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Listening to women's voices : clinicians' perspectives on the benefits of feminist therapy in the treatment of borderline personality disorder

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Abigail Winchester Moore
Listening to Women's Voices:
Clinicians' Perspectives on the
Benefits of Feminist Therapy in the
Treatment of Borderline Personality
Disorder

ABSTRACT

This qualitative, exploratory study examines the perspectives of practicing feminist therapists about the benefits of utilizing feminist therapy for the treatment of Borderline Personality Disorder (BPD). Twelve licensed clinicians were interviewed about their clinical experiences and perceptions of the benefits of feminist therapy in treating clients diagnosed with BPD.

Clinicians discussed the theory and implementation of feminist therapy; how feminist therapists understand BPD in light of current debates on the use of this diagnosis; and the unique benefits feminist therapy may offer in the treatment of BPD. Participants were asked to give their reactions to the BPD diagnosis and the role of trauma in the lives of clients diagnosed with BPD. In particular, clinicians discussed feminist therapy as a framework, lens, and relational method of interacting with clients.

Study results were consistent with the hypothesis that the collaborative, relational approach of feminist therapy is of significant benefit to clients who are diagnosed with BPD. An advantage in treatment is this approach is a flexible, integrative practice, able to embrace other modalities and techniques. Finally, the feminist focus on the therapeutic relationship diminishes pathologizing and highlights strengths and capacities, which help to empower clients diagnosed with BPD.

**LISTENING TO WOMEN'S VOICES:
CLINICIANS' PERSPECTIVES ON THE BENEFITS OF FEMINIST THERAPY IN
THE TREATMENT OF BORDERLINE PERSONALITY DISORDER**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2013

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This thesis is dedicated to the loving memory of Nessa, who passed away during the course of my social work program. She will be always in my heart.

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CHAPTER I

Introduction

The purpose of this exploratory, qualitative study is to examine the perspectives of practicing feminist therapists about the benefits of utilizing feminist therapy for the treatment of Borderline Personality Disorder (BPD). The study focuses on an investigation and description of the conceptual model and implementation of feminist therapy, an appreciation of how feminist therapists understand BPD, and a study of the benefits and limitations of a feminist therapy approach in the treatment of BPD from the perspectives of 12 feminist therapists.

Feminist therapy is both an overarching framework for understanding, and a method of relating to a client. Brown (2009) elaborates the term *feminist*, in relation to therapy, to include a comprehensive multicultural framework that is not only for women, but for everyone. Brown (2009) defines feminist therapy as:

The practice of therapy informed by feminist political philosophies and analysis, grounded in multicultural feminist scholarship on the psychology of women, men and gender, which leads both therapist and client toward strategies and solutions advancing feminist resistance, transformation and social change in daily personal life, and in relationships with the social, emotional and political environments. (p. 4)

A feminist framework for therapy can draw from other techniques for therapy such as Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing Therapy (EMDR), Family Systems Therapy (FST), and a Psychodynamic Perspective (Bateman & Fonagy, 2000; Brown, 2009; Walker, 2009).

For the purpose of this study the definition of Borderline Personality Disorder given by the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, (DSM-V) will be used: “A pervasive pattern of instability of interpersonal relationships, self-image, and affects and a marked impulsivity beginning by early adulthood and present in a variety of contexts” (American Psychiatric Association [APA], 2013, p. 663).

This study utilizes semi-structured interviews to elicit perspectives from 12 practicing clinicians who identify as feminist therapists to explore the utilization of feminist therapy for the treatment of BPD. The relationship between clients carrying the diagnosis of BPD and their therapists is of the utmost importance in positive treatment outcomes. Due to the role of trauma in the development of this disorder, the therapeutic relationship becomes not just important, but essential for the treatment of BPD (Herman, 1997). The primary hypothesis of the current study is that the relationship between therapist and client may benefit greatly from the collaborative, more egalitarian, empowerment model of a feminist approach.

The findings of this study provide an opportunity for the views of practicing feminist therapists to emerge, contributing to our understanding of the potential benefits of this relationally focused, power sharing, egalitarian model of therapy for clients carrying the diagnosis of BPD. Knowledge of the unique benefits contributed by feminist therapy to clients with BPD, as well as fuller clinical insights into the nature and treatment of BPD offered by this approach, will be beneficial to the social work profession as it debates this controversial diagnosis, and reevaluates its work with this difficult to treat population.

