagnosed with Borderline Personality Disorder (BPD). First the diagnosis of

BPD is discussed including its evolution and current definition. Second, psychodynamic

concepts and phenomena are reviewed and then discussed as central to the treatment of

clients diagnosed with BPD; the most important of these phenomena being clinical

countertransference (CT). The last section of this chapter examines the relevance of

gender in the therapeutic situation.

Borderline Personality Disorder (BPD)

The Diagnostic and Statistical Manual IV (DSM-IV), published by the American

Psychiatric Association, is the most recently revised edition of the American handbook

used worldwide by mental health professionals, researchers, pharmaceutical companies,

insurance companies, and policy makers to categorize and diagnose mental disorders by

symptom criteria (APA, 2000). According to the DSM-IV, it is estimated that 1-2 % of

the U.S. population suffers from BPD and up to up to 30% of people requiring mental

health services have at least one personality disorder, including BPD (APA, 2000;

Dingerfelder, 2004).

Borderline personality disorder first appeared in the DSM-III in 1980 and is currently in the DSM-IV with the following diagnostic criteria: "a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:

- Frantic efforts to avoid real or imagined abandonment

- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

- Identity disturbance: markedly and persistently unstable self-image or sense of self

- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)

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

- Chronic feelings of emptiness

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

- Transient, stress-related paranoid ideation or severe dissociative symptoms (APA, 2000, p. 710).

The inner and outer turmoil encapsulating a persona with borderline personality disorder, coupled with intense vulnerability to fears of separation and abandonment, puts the individual in a constant state of upheaval and at a heightened risk for other mental

health problems, repeated job losses, broken marriages, self-injury, suicide, pregnancies, sexually transmitted diseases, motor vehicle accidents, physical fights, illicit drug use, and inappropriate spending sprees. In the most severe form, clients suffering from BPD will exhibit suicidal threats and behaviors, chronic self-destructive acts, impulsivity, rage, violence, and poly-substance abuse (Mayo Clinic, 2006; Quaytman & Sharfstein, 1997). Research has shown that BPD clients are more likely to have a hereditary predisposition for BPD and a history of child abuse and neglect (Mayo Clinic, 2006).

Psychodynamic Understanding of Borderline Personality Disorder

The term "borderline" was first used by Adolf Stern in 1938 to described a group of clients who did not respond well to treatment or fit into either neurotic or psychotic categories (Linehan, 1993). Stern defined the first set of criteria used to diagnose these clients from developmental, temperamental and environmental perspectives. The character traits Stern isolated to describe this population included:

- narcissism

- psychic bleeding

- inordinate hypersensitivity

- psychic and body rigidity

- negative therapeutic reactions

- constitutionally rooted feelings of inferiority

- masochism

- a state of deep organic insecurity or anxiety

- use of projective mechanisms

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- difficulty in reality testing, particularly in personal relationships (Stern, 1938).

Stern's research led to an etiology of BPD focusing on failures in early object relations. He found that one of three factors contributed to narcissistic issues in at least seventy-five percent of his population of BPD clients. The three factors included having a mother who lacked the capacity for spontaneous affection, coming from an abusive or neglectful family, and an absence of security or self-assurance unless provided by an environmental force (Stern, 1938).

Stern's theories of early object relations failures have been supported and enhanced by such leading theorists as Mahler (1971), Masterson (1972), Kohut (1971), and Kernberg (1984). These works along with current research conceptualizing the etiology of BPD have been condensed by the psychoanalytic community in the Psychodynamic Diagnostic Manual. This manual presents a comprehensive picture of BPD which has been used to supplement the DSM-IV's symptom criteria (PDM, 2006).

The PDM (2006) classifies personality on a continuum from healthier to more disordered functioning and as to the nature of the characteristic ways the individual organizes mental functioning and engages the world. Those who are at the disturbed or borderline end of the spectrum are:

> "People who respond to stress in rigidly inflexible ways… have marked deficits in sense of identity, relations with others, reality testing, adaptation to stress, moral functioning, or affective range, recognition, expression, and regulation" (p.18).

The concept of borderline personality disorder is not only descriptive of symptoms, as presented in the DSM-IV, but from a psychodynamic perspective is

structural, meaning within the structure of the human psyche (Kernberg et al., 1989).

Psychical structural hallmarks of BPD are:

- identity diffusion

- primitive level of defensive operations, such as splitting, denial and projective identification

- a capacity for reality testing (Kernberg, et al., 1989; PDM, 2006).

Identity diffusion is defined as "the lack of integration of the concept of self or significant others" (Kernberg et al., 1989, p. 5). In work with BPD patients clinicians recognize identity diffusion by a patient's contradictory behaviors, perceptions of self and others, and the client's subjective experience of chronic emptiness. Due to the lack of integration of self and other, BPD clients are under constant threat of self fragmentation (Kernberg et al., 1989; Spurling, 2003). Spurling (2003) notes that "characteristically, such a person will cling to others in order to take on an identity given by the other person, but then feel threatened and invaded by the other and have to violently withdraw" (p. 27). The sense of self is rapidly changing which often leads to frequent changes in jobs, friendships, goals, values and gender identity. They have unstable and distorted self-images usually characterizing themselves as worthless, damaged, or fundamentally bad (Mayo Clinic, 2006). Because of these diffused behaviors a clinician may find this client difficult to empathize with (Kernberg et al., 1989).

Defensive splitting refers to the clients' division of self and others into "all good" or "all bad". This splitting results in drastic and sudden changes in one's views. In relationships BPD patients abruptly shifts from idealization to devaluation of the other without tolerance for gray areas, making a relationship with a BPD client difficult to

manage. When a BPD client is idealizing the clinician, it is done in a pathological way that there is no room for a clinician's human flaws. Soon, however, the BPD client will dramatically shift this perception to one of devaluation, viewing the clinician as persecutory and dangerous. The client views herself as grandiose in relation to a devalued other (APA, 2000; Kernberg et al., 1989; Mayo Clinic, 2006).

Projective Identification is when a client experiences an impulse, projects it onto the clinician, and then fears that impulse from within the clinician. The client then elicits behaviors in the clinician that validate the projection and fears (Eagle, 2000; Kernberg et al., 1989). Denial is a defense typically used by BPD clients where there are emotionally independent areas of consciousness. Despite being aware of contradictions in perceptions, thoughts, and feelings regarding themselves and others, BPD clients are unable to integrate this information with emotional relevance in a way that would influence a current state of mind (Kernberg et al., 1989).

The primitive defensive structure of borderline personality disorder works to protect the individual's vulnerable self from such contradictory experiences by employing the defenses of splitting, denial, and projective identification. Because of the reliance on these defenses the client suffers from a pervasive sense of confusion between self and other (Kernburg et. al., 1989; Spurling, 2003).

Treatment of Borderline Personality Disorder

The difficulty of conceptualizing and treating BPD has been a major challenge and area of debate among clinicians and researchers (Goldstein, 1990). The debate seems to be based on the theoretical understandings of the disorder and whether or not to adopt a behavioral or psychodymanic treatment perspective. Psychodynamically focused

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treatments such as Transference Focused Therapy (TFT) work to change a client's internal defensive structure and internalized object relation whereas behavioral treatments such as Cognitive Behavioral Treatment (CBT) and Dialectical Behavior Therapy (DBT) focus on behavior changes and symptom reduction.

Psychodymanic theorists, following Stern, were also aware of failures in treatment for BPD clients. The PDM distinguished between treatment styles for neurotic versus borderline individuals, stating that borderline clients "often fared badly in the kinds of treatment that usually help neurotic individuals, especially as they would unexpectedly develop intense, problematic, and often rapidly shift in attitudes toward their therapists" (PDM, 2006, p. 21).

Due to the regressive and self-destructive tendencies of BPD clients clinicians found that the unstructured nature of psychodynamic treatment, which emphasizes childhood memories, dreams, and fantasies, tended to activate rather than reduce pathology (Goldstein, 1990). It is recommended that therapy with BPD clients is best when consistent, active, structured, affectively expressive, and focused on the here and now (PDM, 2006).

Research suggests applying skilled relationship management to the therapeutic dynamic taking into account the client's "extreme anxiety, intense reactivity, potential for disorganizing regression, lack of self- and object constancy, and the profound fears that coexist with their deep need for attachment" (PDM, 2006, p. 28) while providing clear limits and structure (PDM, 2006; Wheelis & Gunderson, 1998). This complicated management requires support, interpretation, limits, and directives from the clinician in

the right combination. Interventions at the wrong time can be disastrous to the relationship between a clinician and a BPD client (Wheelis & Gunderson, 1998).

 However, BPD clients who are closer to the psychotic end of the spectrum tend to require supportive therapy, identifying and building on client strengths. Therapy must be authoritative to provide enough safety for this type of client (PDM, 2006).

Marsha Linehan (1993), who developed the evidence-based Dialectical Behavior Therapy (DBT) treatment for clients diagnosed with BPD, theorizes that a biological vulnerability to emotional dysregulation coupled with an "invalidating environment" over time creates and maintains borderline behavior patterns. In DBT treatment BPD clients are taught the skills to recognize connections between behaviors, thoughts, and emotions. The role of the DBT therapist is to maintain a balance between total acceptance and validation of the client while encouraging the client to change.

Harley, Baity, Blais and Jacobo (2007) report that clients who completed DBT skills group treatment showed significant improvement in symptoms of BPD, depression, and suicidal ideation. However, more than half of BPD clients dropped out of the group, whereas clients in individual therapy were significantly more likely to complete group therapy. They conclude that DBT skills group will be most beneficial if the client is also receiving non-DBT individual therapy.

Treatment Challenges for Clinicians Working with BPD Clients

Despite the theoretical understanding of BPD or the treatment style, clinicians agree that there are a number of therapeutic challenges working with this population. These challenges most commonly revolve around boundary issues, self-doubt as a clinician, clients' negative reactions, especially hostility and anger, and transference and

countertransference issues (Ganzer & Ornestein, 2002; Hoffart & Friis, 2000; McIntyre & Schwartz, 1998; Shaw, 2002; Spurling, 2003; Wheelis & Guderson, 1998). Spurling (2003) reports that a clinician's ability to stay in the role of counselor is constantly being tested and attacked by a borderline client which triggers clinicians to act out against their clients.

Clients diagnosed with BPD have been described by mental health professionals as manipulative, explosive, hostile, dominating, and a constant challenge to work with (McIntyre & Schwartz, 1998; Spurling, 2003). Whereas neurotic individuals are regarded for their own suffering, personality-disordered individuals tend to cause suffering in others (PDM, 2006). It is likely that a BPD client will react to the clinician in limitless and often less-than human ways. This can leave the therapist feeling dominated and paralyzed. Spurling (2003) states that:

> The counselor will be modeled on various attributes of the unhelpful or actively hostile or abusive objects which populate the client's internal world. Hence for periods of the work the counselor's identity as a helpful, understanding and nurturing figure will be under severe attack. (p. 36)

Linehan (1993) however, disputes the "so called 'manipulative' behavior as part of the borderline syndrome" (p. 16). In her experience, Linehan finds that a borderline client is more likely to be direct and forceful but not shrewd. Borderline clients are known for their influence over others through the use of parasuicide or threats of suicide. There is debate over whether or not borderline clients "use these behaviors or communications to influence others artfully, shrewdly, [or] fraudulently" (Linehan, 1993, p. 17).

Wheelis and Gunderson (1998) provide an example of what it is like for a clinician to work with clients diagnosed with BPD. The beginning phase of treatment is characterized by "problems of suicidality, substance abuse, missed appointments, silences, intersession contact, rage, and self-destructive behavior" (p. 122). The therapist needs to be able to withstand the client's anger and acting out without accepting rude, abusive, or unsafe behavior directed towards the clinician (Wheelis & Gunderson, 1998). However, by the end of the first year of treatment the client should be aware of dependence on the therapist with a perception that that is acceptable, and by the second year a clinician should expect sufficient stability in the BPD client's life.

The clinical literature describing psychoanalytic/psychodynamic individual therapy for patients diagnosed with BPD reports difficult transference and countertransference aspects of treatment (APA, 2000; Lecours, Bouchard & Normandin, 1995; Spurling, 2003). It is recommended that clinicians be alert to these dynamics with BPD clients and seek consultation with a colleague, especially if there is a risk for a potential boundary violation (APA, 2000). Some theorists imply that all cases of PBD would be treatable if the clinician could be aware of, address, and adequately work through countertransference (Ganzer & Ornstein, 2002).

Clinical Countertransference (CT)

Clinical Countertransference (CT) is regarded as an abstract and multifaceted phenomenon developed out of psychodynamic theories. Research of the phenomenon proves difficult due to the complexities of its subjective and unconscious nature. Hedges (1992) postulates that a lack of data may also be due to clinicians' fear of exposure and

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scrutiny. Despite the lack of empirical data the CT phenomenon continues to be examined in psychodynamic literature (Hoffart & Friis, 2000).

Freud (1958/1910) published the first literature describing the phenomenon of clinician countertransference as a direct reaction to the client's unconscious anxieties. Freud viewed CT as negatively affecting treatment and his understanding of the client. However, contemporary theory has expanded the conception of CT as a joint creation between clinician and client, where both individuals are bringing their experiences, world schemas, and unconscious anxieties into the room (Kernberg et al., 1989).

Contemporary thought divides countertransference into either subjective or objective categories. The subjective aspect of CT is understood to be a clinician's reaction to a client based on their own unresolved conflicts and anxieties. In contrast, the objective aspect of CT is the clinician's reactions evoked by a client's behavior (Kernberg et al., 1989). Subjective CT is viewed as negatively affecting the therapy, whereas objective CT, if properly examined, can be helpful to the therapeutic process (Ligiero & Gelso, 2002).

CT reactions can be feelings and behaviors. CT based behaviors have been identified as either positive or negative (Friedman & Gelso, 2002; Ligiero & Gelso, 2002). Positive behaviors are ones that seem friendly or supportive towards clients and are "as natural as the love of parents for their children" (Burnat & De Urtubey, 2004). Negative behaviors, conversely, are defined as destructive behavior, such as criticizing, punishing and rejecting the client. Both of these reactions serve the clinician's needs in avoiding client material, which consequently affect the therapeutic relationship and working alliance in an unconstructive way. The positive side is rarely studied and the

authors have noted that more research needs to be done in the area (Friedman & Gelso, 2002).

Clinicians have been found to be often unaware of their erotic countertransference, which is responsive and complementary to client transference and sometimes antedates the appearance of the erotic transference (Burnat & Urtubey, 2004). Knowledge of countertransference is helpful in treatment in order to attaining knowledge of a client's personality and emotional state (Slakter, 1987) and may even be important for a positive therapeutic outcome (McIntyre & Schwartz, 1998).

Clinical Countertransference with BPD Clients

The PDM (2006) reports that the "borderline client's nonverbal behavior and the therapist's countertransference reactions give more useful information than the patient's verbalizations" (p. 28) and should therefore be thoroughly examined. Research suggests that clinicians' countertransference reactions evoked towards BPD clients differ from clients diagnosed without personality disorders (McIntyre & Schwartz, 1998; PDM, 2006). The PDM (2006) uses the term "psychotic transference" (p.21) to describe the type of transference experienced by a personality disordered person in contrast to the transference of less disturbed or neurotic level client. With borderline clients there is a danger that the transference will become real, rather than symbolic, causing a fragmentation of self and loss of reality-testing (PDM, 2006; Spurling, 2003). However, "even if transference does not become psychotic, its intensity makes it hard to bear" (Spurling, 2003, p. 30).

Conflicts will arise in the therapeutic relationship that match the patient's defensive structures of BPD. In the clinical setting, the "splitting" phenomenon may be

evident in a patient's polarized but alternating views of the clinician as idealized (i.e., "all good") or devalued (i.e., "all bad"). When a BPD client perceives primary clinicians as "all bad" (usually prompted by feeling frustrated), s/he is at risk for flight from treatment. APA guidelines (APA, 2000) recommend that "when splitting threatens continuation of the treatment, clinicians should be prepared to examine the transference and countertransference and consider altering treatment" (p. 21).

BPD clients often shift dramatically between idealization and devaluation of the therapist, prompting emotional reactions from the therapist. During devaluation a clinician unconsciously defends against feelings of professional failure or inadequacy, often reacting with strong feelings such as hatred, annoyance, or boredom towards the client. By putting such a strong focus on the clinician, the client is able to keep his or her deficits out of the limelight. A clinician may be tempted in this situation to underestimate the client's severity of distress and to decrease attention to boundary issues, which are essential to work with BPD clients.

Boundary violations are defined as egregious and potentially harmful transgressions of the therapeutic contract and framework and abuse of the clinician's power (Bridges, 2005; Gabbard & Lester, 1995). The APA guidelines (2000) specifically discuss boundary violations in treatment of BPD clients. Due to specific transference-countertransference enactments, which are at a high risk for occurring with clients diagnosed with BPD, a clinician may be called on as a pseudo-parent to provide the love the client missed from parents. The DSM-IV reports:

> "Therapists may have rescue fantasies that lead them to collude with the patient's wish for the therapist to offer that love. This collusion in some cases leads to

physical contact and even inappropriate physical contact between therapist and patient" (APA, 2000, p.22).

McIntyre and Schwartz (1998) report that clinicians tend to either be oversympathetic to BPD clients, viewing them as weak and deprived of love and attention, or to be overly harsh and punitive, perceiving them as demanding, manipulative, hostile, and in need of strict limits. This dramatic split in treatment and perception of BPD clients may demonstrate a countertransference reaction to the unconscious splitting behavior demonstrated by BPD clients. Research describes a similar clinical split in inpatient settings where clinicians are often heatedly divided in their opinions on how best to treat those diagnosed with BPD; clinicians later realize their conflict was actually one that the patient was deeply struggling with (Quaytman & Sharfstein, 1997).

Shaw (2002) discussed countertransference with clients who self-injure. These clients are typically diagnosed with personality disorders, notably BPD. When working with clients diagnosed with BPD it is likely that the clinician will be confronted with self-injurious behaviors, such as cutting or burning, since this is part of the DSM-IV criteria for the disorder. Despite rationale for such behaviors, many health professionals consider self-injurious behavior to be attention-seeking or manipulative, which provides a pejorative view of the client (Linehan, 1993; Shaw, 2000). Viewing a client's behavior in this way may have negative effects in the therapeutic relationship, especially in regards to countertransference reactions.

Management and Supervision of Clinical Countertransference

Winnicott (1949) argued that it is essential for the clinician to "be thoroughly aware of the countertransference [so] that he can sort out and study his objective reactions to the patient" (p. 70). It is essential for a clinician to tolerate and work with the transference in a way that provides for a much needed container to hold and process a client's therapy. If a clinician cannot find a container for the countertransference reactions, those feelings will determine the treatment in a negative way (Spurling, 2003; Winnicott, 1949).

Winnicott (1949) talked about a clinician's love, hate, and fear and argued for self-disclosure of countertransference. He stated that in certain cases a client actually seeks the clinician's objective hate as a way to obtain objective love, since one cannot exist without the other. The disclosure of hateful feelings actually protects the therapist from acting on these feelings towards the client. It is therefore essential that clinicians recognize and work with countertransference sentiments of hate, anxiety, and vulnerability to help clients to better control these feelings. By speaking about those feelings, the clinician and client are less likely to act them out, while at the same time they are strengthening the therapeutic attachment (Curtis, 1999).

Research reveals that clinicians will be less reactive to countertransference in a way that disrupts treatment if they are able to manage it through supervision or group consultation (APA, 2000). Appropriate management of intense feelings in both patient and therapist is a cornerstone of good psychotherapy. Spurling (2003) suggested that self-knowledge and self-exploration are essential to containing the therapeutic relationship and should be acquired in personal therapy. Consulting with other clinicians,

enlisting the help of a supervisor, and engaging in personal psychotherapy are useful

methods of increasing one's capacity to contain these powerful feelings (APA, 2000;

Spurling, 2003).