Although a minority voice within the social work profession as a whole, one of the strengths of feminist therapy is that it offers a standpoint that is both structural and systemic in looking at the problems surrounding BPD, a diagnosis many regard as primarily affecting

women (Becker, 1997; 2000). Another strength is its integrative and eclectic therapeutic process, allowing its practitioners to utilize other techniques or additional therapies as seem effective for clients. Above all, it is a relational therapy, whose successes in the treatment of BPD owe much to its enhanced emphasis on a strong therapeutic relationship.

These and other issues will be explored more fully in the chapters that follow. The literature review in Chapter 2 will examine the BPD diagnosis and its current treatment, including a review of the literature on feminist therapy. The description of methodology in Chapter 3 will explain more fully the design of the research and how the study was organized and approached. The findings are outlined in Chapter 4, which will contain an account of the interviews and responses by the participants and offer a summary of the research. The final Discussion chapter will consider the findings of this study in light of the literature on feminist therapy and BPD, and consider its implications and significance for social work practice, policy, and further research.

CHAPTER II

Literature Review

This chapter reviews existing literature related to the etiology, diagnosis, and treatment of Borderline Personality Disorder (BPD). The first section of the literature review defines Borderline Personality Disorder and discusses its symptoms and prevalence. It goes on to discuss the stigmas and stereotypes attributed to BPD and challenges to the therapist in treatment. The second section describes common approaches to treatment of Borderline Personality Disorder. The third section explores the role of trauma in Borderline Personality Disorder, including the impact of repeated trauma in childhood and relational consequences of trauma. The final section explores feminist therapy as an alternative treatment for Borderline Personality Disorder.

Borderline Personality Disorder

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) describes Borderline Personality Disorder as: “A pervasive pattern of instability of interpersonal relationships, self-image, and affects and a marked impulsivity beginning by early adulthood and present in a variety of contexts” (APA, 2013, p. 663). Instability in interpersonal relationships may include extremes of idealization and devaluation, fear of abandonment and frantic attempts to avoid it. An unstable self-image can be seen in identity disturbance, and a chronic feeling of emptiness. Impulsivity may include self-damaging behavior related to sex, substance abuse, reckless driving, spending, or binge eating, self-mutilation, and/or recurrent suicidality. Finally, affective instability may manifest in intense episodes of distress, irritability and anxiety,

inappropriate anger and aggression, and transient paranoid or dissociative symptoms (DSM-V; APA, 2013).

Borderline Personality Disorder accounts for 30-60% of diagnoses of personality disorders and is said to affect 2% of the population at large, including 20% of those seen in inpatient facilities and 10% of those in outpatient mental health care. Women represent 75% of those diagnosed with BPD (DSM-V; APA, 2013). Self-injury such as cutting is frequent in clients who make up this group, as are suicide attempts. Suicide rates amongst those diagnosed with BPD are high, at 8-10% for this population (DSM-V; APA, 2013).

In a study comparing hospitalized patients with BPD and a control group of those without the symptoms/diagnosis, it was discovered that the population diagnosed with BPD is a heterogeneous group in particular personality adaptations, who share common cornerstone characteristics, of feelings of emptiness and loneliness (Numberg, Hurt, Feldman & Suh, 1988). This study concluded that unstable relationships, impulsive behavior, chronic feelings of emptiness and loneliness, self-harm (including suicide attempts), and identity disturbances with additional symptoms distinguishing subtypes (Numberg et al., 1988), are common characteristics of BPD. Chronic feelings of deep emptiness and loneliness and disruption in relationships and attachments are at the core of the diagnostic picture for BPD. As a result of these characteristic feelings, this population often struggles in interpersonal relationships, including relationships with a therapist (Danielson, 2009; Maleval, 2000).

Stigma and Stereotypes

Borderline Personality Disorder is a challenging diagnosis for the clinician to treat and myths and stereotypes about BPD can make appropriate recognition and willingness of clinicians to treat this disorder particularly difficult (Hersh, 2008). There are gender stereotypes about the

disorder, such as the widespread belief that only women are afflicted with it, as well as the view that it is “untreatable,” and the best that can be hoped for is that patients be contained in treatment and through hospitalization. BPD has thus become a controversial and often stigmatized diagnosis. It is not well understood by the mental health community as well as the public. It is a challenge for clinicians not only in diagnostic accuracy, but in the creation and implementation of treatment (Hersh, 2008).