<center>*Gender in the Clinical Situation*</center>

The interaction between client and therapist is central to psychodynamic therapy;

therefore research has attempted to understand how clinician characteristics, including

gender, have affected therapy with BPD clients. Dent (1978) hypothesized an

"interaction effect" through observation that some therapists were effective with certain

clients while others were not. Research has shown that a number of clinician factors,

including gender, have an affect on the therapeutic relationship between clinician and

client. Other factors shown to have an affect of the therapeutic relationship include

clinician age, education, experience, depression, and empathetic warmth (Jacobs &

Warner, 1981; Lecours et al., 2003; Masterson, 1983; Narud et al., 2003; Spurling, 2003).

Gender is a social construct that divides people into categories of men and women

that are assumed to derive from their biological sex of male and female. A person's self-

concept of his or her gender, regardless of sex, is termed one's gender identity. When

gender identity differs from biological sex the person is identified as transgendered (Lev,

2004). Gender and gender role are "learned and achieved at the interactional level,

reified at the cultural level, and institutionally enforced via the family, law, religion,

politics, economy, medicine, and the media" (Gagné, Tewksbury & McGaughey, 1997, p.

478, as cited in Lev, 2004) and "expressed in a variety of ways, including clothing,

mannerisms, grooming or adornment habits, voice inflection, and social interests" (Lev,

2004, p. 84).

Western culture prescribes gender roles expecting men to be "independent, logical, objective, active, competent, and instrumental" (Lev, 2004, p. 85). Women are assumed to be "passive, dependant, emotional, warm, expressive, and nurturant" (Lev, 2004, p. 85). Gender roles assigned to women are considered less mentally healthy and have been found to be valued less by both men and women. These differences always privilege men, creating an androcentrism assuming women to be "the other" (Lev, 2004). Research exploring clinician gender has found women clinicians to be more relational, affective, and empathetically oriented, where as men are thought to be more instrumentally and rationally oriented (Booth-Butterfield & Booth-Butterfield, 1990; Hoffman, 1977; Johnson & Stone, 1989; Lecours, et al., 1995).

Gender and Clients Diagnosed with BPD

Literature debates the impact of gender power inequalities within the therapeutic setting and how the sex of the therapist and client respectively impact on the transference and countertransference. Feminist literature has highlighted the influences of historical and cultural factors behind the formation of sexual and gender identity (Maguire, 2004).

Most clients diagnosed with BPD are women; therefore it is hypothesized that stereotypes of women are more heavily applied to BPD clients than to other clients seeking treatment (Barrett, 2000). The traditional gender role prohibition against female anger, criticism, rebellion, domination, and aggression has been demonstrated to be affectively conflictual for clinicians of both genders (Bernardez, 1987), which may be significant given that clients diagnosed with BPD tend to display frequent displays of inappropriate and intense anger (APA, 2002).

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Clinician gender has been found to be a significant factor in treating clients

diagnosed with BPD. Women clinicians have been found to display more empathetic

warmth towards their BPD clients than male clinicians (Hoffman, 1977), which has been

associated with deterioration or lack of improvement in PBD clients (Jacobs & Warner,

1981). Narud et al. (2003) found that women clinicians had experienced significantly

more suicides among personality disordered clients than men clinicians, though there is

no discussion as to what accounts of this outcome. They also found that women

therapists reported hearing more complaints from colleagues concerning treatment with

BPD clients.

Kulish (1993) investigated clinician gender in relations to transference and

countertransference and concluded that gender serves as a significant organizer of a

client's response to the therapeutic situation due to client's ongoing projections of

transference paradigms onto the clinician. It is hypothesized that clinicians unknowingly

and inevitably apply society's traditional understanding of gender to BPD clients (Abrams

& Curran, 2004).

Women Clinicians Treating Women Clients

Kulish & Holtzman (2003) studied the positive and negative effects of women

clinicians treating women clients and found that women clinicians can foster positive

feminine identifications for women clients who may be lacking such models. However,

on the negative side, Kulish wrote "celebration of the beneficial effects of reworking

separation themes between women may obscure other issues" (p. 566). She also noted

how women clinicians often miss or misinterpret 'oedipal' and/ paternal transferences and

that:

Female analysts respond defensively to the competition and envy of their female patients and often resist being seen as the rival 'oedipal' mother. Instead they tend to get involved in or lost in earlier pre-oedipal mother-daughter issues and often become too merged or over-identified with their patients. They become 'too maternal' and overprotective, warned of another pitfall in this dyad, in which patients and analyst collude in idealized 'good' mother transference, often erotized. The bad mother image is split off and displaced on a person outside the therapeutic situation, male or female…this picture may mask unrecognized erotic oedipal father transferences (pp. 566-567).

Bernstein (1991) warned that it might be too easy for a woman to identify with another woman's hostilities toward men rather than analyze them. Bernstein (1991) also highlighted the competitiveness in the female analyst toward the patient and the patient's mother. By insisting how bad the original mother is may hide fare more threatening erotic, loving feelings toward their mothers that both analyst and patient fear. Eastwood (1991) found that certain women clients deal with issues of sexuality, reproduction, aggression, and dependence in ways that may generate intense reactions in their women clinicians.

Bernardez (1987) reported that women therapists' gender role biases, their view of their own gender restrictions, and their relationships with their mothers are important considerations for the therapeutic process.

Men Clinicians Treating Women Clients

Literature reveals that male analysts may foster traditional sex roles and replicate patriarchal power structures and may unwittingly foster unhealthy compliance on the part of their women clients. While assuming the paternal role man clinicians may keep their women clients in an oedipal dynamic or paradoxically infantilize them (Kulish & Holtzman, 2003; Lerner, 1980). Person (1983) wrote that the male analyst may

unconsciously encourage gendered behaviors in their women clients to boost and protect

his ego.

There is evidence that male clinicians are more vulnerable to acting upon strong

erotic countertransference than women clinicians (Gabbard & Lester, 1995; Kernberg,

1995). Literature reveals that sexual boundary violations occur most frequently between

male clinicians and female clients (Dahlberg, 1970; Butler & Zelen, 1977).

Clinicians Treating Clients of the Opposite Gender

Literature reveals that differences in cross-gender transferences that seem to

adhere to the manifest gender of the clinician were the result of countertransferences, or

intolerances for cross-gender transferences depending on the clinicians comfort in

experiencing themselves in the guises of the opposite sex (Goldberg & Evan, 1985;

Goldberg & Holmes, 1993; Raphling & Chused, 1988). Kulish (1989) writes that

'oedipal' transference usually materializes along the lines of the manifest gender of the

clinician, with the feelings toward the opposite sex being played out in displacement.

Literature reports that women clinicians may have difficulty experiencing

themselves as the 'oedipal' father, with paternal and erotic transference being most

problematic. Men clinicians may be uncomfortable experiencing himself as the 'oedipal'

mother (Bernardez, 2004; Kulish & Holtzman, 2003). Kulish & Holtzman (2003) discuss

a negative 'oedipal' transference where a woman client has sexual fantasies about her

women therapist, which may add another layer of difficulty to the countertransference.

There is evidence that clinicians encourage the development of gender-consistent

transferences. Women clinicians describe transferences pertaining to oral issues,

especially with their women clients, and less often recognize oedipal material than men

clinicians. Men clinicians were found to be more sensitive to competitive oedipal issues,

especially with men clients (Kulish & Mayman, 1993). It has been found that women

clinicians tend to avoid countertransference to a client's erotic or 'oedipal' transferences

where men clinicians tend to me more aware of erotic transference and may err in the

direction of seductiveness in the countertransference. Lack of attention to 'oedipal'

transference and countertransference may lead to infantilization, pre-oedipalization or

cultural stereotyping of women, which hinder the effectiveness of treatment (Kulish &

Holtzman, 2003).

Other Clinician Characteristics

Research has shown that, in regards to age, younger clinicians reported

experiencing more violations of treatment contracts and needing more supervision. Older

therapists more often found contraindications for psychotherapy when working with these

clients (Narud et al., 2003). How age of the therapist relates to countertransference

reactions is unknown at this time.

Experienced clinicians were found to feel that they established a more stable

alliance with their BPD clients than less experienced clinicians. They also had more

ambitious therapeutic aims and were willing to take on clients with complicating

substance abuse. Less experienced clinicians more often found contraindications for

treatment (Narud et al., 2003). McIntyre and Schwartz (1998) found that as years of

experience increased the degree of countertransference decreased.

Summary

Countertransference phenomena reveal a clinician's unconscious internal schemas and anxieties, which are highly influenced by one's gender identity development (Kernberg et al., 1987), in response to their clients. It is therefore hypothesized in this study that constructions of gender will have an effect on how countertransference is experienced in treatment of BPD clients, where gender has been already been found to be a significant variable.

There is no currently published literature examining clinician gender as a factor of CT specifically in treatment of BPD clients. This study attempts to fill that gap in knowledge by investigating clinician gender as a variable of clinician countertransference in treating clients diagnosed with Borderline Personality Disorder (BPD). The following chapter outlines the methodology used to investigate the research question.

CHAPTER III

METHODOLOGY

Research Design

This study is an exploration of gender as a factor of countertransference for clinicians treating clients diagnosed with Borderline Personality Disordered (BPD). In particular, this study investigated five themes,

- Understanding and treatment of BPD clients

- Experiences treating BPD clients including examples of transference, defensive splitting and projective identification, and boundary concerns.

- Feelings or reactions typically experienced when working with BPD clients and how to manage them in and out of session.

- Largest concerns in treating BPD clients

- Clinician gender as it relates to treatment of BPD clients

An exploratory research design was implemented to provide flexible, descriptive and qualitative data examining clinician countertransference in working with clients diagnosed with BPD. Qualitative data regarding clinician experiences of borderline clients in therapy was collected through in-person interviews with both men and women clinicians. Literature reveals both countertransference and gender as important factors in the treatment of Borderline Personality Disorder with the conclusion that more research is needed to understand these factors in relations each other. Therefore, questions eliciting responses regarding countertransference and gender were included in the interview guide.

Sample

The sample population consisted of clinicians from two community counseling centers in Central Massachusetts. Participants from these two centers were recruited as a sample of convenience through flyers posted in the agencies and distributed in clinicians' mailboxes (Appendix B). Participants were also recruited at staff meetings and via phone messages using the recruitment points set forth in Appendix C. The researcher identified the sample by collecting names and numbers of clinicians who expressed an interest in participation in the study through responding to the flyers, staff meeting presentations or phone calls.