Challenges for the Therapist

A study of therapists’ responses to clients with BPD as opposed to other diagnostic pictures concluded that therapists held a distinctly more negative view towards patients with BPD, and also feelings of dissatisfaction with sessions, despite desiring to help their clients (Bourke & Grenyer, 2010).

The relational impairments of BPD affect not only the personal life of the sufferer, but the extent to which the client and their therapist are able to maintain a relationship.

This relationship is likely to be as charged with emotion as any other in the life of the BPD sufferer...the client will idealize the therapist and at other times perceive betrayal and wish to flee. Such splitting presents as the most common obstacle to completing treatment. (Moskovitz, 2001, p. 88)

These clients can be difficult to retain in therapy, and combined with the unique demands this group may make on a therapist’s time and emotional energy, may become especially difficult to treat. Frequent self-harming including suicide attempts, volatile moods, alternating valuation and devaluation of the therapist, significant and often urgent need for extensive contact between sessions, repeated crises, irritability, as well as at times frequent inpatient hospitalizations may be included in their symptomatic behavior, placing corresponding burdens on the therapist to

treat. This population may enact the process of other relationships in their life by moving from therapist to therapist, often giving little chance for a long-term treatment (Moskovitz, 2001, p. 88). In these ways, therapists face many unique challenges to establishing a long-term therapeutic relationship with these clients

Common Approaches to Therapy for BPD

There are different approaches to the treatment of BPD, including medication and psychotherapy. Medication is utilized adjunctively with therapy to treat some of the symptoms associated with BPD such as struggles to regulate mood or affect, anxiety, impulsivity and depression (Van Kessel, Lambie, & Stewart, 2002). Several approaches to psychotherapy have also been used with this population. Psychodynamic approaches emphasize therapy as a restorative holding environment, that is responsive and nurturing to the client, ensuring the experience of safety and containment of difficult and sometimes intolerable emotions and affect, which is necessary for a trusting relationship with the therapist in order to move forward with treatment. Psychodynamic approaches treat BPD as a developmental disorder and may utilize different techniques and modifications, and be informed by different theories (Van Kessel et al., 2002).

Another approach to BPD is cognitive behavioral therapy (CBT). General CBT intervenes to change thoughts in order to bring about emotional and behavioral change. CBT may be used to directly address three fundamental cognitive schemas of BPD: “I am powerless and vulnerable; the world is dangerous and malevolent; and I am inherently unacceptable” (Beck, Davis & Freeman, 1990, p. 198). Modifying standard CBT to better meet the needs of clients with BPD is accomplished by increasing the focus on the therapeutic relationship, and integrating insights from Object-Relations Theory (Kellogg & Young, 2003).

Dialectical Behavioral Therapy. Originally developed by behaviorally trained researcher Marsha M. Linehan for women with histories of suicidal ideation or tendencies to self harm, Dialectical Behavior Therapy (DBT) has become a program designed specifically for those diagnosed with BPD (Linehan, Armstrong, Suarez, Allman & Heard, 1991). Based on a bio-social theory, Linehan posits that due to undetermined biological or environmental causes BPD sufferers experience a rapid rise of heightened emotional states and their retention for extended time periods before returning to their baselines, leading to lives of alternating peaks, valleys, and recurrent crises. BPD is seen as occurring in an emotionally vulnerable individual who has grown up in an invalidating environment. In this view clients with BPD evidence dysregulation in areas of emotions, cognitions, relationships, behavior, and sense of self (Linehan et al., 1991).

Dialectical Behavioral Therapy focuses on three “dialectical” or triadic dilemmas in the client’s life. The first dilemma is between their emotional “vulnerability” and the “invalidating environment,” resulting in “self-invalidation.” The second dilemma is between the pattern of “unrelenting crisis” and the consequent tendency to “inhibit negative affect,” loss, and grief, resulting in “inhibited grieving.” The third dilemma is that in their dysfunction they actively find people to solve their problems, termed “active passivity,” yet in response to the “invalidating environment” are really more dependent, resulting in “apparent competence” (Linehan et al., 1991).