Inclusion criteria for participants required that clinicians have credentials as an LICSW, LCSW, or LMHC, and have treated clients diagnosed with Borderline Personality Disorder in individual therapy for at least a year at the time of study recruitment. The sample included 12 clinicians, 3 men and 9 women. The researcher made efforts to obtain a diverse sample of clinicians in terms of gender, experience, and age, though availability of such was not achieved. Despite efforts to obtain equal number of men and women clinicians, the sample holds a majority of women participants. Racial and ethnic diversity were almost impossible to achieve within the agency settings where recruitment took place.

Data Collection

Following the Smith College School for Social Work Human Subjects Review Committee's approval (Appendix A) the researcher identified eligible participants and contacted them via phone to schedule individual interviews with each participant at a

mutually a convenient time and location. Interviews were conducted in clinical office

space due to sensitivity of material discussed and confidentiality needs.

The structure of the interview included the researcher reviewing the nature of the

study, obtaining informed consent (Appendix D) from the participant, and asking

participants to complete a demographic data sheet (Appendix E). After signing the

consent form and providing demographic information, the interview process began with

the participant being given a copy of the interview guide (Appendix F) to follow along as

the researcher asked each question. Each interview took approximately thirty minutes to

complete. After each interview, as a thank-you for their participation, clinicians were

given a $5 Dunkin Donuts gift card and a stress ball. Each interview was tape recorded

for later transcription, with the permission of respondents.

Ethical Considerations

Participant identities were protected by assigning code names to each respondent.

All data (tapes and transcripts) were stored in a secure place. Consent forms were kept

separate from completed interviews and tapes. Data and tapes will be kept secure for

three years as required by Federal regulations and after that time, they will be destroyed

or continue to be kept secured as long as needed. When no longer needed, data will be

destroyed.

Data Analysis

The interviews were digitally recorded during the interview process through the

use of audio recording equipment. The recorded data was then transcribed by the

researcher. After the interviews were transcribed, data from participant responses were

coded and grouped according to the specific topic areas outlined by the semi-structured

interview guide. Open and axial coding were used to categorize data according to established qualitative data analysis methods (Anastas, 1999).

Research Plan Strengths and Limitations

The strengths of this study include the researcher's access to clinicians who conduct individual therapy with clients diagnosed with borderline personality disorder. Data were collected in person in an interactive way that allowed for participants and researcher to ask for clarification during the interview.

Limitations of the study include the convenience sample used in recruitment of participants. Those who showed interest in participation may have had differing experiences working with clients diagnosed with borderline personality disorder than those who refused or showed no interest in participating, which may indicate a bias in the study. There were also limitations with the regard to the diversity of the sample, as noted above. Generalizability of the findings is limited by the lack of diversity and the small sample size. Findings from the 12 study participants are detailed in the following chapter.

CHAPTER IV

FINDINGS

The purpose of this study was to explore gender as a factor of clinical

countertransference for clinicians treating clients diagnosed with Borderline Personality

Disordered (BPD). This study attempted to investigate this question by focusing on the

following themes:

- Understanding and treatment of BPD clients

- Experiences treating BPD clients including examples of transference, defensive splitting and projective identification, and boundary concerns.

- Feelings or reactions typically experienced when working with BPD clients and how to manage them in and out of session.

- Largest concerns in treating BPD clients

- Clinician gender as it relates to treatment of BPD clients

This research will be presented in sections beginning first with participant

demographic characteristics summarizing age, gender, race/ethnicity, clinical licensure,

and years of experience working with clients diagnosed with Borderline Personality

Disorder. Subsequent sections of the findings are presented in accordance with the

interview guide starting with clinical understanding and treatment of BPD clients,

psychodynamic principles and phenomena, clinical countertransference, clinical

concerns, and finally gender.

Demographics

Twelve clinicians participated in this study (n=12), including three men and nine women. All participants identified as Caucasian and worked as outpatient clinicians at two outpatient mental health clinics in Central Massachusetts. They ranged in age from 29-72 years, with a mean age of 53 years; one participant declined to answer (n=11). Eight participants were licensed as LICSW (Licensed Independent Clinical Social Worker), three were LCSW (Licensed Clinical Social Worker, and 1 was LMHC (Licensed Mental Health Clinician). All participants had at least one year of individual counseling experience with clients diagnosed with Borderline Personality Disorder. Years of experience ranged from 4- 50 years, with a mean of 19 years of experience.

Understanding and Treatment of Borderline Personality Disorder

Participants discussed an understanding of borderline personality disorder focusing on the DSM-IV criteria and psychodynamic theory and concepts. Participants appeared to conceptualize borderline personality disorder a number of ways highlighting intensity of moods, especially anger, instability in relationships, disturbances in identity, fear of abandonment, reality testing, trauma history, pain and suffering, substance abuse, ambivalence about and resistance to treatment, and client strengths. They also shared how they work with these clients in treatment.

Responses also included descriptions of BPD psychodyanamic principles and phenomena in understanding clients diagnosed with BPD including transference, countertransference, intense and primitive ego defenses including splitting, merging, projection and projective identification. Boundary issues were cited as concerns as were

self-harm behaviors, diagnosis concerns, and gender issues. Findings regarding

clinicians' understanding of BPD are presented according to the themes identified below.

Mood Instability

Mood instability was reported by 6 of the 12 (1 man, 5 women) participants as a

primary factor in understanding clients diagnosed with borderline personality disorder.

Ms. Black said "they're volatile in their emotions so within the space I just had an

example this morning of weeping, wailing, shouting, crying, anger, rage and all kinds of

emotions express in a very short period of time."

Four participants (2 man and 2 women) reported helping clients identify and label

feelings and triggers as a goal of treatment. Six participants (3 men and 3 women)

reported that helping BPD clients develop coping skills to manage extreme emotions was

a major goal in treatment.

Anger and Aggression

Four participants (2 men and 2 women) spoke of extreme anger and aggression as

characteristics of borderlines they treated. Both women spoke of their BPD clients

making threats on several occasions. Mr. Orange described this characteristic in his

borderline clients as "inherent rage that's never satisfied, it's never been resolved; it will

always come out towards someone who's in a position of authority."

Mr. Purple described his borderline clients to be aggressive and hostile at times

and described retaliatory behavior of a male client diagnosed with BPD:

> He prided himself in taking advantage of people, getting the best of you, law
> suits, filing law suits against people who mistreated him, it could be a store clerk,
> it could be Filenes, his response to events would be to challenge it, to attack it.

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Unstable Interpersonal Relationships

Eight participants (3 men and 5 women) mentioned difficulties in relationships as being a primary issue in the lives and treatment of their BPD clients, which included the building and maintenance of a trusting and safe therapeutic relationship. These participants described clients as alternating between idealization and devaluation, seeing everyone as either good or bad. Ms. Yellow stated:

> The main issue that I usually think of with borderline personality disorder is about rigid thinking. Their thinking is black and white…they are about extremes and it makes it obviously very difficult because so many things that come into life and mental health are gray…the conflict is really profound…they also project strongly those images onto people…so if you're all good, that's where your at, but you can anticipate that you're going to be bad at one point in time.

Two women participants reported that building a therapeutic relationship is a long phase of treatment, but eventually this issue becomes less prominent as trust builds and treatment progresses. Three participants (1 man and 2 women) reported that consistency in treatment is essential in building a trusting and safe therapeutic relationship.

Identity Disturbance

Five out of twelve participants (3 men and 2 women) cited identity disturbance as a major deficit in borderline functioning. Ms. Gray said of her BPD client "she had no sense of identity, including sexual, whether she was gay, straight, or bi and what happened was she developed an erotic transference to me. Participants talked about clients lacking an identity and use psychodynamic concepts to illustrate this deficit. Mr. Orange said:

> If a borderline truly takes a look at themselves, they're frightened because there isn't that much to see, there's not much substance to hold on to because they really don't know who they are after all is said and done.

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Three participants (2 men and 1 woman) mentioned narcissistic qualities in their BPD clients.

Three participants (2 men and 1 woman) agreed that identity work is a major goal of treatment in their work with all borderline clients. Ms. Gray stated "don't define them. Our work is for them to make meaning of who they are, their experience, how they're affected today."

Fear of and Desperate Attempts to Avoid Abandonment

Four (2 men and 2 women) of the twelve participants described a borderline's fear of abandonment and desperate attempts to avoid being abandoned. Ms. Yellow said:

> They're terrified of abandonment, of driving everyone away 'cause they feel that they're not worth it. Underneath that is a completely unintegrated self and when you see how far apart these parts of themselves are you understand how deep their pathology is.

Mr. Purple reported "they have all manners of ways of getting you to pay attention to them" and then described an incident with a BPD client where the client took someone's purse in an attempt stop that person for leaving. Two participants (1 man and 1 woman) referred to this type of behavior as manipulative.

Sense of Reality

Seven of the twelve participants (3 men and 4 women) described deficits in reality testing and poor insight. Ms. Gray described a low functioning borderline with "not a lot of insight into what is wrong." Mr. Red similarly stated about borderline clients:

> They are generally ego dystonic and they don't understand that they have borderline tendencies. The world is against them, their bosses are against them, their lives are not going well, their husbands are idiots, everybody, their children are ganging up on them, yet if you tell them they have a personality disorder they absolutely don't believe you.

Ms. Green attributed issues of reality testing to trauma and said of her borderline client that after years of rape by her brother: "Her outlook toward the world is really screwed and twisted of course."

One participant, Ms. Black described the capacity for reality testing and insight of a higher functioning BPD client. Ms. Black said, as if to her client:

> "You have great understanding, great insight, you really understand what's going on and the dynamics, you know what you need to do…what you need to do to make yourself, your life better, but you don't do it. You don't do it."

Five participants (3 men and 2 women) reported that reality testing and problem solving are treatment goals. Mr. Purple said: "The goal of treatment is to make them think."

Trauma History

Six participants (2 men and 4 women) referred to trauma histories of their BPD clients. Three of the women argued that client symptoms could be best understood from a trauma perspective and therefore used that lens in diagnosis and treatment of these clients. Ms. Green stated:

> I don't even thing in terms of borderline as a diagnosis. I think in terms of trauma. I think that borderline personality disorder is a very loose characterization…a pattern of coping skills people use especially those with chaotic childhoods or exposed to a lot of abuse.

With a trauma history as an understanding for a diagnosis of borderline personality disorder clinicians used treatment strategies traditionally aimed towards those diagnosed with chronic PTSD. Ms Pink reported:

> I ended up working with a lot of women with PTSD and low and behold most of them met criteria for borderline personality disorder but I really come at it from a trauma standpoint, dissociative disorder standpoint and have found it has been

very effective as least with the people who are committed to working hard in long term trauma treatment.

Pain and Suffering

Six participants (2 men and 4 women) talked about the enormous amount of pain and suffering their borderline clients were living and coping with. Ms. Gray said: "I think what people forget is behind all the difficulties working with someone on Axis II, particularly Borderlines and Narcissists, is a lot of pain, a huge amount of pain, there's all this pain being acted out." Five participants (2 men and 3 women) described their BPD clients as "fragile," "vulnerable," and "dependant."

Substance Abuse

Four participants (1 man and 3 women) found substance abuse to be a significant issue in treating BPD clients. Ms. Pink said of her client:

> Drinking is a significant issue, and while she's drinking her affect has become more unstable, she's fighting with people, she's really regressed behaviorally because of this disinhibition and has cut herself badly a couple of times.

> Mr. Orange said:

> It's not unusual for a borderline person to have difficulties with substances. It really doesn't matter which one. I've worked with clients who are involved with alcohol, heroin; actually heroin is a big one. A lot of female heroin users have a borderline personality dynamic. A lot of them incurred sexual and physical abuse at an early age, hence the boundary issues. It's not a coincidence that they chose a selection of 'pain-killer' substances to deal with the pain.

Ambivalence and Resistance

Five participants (2 men and 3 women) described their BPD clients as ambivalent about or resistance to clinical treatment. Ms. Teal and Ms. Pink noted that these clients don't do the work in between sessions and go through periods of time where they cancel or don't show for appointments. Ms. Pink said:

I've had the experience of having someone show up for every session but not do the work between sessions, want to see me more frequently and actually come in an show up for the sessions but not really use the therapy well between sessions. And I've had the experience of people saying they want to come in and really work on stuff and they set up appointments and cancel them, you know, at the last minute.

Mr. Red says of his BPD clients' ambivalence:

These clients come into counseling because everything is so bad in their life but they don't really believe that anything is wrong with them, it's everyone else that has the problem, there's really no reason for them to be coming to counseling. So they are often looking for reasons not to believe in their therapist.

Power Struggles

Three participants (1 man and 2 women) advised avoiding power struggles with

BPD clients. Ms. Blue advised:

One of the most important things in treatment is to try never to get into power struggles with them. If I feel a struggle coming I am more likely to just back off and not get into a struggle with them; find another way in. So you have to be kind of careful about how you present stuff and not take what they say personally when they fire you, and not get into power struggles.

Overloading

One participant, Ms. Green, mentioned overloading as a behavior of her

BPD clients. She said of her client, she "needs to tell you all of the traumas that ever

happened to her in great detail and that strategy often leads to people overloading. So you

try to pace the therapy."

Client Strengths

Nine participants (3 men and 6 women) talked about a variety of strengths in their

BPD clients. Five of those participants (2 men and 3 women) specifically talked about

how "smart" their clients were. Four participants (1 man and 3 women) refer to their

BPD clients as "charming," though this description is not exclusively used in a positive way.

Length of Treatment

Seven participants (2 men and 5 women) reported practicing long term treatment with borderline clients. Ms Green said:

> Treating BPD and trauma disorders goes against the grain of managed care where you're supposed to have a behaviorally significant plan in 8-10 weeks, and those things are good things you can do, you can do some of that, but so much about BPD is about attachment and lack of attachment figures. It really is just a longer term thing and no amount of short term interventions, well, they'll help, but forming an attachment relationship is something that happens over time.

Treatment Modality

Four women participants report Dialectical Behavior Therapy (DBT) as helpful for treating BPD clients. Ms. Teal said:

> In terms of working with them in treatment just doing a lot of the stuff spoken in the DBT stuff, working on having a more balanced mind and not feeding negative thought patterns, really working on skill building, you know, just positive coping skills…I was best able to work with people with BPD where they were doing partial treatment programs at DBT centers where they have people they can check in with around skill building.

Two participants (1 man and 1 woman) said they incorporate principles of Cognitive-Behavioral Therapy (CBT). One man participant said he treats his BPD clients from a psychodynamic perspective.

Mr. Orange noted: "Do not look back in lament, or forward in fear, but around in awareness," which he believes to be "very, very, very apropos in working with borderlines." He said a clinicians job "in a lot of ways is to help them formulate a here and now because they're constantly struggling with the past and they are petrified of the future, very much so, and they are torn all over the place."

Treatment Outcome

Four participants (1 man and 3 women) reported positive outcomes in treating

BPD clients. One woman said she believes in a positive outcome for these clients, but

has not experienced any of her borderline clients sustaining positive growth while under

her care. A man respondent, Mr. Orange said:

> The role of the therapist in working with BPD clients is that of a safety line. They
> will hold onto you, clutch onto you, and they should because they live in a sea of
> unrest and a lot of unknowns. So we figure out how to be effective life line via
> consistency, structure, and maintaining boundaries. To create a holding
> environment where the individual can develop a level or semblance of comfort
> and begin to formulate a development of some coping skills in helping them
> strengthen their ego boundaries.

Continuum

Two men participants discuss BPD diagnosis as a continuum with higher

functioning BPD clients doing better in treatment. Mr. Orange says:

> With a high functioning Borderline you have more of a chance. Defensive
> mechanisms are going to be more sophisticated, ego strengths are going to be a
> little better and you stand a better chance in terms of helping them sort of quasi
> develop coping skills that will reframe the defense mechanisms that they use.

Empathy and Warmth or Directive Approach to Treatment

Two women reported using warmth and empathy in treatment of BPD clients.

Ms. Brown believed that a warm approach is best. He said:

> I think some people think you need to be very firm, clinical, sort of distance
> keeping or whatever and I'm not a person who's very distance keeping so I don't
> agree with that but I do recognize the importance of boundaries. I just think being
> a warm, consistent caregiver is very important.

> One participant, Ms. Gray, believed a directive approach is more appropriate then

using warmth and empathy in treatment of BPD clients. She said:

When you're empathetic and understanding it's like you're overwhelming them. My sense is that a more directive approach would be better with them, I think it's a more comfortable approach, you stay away from the red flags of affect and particularly empathy.

Psychodynamic Phenomena

In discussion of clinical experiences clinicians described psychodynamic phenomena including transference, ego defensives such as splitting, merging, projection and projective identification. Six participants (3 men and 3 women) referred to BPD clients' defensive structures as "extreme", "primitive," and even "fierce." Seven participants (2 men and 5 women) cautioned clinicians against "feeding into defenses" by remaining non-reactive in treatment.

Five participants (2 men and 3 women) talked about reframing BPD clients' primitive defense mechanisms as essential coping strategies needed for survival. Ms. Violet said of these defenses:

The reality is that it has also been a strength in their lives in some ways because it's protected them…it's protected them from being hurt and it's protected them from terrible things in their lives, and so while it's frustrating for us, it's a really good defense for them and so I just need to remind myself of some of that stuff.

Transference

Participants discussed the difficulties for BPD clients in distinguishing different kinds of relationships from one another. The psychodynamic understanding of transference was cited by participants as a way of contextualizing BPD thoughts and behaviors. Nine of the twelve participants (3 man and 6 women) discussed experiences of client transference in treatment. Five participants (all women) reported a maternal transference, one woman reported a paternal transference, three participants (1 man and 2 women) report peer transferences, and six participants (2 men and 4 women) reported

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erotic transference. Ms. Black reported experiencing all transferences mentioned above

and said of her client's erotic transference, "she wanted to tell me her masturbation

fantasies about me and I told her I had a feeling of distaste about this. I didn't want to

hear it." Ms. Gray reported experiencing transference with BPD clients where she was

"seen as an object with them as much as with people in their lives, to fulfill their needs, to

make them feel better."

Ms. Black discussed her client's erotic transference and her pattern of blurring

relationships:

> She's fallen in love with me...I'm very explicit with her about what I am and what
> I'm not and I have been discussing with her recently she has fallen in love with
> another woman, who's gay, which is fine, which would be fine except
> interestingly enough this is an older woman, again her pattern is with older
> women. What am I? I'm an older woman by comparison to her…and she's a
> therapist, how interesting.

Ms. Black gave an example of transference from a male BPD client:

> But this man also I think has developed a transference to me which is a sort of
> you know pattern of his relationship. His wife is a substitute mother, in the house
> he is treated as a child. I try all the time to treat him as an adult, which he is an
> adult, but you know that's part of the pattern in the transference. I think it's a
> problem.

Ms. Gray reported difficulties identifying erotic transference at first, "I thought it

was more the transference of the mother and it wasn't; it was an erotic transference when

she was toying with the idea of being gay, and that transference was really, really fierce."

Mr. Orange said:

> Ok, physical attraction, emotional attraction with a borderline, it really doesn't
> matter cause in a lot of ways it's not a sexual impulse they have, it's more of an
> asexual orientation that they have. I'm not saying they're not going to be
> provocative sexually or physically, but in reality you take a look at where they're
> at psychodynamically that they really don't have a preference sexually. They are
> working more on the impulses or the lack of connections.

Defensive Splitting

Eight participants (1 man and 7 women) discussed splitting as a common issue in working with BPD clients. All seven women participants discussed being idealized by these clients, however only five of them reported being devalued. Ms. Gray summarized how her clients respond to her: "The idealizing – you're the best therapist I've ever had and next week you're the worst person in the world and very definitely the worst therapist in the world."

Four of these participants (1 man and 3 women) discussed third party splitting where the client viewed the therapist in opposition with someone else in their lives and commonly with other providers. Ms Gray described a clinical split demonstrated by her BPD clients: "We [agency] provide both medication and therapy here and there's the pitting between the med provider and the therapist – one person understands me more than the other."

Merging

Five participants (2 men and 3 women) discussed experiences of BPD clients attempting to merge with them. Ms Gray said, "They actually want to absorb you, they want to take you in." She continued in describing a specific BPD client's attempts to merge: "She wanted to know about my clothes, in terms of dressing like me, where did I buy things, what were the labels, etc." Ms. Blue said: "Sometimes I used to describe it as like they want to live in your back pocket, and come home with you." Mr. Orange described how a BPD clients' lack of identity lead to merging:

> The borderline in their attempts to connect with another object or a person
> essentially takes on that individual, takes on part of that individual, becomes part
> of that individual, obviously they don't know this is going on because of poor ego

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strengths, but they begin to merge with or attempt to merge with the other ego of the other person.

Projection and Projective Identification

Four women participants discussed their experiences with borderline clients of projection and projective identification. They reported identifying with their clients' anger, helplessness, and doubt in the benefits of treatment. Ms. Gray said: "The projective identification is really tricky. They try to get you to play out what their expectation is and they try to involve you in it."

Boundaries

All twelve participants discussed boundary issues in their experiences working with BPD clients. Five participants (2 men and 3 women) reported that borderline clients will always test the boundaries of the therapeutic relationship. Seven participants (1 man and 6 women) gave examples of clients wanting the therapeutic relationship to be more personal and going to lengths to extract personal information from their clinician. Ms. Violet said of her BPD clients: "They can be so likeable and they can draw you into it so much that you want to be, I don't know that you want to, but it's easy to divulge personal information or become really friendly with them."

Three of the women participants described how a clinician might end up working above and beyond the therapeutic hour for many of their borderline clients. Ms. Teal wondered: "Oh my gosh, what has happened in our relationship that she feels like she's going to decide how I'm spending my time?" Ms. Brown described:

> Phone calls in between sessions; she would call a lot and leave lots of messages, desperate messages, and I would return every single phone call the day it was given to me and it just was bad, I mean it wasn't a good thing for us. I think I've

learned to be more clear about what is an okay reason to call and what is not an ok reason to call and we're still working on it.

Eight participants (3 men and 5 women) reported that close attention to boundaries and limit setting is essential to maintaining a safe and therapeutic relationship with borderline clients. Ms. Blue said of her borderline clients:

> The more we do for her the less she believes she can do for herself…You don't need to be the one who fixes every problem. You just have to be able to sit with what the problem is and help them figure out how to handle it themselves and not to be so involved.

Mr. Orange said: "Consistency with boundary issues is the best line of defense for a clinician. Maintain consistent boundaries and be prepared to be tested all over the place."

Clinical Countertransference

Participants were asked to discuss feelings and reactions they typically experience working with clients diagnosed with BPD. They mentioned both positive and negative feelings and reactions. Participants also discussed managing these feelings in and out of session. Mr. Purple said: "Clients with the diagnosis BPD probably exhibit stronger feelings in me as a clinician than other clients that I've seen."

Positive Countertransference

Seven participants (2 men and 5 women) described a positive CT where they found their clients to be very likeable, and they wanted to work for them well beyond the therapeutic expectations, and to experience positive feelings about themselves as a clinician during a session. Ms. Teal spoke of an "intense connection" and even felt like "the best therapist" when sitting with her BPD clients. Five of the seven clinicians who reported positive CT also reported negative CT.

Negative Countertransference

Eight participants (2 men and 6 women) reported negative CT, including feelings of apprehension, annoyance, helplessness, anger, frustration, vulnerability, and hurt. They reported at times feeling attacked or bullied. Ms. Green reported similarly about her BPD clients "they know how to zing you and get to the part that is most vulnerable." Two women participants said that in treating these clients they sometimes doubted their own clinical competence.

Ms. Teal talked of maternal CT and how her client was able to use it to get a reaction by disclosing neglect of her children and then begging the clinician not to report. She said: "So I was more targeted as a woman in some ways or was more vulnerable as a woman in terms of my reactions and having to act on protective concerns." Ms. Yellow said:

> I think as a woman and a mother I have a strong need to nurture and protect. I think that women have had that role assigned to them to nurture and I think I'm pretty good at that. So that probably plays into how I'm dealing with her and how I am feeling attacked in certain ways. I suspect a man would deal with it very differently.

Three clinicians (1 man and 2 women) reported negative visceral reactions in working with BPD clients. Mr. Orange stated: "I cringe" while Ms. Yellow said: "I have this odd sensation that the air is being sucked out of the room." Ms. Gray reported: "I can tell you that my shoulder and neck will start to hurt. I'll have a headache by the end of my session with her. That's how hard I'm working. That's how hard she's working."

Erotic Countertransference

Two men discussed erotic CT, though they did not disclose personal examples. No women participants mentioned erotic CT unless discussing risks for male clinicians

working with BPD clients. Ms. Brown said of her experience of erotic transference from a woman client: "I would imagine for most heterosexuals that might be a harder thing for a male therapist than a female therapist." Ms. Teal said:

> I wonder as a man if you feel more vulnerable around your gender because things get played out in a more sexualized way…where there's this extra layer of falling in love with your therapist or what not. I can't think of anything I did differently as a woman than I might have as a man with my clients that were Borderline.

Years of Clinical Experience

Five (1 man and 4 women) participants stated that CT became less of an issue in working with BPD clients as their years of experience as a clinician increased. Ms. Black said:

> I don't have countertransference issues, I'm clear in my head, I mean with this many years of experience believe me I don't get pulled into, you know. Patients are patients, my private life is my private life and there is a boundary between that and I don't get myself in a muddle emotionally about what's going on.

Ms. Green said:

> This is one I took to supervision consistently and I think that's really important. Borderline cases are hard. I don't think they ever get easy, but I think that when you see a certain number of them, you know everyone is individual, but you start to develop a certain skill set or knowledge base on what is going on.

Managing Countertransference Out of Session

Participants repeatedly discussed the importance of managing CT out of session. Ms. Yellow said "I've done lots of supervision about her because she pushes my buttons in a particular way that other people don't." Nine participants (2 men and 7 women) stressed the importance of supervision in managing CT. Four women reported utilizing peer consultation in order to manage CT with BPD clients. Two women found support in literature, specifically referring to "The Crunch" by Paul Russell (2006). Mr. Orange stated: "Depending on where you're at with your own issues you might want to

get involved in treatment for yourself because borderlines will certainly bring out any unresolved issues in the therapist, that's a given." Three women participants reported that CT was not an issue for them due to managing it well on their own.

Managing Countertransference in Session

Eleven participants (3 men and 8 women) discussed managing CT while maintaining a therapeutic connection as a major concern in treating BPD clients. Ms. Blue described her concerns:

> How difficult will it be to ride out their moods and sort of manage the different reactions that they give to us, you know what I mean? Because they can be prickly and sometimes it can be hard to always not be reactive to that and to always be able to sit with them and not have it get to you, cause sometimes, truth be told, you get annoyed when they start to be complaining about everybody and wanting to fire you.

Two women participants advised not taking what their clients do personally. Other advice included remaining in your therapeutic self, staying in the moment, remaining calm and non-reactive, and having patience and tolerance.

Six participants (5 women and 1 man) said they would disclose feelings of CT to a client diagnosed with BPD if it were appropriate and beneficial for treatment. Ms. Black said of her BPD client: "I let her know because she needs to know. People need to know when they've pushed you too far."

Treatment Concerns

Participants were asked about their largest concerns in treating clients diagnosed with BPD. Concerns include safety issues, level of difficulty in treatment, client's quality of life, and diagnosis concerns. Countertransference was also cited a major concern; this has been detailed in the previous section.

Safety

Seven participants (2 men and 5 women) stated safety issues, including impulsive actions or threats of self-harm, harm to others, and suicide, were major concerns in working with BPD clients. Ms. Gray said of her largest concern:

> I guess it would be the obvious one, are they going to hurt themselves or somebody else? Cutting is one thing, and a number of them do cut with no intent of killing themselves or harming themselves more seriously, but I think these threats, and you never know when they're just crying wolf or intending to do something so they can throw you off balance…It's the acting out and I think those would be the obvious concerns. When do you take them seriously, when do you act, when do you find you're being sucked into their threats that they themselves may not even take seriously?

Four participants (1 man and 3 women) reported that containment and safety planning and support building are essential to treatment of BPD clients. One woman participant reported using safety contracts to help BPD clients manage these behaviors.

Level of Difficulty

Eight participants (2 men and 6 women) referred to their BPD clients as "difficult" or "challenging to work with." Two women participants reported that BPD clients were not their most difficult clients. Four participants (3 men and 1 woman) discussed concerns in the level of difficulty in treating BPD clients. Treatment of BPD clients was described as requiring an enormous amount of time and energy where progress is slow, taking a number of years to see stable improvement of symptoms. Mr. Purple described his concern of such difficult and not always rewarding efforts in treating BPD clients:

> My largest concern with BPD clients is that you have to work so hard during treatment, you're working, you're preparing, before and after the session. You are doing too much of the work…They want me to do all the work and make the

goals and write all the stuff and if they like it then? And if they don't? And that's a big concern. Are we spinning our wheels?

Mr. Red said: "I have to watch every single word I say to him, and it's like walking on eggshells; it's really difficult."

Two women participants recommended not having any more than two BPD clients on one's case load at a time due to the level of work involved in treating them.

Quality of Life

Four participants (1 man and 3 women) described major concerns about their clients' happiness and quality of life, which was complicated by BPD symptoms and behaviors. Ms. Black said of her BPD client: "My concern is to see her have a happier life where she is able to work, to make some money, to have some friends, to develop a healthy relationship with another woman." Mr. Red said about his concerns:

> They are almost invariably people who really damage themselves frequently, and not as much in the physical way, they blow through jobs, they set themselves up, they at times are trusting with people in untrustworthy ways, they're controlling and precise in ways that make it impossible for people to have relationships with them.

Diagnosis Concerns

Seven participants (1 man and 6 women) discussed diagnosis concerns including the bad reputation that goes along with it. These participants struggled with whether or not to use the diagnosis at all. Ms. Brown said:

> I hate when I'm at trainings or whatever and hear when people are really negative around borderline clients because I see them as people who are having a really hard time with relationships and so that's why I sort of refuse to write that diagnosis on her paper because I just, people talk so negatively about it like 'they're manipulative.' And I just don't see it that way, just because that's what she's feeling, not because she is being manipulating.

Ms. Green said "I'm not convinced what the definition of BPD means and I think it's a cluster of general personality traits that tend to come about when people have been terribly traumatized."

Gender

Issues were present in the data with regard both to clinician and client gender.

Clinician Gender

Four participants (1 man and 3 women) felt that gender was not an issue in treatment and two women report never having given it much thought. Ms. Green wondered when asked about her gender in working with clients diagnosed with BPD:

> I think that's such a fascinating question because I sit around thinking of how my differences affect the therapeutic relationship, but I don't even, maybe I make an assumption that because we are the same that's a good thing, but maybe it isn't.

One woman felt that her gender was significant on rare occasions and six participants (1 man and 5 women) said that gender was only significant within the political, cultural, and social context, and did not necessarily interfere in treatment of BPD clients. Mr. Orange said:

> Believe it or not gender doesn't you matter, when all is said and done. But before you can even get to that you have to deal with all the surface stuff that the borderline is formulations. So now we're talking about provocative behavior, sexual innuendos, transference all over the place.

One man participant felt that gender is significant in clinical treatment. Mr. Red says:

> I mean the idea is that you really do have to be careful about gender roles. Like anything else behavior's sexualized. In a field where probably 70-80% of the people are females, you have to be a little bit more careful as your role as a man. It's the same thing in other fields, like male nurses. People think 'why would you ever want to be this? He must be a pervert.' I mean if just being a guy is that

threatening to some people, what can you do? It's not anything I did. It's a gender issue. But we have to be aware of that in clinical services with our clients.

Women Clinicians

Five women cited benefits of being a woman treating BPD clients as strengths in relating emotionally, connecting, nurturing, and role modeling. Ms. Blue said "When I think of my gender, if it's a woman client and me being a woman that I just know what more to expect because I'm more familiar with female moods and reactions." Ms. Green said: "Most borderline clients I work with are female and they've requested a female, usually, not always, because I think they feel that a woman could relate to them more."

Two women felt that they might be at times more vulnerable as a woman treating BPD clients. Ms. Yellow said:

> As a woman it is a tricky thing because if I start to show anger I think that it is experienced very differently by the clients because traditionally when women start to be aggressive you are seen as bitchy. So I'm always conscious of wanting to appear strong but not like a bitch. Nurturing at the same time, like the whole thing, and it's probably not realistic.

Four women reported gender being an issue when their BPD client is lesbian, bi-sexual or questioning due to issues of erotic transference.

Men Clinicians

Two men participants reported some difficulties being a male therapist including stereotypes of male aggression, erotic transference and countertransference and subsequent boundary concerns. Two men discussed gender bias in a field dominated by women clinicians. Mr. Red described work with borderline patients to be difficult because as a male clinician, "our tendency is to want to grab something and heal it, right? You want to fix somebody quick."

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Five women, in response to questions of gender, attempted to imagine themselves as men therapists treating BPD clients. Four of the women simply responded similarly to Ms. Pink: "I don't know how to answer because I've never done treatment in any other gender." Two women, however, wondered if being a man treating BPD clients would leave them more vulnerable to issues of erotic transference and countertransference.

One male participant thought that an advantage to his gender "might be that I could work well with men, but not necessarily." No other clinicians cited benefits of being a man clinician in the treatment of BPD clients.

Client's Gender

Four women participants reported a gender bias with more women being diagnosed with BPD far more than men. Nine participants (2 man and 7 women) wondered about men clients who fit the criteria for BPD. For example, Ms. Gray asked: "It never occurred to me until I saw your question if my gender could play any role in it. I sort of wonder now when you ask this, did I miss a diagnosis with any males?" Five women said they had no men clients with BPD, while two women reported having BPD clients who are men. Ms. Blue reported that the dynamic is same with both genders of clients. Ms. Violet said "I couldn't name a borderline client that is a man. I wonder if it's my issue or more of a societal issue that we sort of look at hysterical women but men as more narcissistic."

Mr. Orange said:

Traditionally BPD has been associated with women, however if you take a look at the diagnosis and the quintessence of borderline you could see how it will pertain to males as well, and not just homosexual males. So it's the narcissism or the antisocial behavior that jumps out and the borderline dynamics are at the core

function of where this person is at characterologically [sic] and this gets missed or pushed to the side.

Two men described treatment of men diagnosed with BPD and three women clinicians discussed men who they believe to have been fit criteria for BPD but only saw them for one or two sessions before the men dropped out of treatment. Ms. Yellow said:

> I really have to think about borderline clients that are men and if I've ever had any, certainly I've had clients with very primitive defenses. I am thinking of a man who really presented with characterological pathology but I only saw him for two sessions before he became angry and walked out of my session. He never came back. I pushed him too hard. And I think that's probably about me being a woman too.

Summary

The findings from interviews with 12 clinicians revealed several key themes with regard to gender and countertransference issues in working with BPD clients. Major findings reveal that gender identity is meaningful in the countertransference experiences of clinicians treating BPD clients due to the pervading assumptions and stereotypes held by both clinicians and clients. Additional findings suggest that erotic countertransference appears especially difficult for women clinicians treating BPD clients, whereas men clinicians may need to explore pre-oedipal transference and countertransference in working with BPD clients.

CHAPTER V

DISCUSSION

The purpose of this study was to explore clinician gender as a factor of clinical

countertransference for clinicians working with clients diagnosed with BPD. Participants

were interviewed regarding their clinical experiences treating clients with this diagnosis.

This chapter will discuss major the findings and how they are relevant to reviewed

literature, with particular attention to clinician gender and the psychodynamic phenomena

of transference and countertransference. Research and clinical practice implications are

then discussed along with strengths and limitations of the current study.

Major Findings

Participants in this study showed an understanding of BPD clients congruent with

current literature, including symptom and behavioral criteria detailed in the DSM-IV

(APA, 2000) and PDM (2006) and current literature outlining the ways this disorder can

interfere with daily functioning (Quaytman & Sharfstein, 1997; Mayo Clinic, 2006).

Also congruent with literature were the experiences of psychodynamic principles

and phenomena, including primitive defenses (Kernberg et al., 1998; PDM, 2006). These

defenses were found to make treatment of these clients more difficult, requiring closer

clinical attention to boundaries, relationship building and management of psychodynamic

phenomenon including the management of countertransference (PDM, 2006; Spurling,

2003; Wheelis & Gunderson, 1998). Data support the literature revealing the necessity of

close supervision (Spurling, 2003; Winnicott, 1949) and years of clinical experience to manage treatment of BPD clients most effectively (McIntyre & Schwartz, 1998).

In congruence with literature the participants were concerned about negative stereotypes attached to clients holding the diagnosis of Borderline Personality Disorder and used reframing to understand negative behaviors as attempts at coping rather than manipulation tactics (Linehan, 1993) . However despite literature discussing the reputation of BPD clients causing the suffering of others (McIntyre & Schwartz, 1998; PDM, 2006; Spurling, 2003) the participants in this study seemed aware of and concerned about the amount and intensity of their BPD clients' pain and suffering.

Not reviewed in the literature, but a concern of participants in this study, is the validity of the diagnosis due to the predominance of women holding the diagnosis, the prevalence of trauma in the lives of these clients, and the comparable PTSD symptom picture described in the DSM-IV.

Gender Findings

Despite literature showing that gender is relevant to experiences of transference and countertransference (Kulish, 1993) participants in this study either felt that clinician gender was irrelevant or had not given much thought as to how their own gender might influence clinical treatment of clients diagnosed with BPD. Most clinicians felt that gender was important but only on a surface level and that it was ultimately irrelevant in treatment of clients with the diagnosis of BPD.

Most of the clinicians appeared to make the assumption that commonality of gender between clinician and client was more favorable. More than half the women reported benefits in being a woman clinician in working with these clients. Women

clinicians attributed themselves with strengths in relating to, connecting with, nurturing, and role modeling for BPD clients, who were most often women as well. This is concurrent with literature stating that women clinicians tend to be more empathetic (Hoffman, 1977).

Interestingly two of three men clinicians discussed their gender role as complicated due to the domination of women in the field, whereas the third man said nothing at all about his own gender.

Two of the three men reported difficulties because of their gender in working with BPD clients. It should be noted that the third man, who did not report significant difficulties, worked mostly with men clients. The only strength in working with BPD clients from a man clinician's point of view was in working with male clients diagnosed with BPD. This may indicate that gender is significant in some way though it appears difficult to conceptualize without further study.

Both men and women clinicians talked about experiences of erotic transference with their clients; however the majority of women participants did not mention erotic transference until asked about gender, whereas the men discussed it when specifically asked about transference. Participants thought that erotic transference had more to do with the identity disturbances common of BPD clients rather than with the gender or sexual orientation of the clinician. It is therefore unlikely that clinicians can assume traditional gender stereotypes if clients have difficulty understanding their own gender identity and distinguishing one relationship from another.

Two of the three men discussed issues of erotic countertransference, whereas no women clinicians mentioned it unless discussing potential risks for men clinicians. This

supports the literature that women tend to either miss or avoid issues of erotic

transference and countertransference more than men clinicians do (Kulish & Holtzman,

2003). Interestingly the men focused almost solely on erotic transference and

countertransference in working with BPD clients. This may be due to a heightened sense

of male stereotypes in a field dominated by both women clinicians and clients. It is

unknown whether or not pre-oedipal transference occurred in treatment with these clients

or was simply missed by men clinicians, just as the women clinicians were likely to miss

or avoid oedipal transferences. However it is worth noting that Mr. Purple discussed a

man BPD client who "wanted to offer me things, to take care of me" and describes this

man as seeking approval or praise from the clinician. This appears to be part of a pre-

oedipal transference, though Mr. Purple did not identify this behavior as transference.

More than half of the women clinicians in attempting to conceptualize their own

gender thought to imagine themselves as men clinicians. No men clinicians tried to

imagine themselves as women clinicians. This may indicate something in how women

understand and conceptualize their gender as in opposition of the other.

Research Implications

One issue briefly discussed in the literature is prevalence of trauma

histories in the lives of their BPD clients (Stern, 1938). Some respondents were

concerned over the validity or of discrimination based on the diagnosis of Borderline

Personality Disorder. Experiences of trauma were cited a number of times as pertaining

the lives, symptoms, and behaviors of many clients diagnosed with BPD. Some

clinicians believe that PTSD maybe a more appropriated diagnosis given the

predominance of sexual abuse histories shared by their BPD clients. Research is being

undertaken to understand how gender, trauma, and countertransference might influence understanding and treatment of clients diagnosed with BPD (Barrett, 2000).

Though the literature talks mostly of negative and difficult experiences with BPD clients (Spurling, 2003), the majority of the participants in this study pointed out strengths of their BPD clients and reported positive feelings regarding working with them in treatment. It may be important to focus more research on the strengths of these clients, which would also respond to the concerns regarding the negative stereotypes often attached to this population of clients.

Implications for Clinical Practice

Participants were hopeful, in accordance with literature, that BPD clients can be successfully treated (Garzer & Ornstein, 2002). Also congruent with literature, participants agreed that long term treatment is required for BPD clients to demonstrate sustained improvement. They also agreed that relationship and safety issues are most prominent in the first year of treatment with BPD clients and stabilization tends to begin in the second year of treatment (Wheelis & Gunderson, 1998). Participants appeared concerned over how the current system of managed care affects the care of clients diagnosed with BPD in the length and frequency of care these clients appear to require.

Participants reported using a variety of treatment styles in their work with BPD clients including psychodynamically-based interventions, CBT, and DBT. One third of participants reported that DBT was helpful to their BPD clients, supporting evidence in the literature of it's effectiveness in reduction of symptoms (Linehan, 1993). None of the clinicians reported having DBT training but supported their clients in attending DBT skills groups in addition to individual therapy. This combination of treatment has been

shown in the literature to be more effective than either treatment alone with a greater tendency for clients to follow thorough with treatment (Harley et al., 2007). This finding may be helpful in understanding the ambivalence and resistance to treatment reported by participants in this study working with BPD clients.

In accordance with reviewed literature (PDM, 2006) participants recommended that a clinician be consistent, active, structured, affectively expressive, aware of boundaries, and focused on the here and now when treating clients diagnosed with BPD.

Strengths and Limitations of the Study

The strengths of this study include the researcher's access to clinicians who conduct individual therapy with clients diagnosed with BPD. Clinicians were interviewed face to face where they could discuss, process, clarify, and give context to their experiences treating BPD clients. The setting of each interview was a strength in that each was conducted in clinical offices where BPD clients are actually treated. Participants appeared able to invoke detailed memories of experiences with their clients as if they were in the room.

A limitation of this study is the small number of men clinicians in the sample, and the absence of clinicians who identified as transgendered. More men clinicians need to be interviewed in further research of the complicated dynamics between gender, CT phenomenon, and what it means to be a man in a profession dominated by women. Further research will hopefully examine the experiences of transgendered clinicians in their clinical treatment of clients diagnosed with BPD.

There is also a lack of racial and ethnic diversity among clinicians in this sample. Much more study involving therapists and clients from a variety of cultural and ethnic

backgrounds is needed. Clinicians who responded to recruitment for this study may have had significantly different experiences working with clients diagnosed with BPD, which may indicate a bias in this study.

Conclusion

Based on the findings from these qualitative interviews it seems that gender identity is meaningful in the countertransference experiences of clinicians treating clients diagnosed with BPD due to the pervading assumptions and stereotypes held by both clinicians and clients. Gender identity may or may not be meaningful in the understanding and treatment of BPD as the literature suggests; however, as revealed by the participants in this study, gender appears to be significant as to the process of treatment, including CT experiences and reactions.

Clinicians need to be more aware of transference and countertransference scenarios that do and do not align with their manifest or traditional gender roles, especially due to the relationship and identity issues common of BPD clients. Negative erotic countertransference appears especially difficult for women clinicians treating BPD clients, potentially due to gender stereotypes denying women their sexuality and aggression, and/or taboos against homosexuality. Additionally, men clinicians may need to explore pre-oedipal transference and countertransference in working with BPD clients in addition to the erotic. Further research in all areas would enhance the currently limited understanding in the literature of the interplay of gender and countertransference in work with clients diagnosed with borderline personality disorder.

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Appendix A

Human Subjects Review Board Letter of Approval

February 13, 2008

Alyssa Wyman

Dear Alyssa,

Your revised materials have been reviewed. All is in order and we are happy now to give final approval to your project.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your study.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Faith Little, Research Advisor

Recruitment Flyer

Wayside Clinicians:

Volunteers Needed for Study of Your Work with Borderline Clients

If you are a clinician who treats Borderline clients, I would like to interview you for a study that will serve as my Master of Social Work Thesis at Smith College School for Social Work.

If you meet these qualifications…

- A practicing clinician with an LICSW, LCSW, or LMHC

- Have treated clients diagnosed with Borderline Personality Disorder in individual therapy for at least one year

- Are willing to participate in 50 minute interview to discuss your experiences in treating Borderline clients

    …then you are invited to participate in the study

As a thank-you for participating, you will receive a
$5 Gift card to Dunkin Donuts and a Stress Ball.

Appendix C

Recruitment Points

- Introduce myself as a Smith Intern working at Wayside under the supervision of Cathy Campbell

- Describe Smith requirements to include a Thesis for which I have proposed to speak with Clinicians about their experiences working with Borderline clients

- Inform my audience of my interest in countertransference and in gender when working with this client population

- List my criteria for participation:

  (A practicing clinician with an LICSW, LCSW, or LMHC; Have treated clients diagnosed with Borderline Personality Disorder in individual therapy for at least one year; Are willing to participate in 50 minute interview to discuss your experiences in treating Borderline clients)

- Show prizes of a $5 Dunkin Donuts gift card and a stress ball that will be given as a thank for participating and donating time to the advancement of my degree in social work

- Thank everyone for their attention and give each person a flyer with my contact information

Appendix D

Informed Consent

Dear Participant,

I am conducting a study researching clinician gender as a factor of clinical countertransference in treatment of clients diagnosed with Borderline Personality Disorder. The data collected will be used as a contribution to research in this area as well as for a thesis. The thesis is in partial fulfillment for the Masters of Social Work requirements at Smith College School for Social Work. Results may be used in publications and presentations.

You are being asked to participate because you are licensed as an LICSW, LCSW, or MLHC and have provided individual therapy for clients diagnosed with Borderline Personality Disorder for at least one year. As a clinician who has worked directly with these clients, you have a unique perspective and experience that is highly valuable in advancing the understanding of countertransference and helping identify the implications for practice.

The length of time requested to participate in the study interview is approximately 50 minutes. Your participation would consist of one face-to-face interview. The interview will be scheduled at a mutually convenient time and location. The place of interview will be sensitive to confidentiality needs. Before the interview begins you will initially be asked to complete a short demographic data sheet that asks about your age, gender, licensure, and years of clinical experience. After the questionnaire you would be asked to respond to some open-ended questions designed regarding your clinical experiences in treatment of Borderline clients. With your permission this interview will be tape recorded and later transcribed by me. (If you don't agree to be taped I will relay on detailed notes.)

The primary risk of your participation may include experiencing distress in examining your responses towards your Borderline clients.

There are potential benefits that you may experience through your participation. These include having a space for you to discuss your struggles and insights in managing you reactions. You will also be advancing the fields of Social Work and Psychology in examining the impact of gender and countertransference in clinical treatment to improve the care and quality provided to Borderline clients.

As a thank-you for completing the interview you will receive a $5 Dunkin Donuts gift card and a stress ball.

Strict confidentiality will be provided by the researcher in protecting all of your interview data, both written and taped. In regards to the recorded data, no identifying information of yourself, you agency affiliation, or of the clients discussed will be recorded in the data analysis of the reports. You will be asked not to use client names or identifying data about your clients when you are providing illustrative case material during the interview. Your identity will be protected, as names will be changed in the analysis of the data. Your name will never be associated with information you provide in the demographic data sheet or in the interview. For example, you will be identified as "Participant 1" and not by your name or agency. In accordance with federal regulations, interview data and transcriptions will be kept in a secure location. The researcher will hold these materials in confidence for three years. After the three years the material will be appropriately destroyed.

Data obtained may be used for future presentation, panel discussions, or further expansion of research area. Data will be reviewed by my research advisor only after identifying information is removed. Illustrations and brief quotations will not be connected with identifying information about you or your clients you may discuss.

Your participation is completely voluntary. You may withdraw from the study if you so choose, including before, during, or after the interview without penalty. However, the final date for withdrawal will be April 1, 2008, when the report will be written. If you decide to withdraw, all data describing you will be immediately destroyed.

I appreciate your commitment to research and your contribution to the field in attempt to better understand clinician gender as a factor of clinical countertransference in treatment of clients diagnosed with Borderline Personality Disorder.

Your signature below indicates that you have read and understand the above information. It also confirms you have had the opportunity to inquire about the study, your participation, your rights, and that you agree to participate in the study.

Participant Signature_____ Date_____

Signature of Researcher_____ Date_____

<center>**PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS**</center>

Appendix E

Demographic Data Sheet

Age (Please write in):

Gender (Please circle one): Woman Man Transgender

Race/Ethnicity (Please write in): _____

Licensure (Please circle one): LMHC   LCSW   LICSW

Years of Experience Treating Borderline Clients (Please write in)_____

Appendix F

Interview Guide

1. Please tell me about your understanding of clients diagnosed with
   Borderline Personality Disorder and how to work with them in treatment.

2. Please discuss your experiences working with Borderline clients including
   any specific examples of transference, defensive splitting and projective
   identification, and boundary concerns.

3. Please tell me about any feelings or reactions you typically experience
   when working with Borderline Clients and how you deal with them in and
   out of session.

4. Please identify your largest concern in working with Borderline clients.

5. Please discuss how your gender as a woman/man/transgender might
   influence your work with Borderline clients.