The applications involve the therapist recognizing that the client’s behavior is understandable, the client wants to change, and needs to take responsibility for change. The therapist relates to the client in two opposed styles: primarily gentle “reciprocal communication,” but when needed “irreverent communication” to re-direct a client when they are stuck. DBT

emphasizes “contracts” and “skills teaching” in four primary modes: 1) individual therapy, 2) group skills training, 3) telephone contact (for skills support only), and 4) therapist consultation groups (for ongoing support and training of therapists). When compared with other community treatments in general, DBT is viewed as generally more effective in helping to regulate the symptoms associated with BPD (Linehan et al., 1991), and has become a standard for longer-term treatment of these clients. All of these approaches help the individual to function in life and in their inter-relational functioning, which is particularly important for this population, given the propensity for instability in relationships that becomes a devastating, and isolating cycle, as the BPD sufferer clings desperately in avoidance of real or perceived abandonment. Though there is currently no one universal treatment approach for the treatment of BPD, DBT is currently the most widely researched and utilized model of treatment for this population (Van Kessel et al., 2002). In a study of 108 women with BPD it was found that DBT markedly decreased the suicidality and aggressive anger in this population (Neacsiu, Rizvi, & Linehan, 2010). Additionally, in a study of a psychotherapeutic day hospital that utilized DBT, it was found that DBT was highly effective in treating the symptoms of BPD (Linehan et al., 1991). Given these results, DBT has become the standard treatment for this population.

Common elements of effective treatment. Treatments that are the most effective are those that are clear, structured, consistent, make efforts to obtain compliance and attendance, are long term and encourage a powerful attachment between the client and therapist (Bateman & Fonagy, 2000). It is also found that qualities of the successful treatment include: reducing blame or criticism of clients, treating clients as capable (rather than fragile), emphasizing hope and recovery, and providing a framework for coping with risk (Van Kessel et al., 2002).

The Role of Trauma in Borderline Personality Disorder

Research consistently demonstrates that those diagnosed with BPD are very likely to have experienced significant trauma during childhood. In fact:

Four out of five clients with BPD have a clear history of strikingly traumatic experiences. An overwhelming majority have been physically and/or sexually abused.

Many have witnessed severe violence among others in their household. Most commonly they have been traumatized repeatedly in more than one way. (Moskovitz, 2001, p. 31)

In a study of women on an inpatient unit with histories of either early onset or late onset sexual abuse, it was found that those with the early onset had a markedly higher rate of BPD (McLean & Gallop, 2003). Similarly, a study of children displaying early signs of BPD found a correlation between ongoing trauma by a caregiver and the symptoms of BPD (Seese, 1997). This may be because repeated trauma during childhood is experienced differently than other forms of trauma (Herman, 1997). Individuals who experience repeated trauma show higher rates of heightened emotional dependency (Allen & Lauterbach, 2007). It is also possible for fragmentation to occur in personality development following a history of previous or ongoing trauma in childhood. This fragmentation in personality development can be affected by biology as well as attachment (Williams, 2006).

Secure attachments, or consistent bonds with a trusted person, are necessary for healthy relationships in adult life. Trauma during childhood interfering with secure attachments to a trusted adult caregiver has negative consequences not only during childhood, but in adult life as well; therefore, intimate relationships can be affected by trauma, particularly childhood trauma affecting attachment in childhood (Zubriggen, Gobin, & Kaehler, 2012). For these children, “preservation depends on keeping hope and meaning as well as faith in significant figureheads. All of the child’s adaptations serve one purpose, and that is to preserve attachment to his or her

caregivers at all costs” (Williams, 2006, p. 32). Indeed, people seek attachment in times of danger and duress, and are apt to develop strong emotional ties to caregivers, even in the face of abuse. Early attachments to caregivers who cause harm can lead to confusion between pain and love (Herman, Perry & Van der Kolk, 1989). Individuals who have suffered this type of victimization may find anger directed at themselves or others to be a central part of their struggles in interpersonal relationships

Lindblom and Gray (2010) discuss Betrayal Trauma Theory (BTT), which holds that certain traumas, such as incest, should be uniquely categorized as “betrayal trauma.” Betrayal trauma is a subcategory of trauma in which the violation of trust, within a close relationship, occurs in the context of a traumatic event. Because of this type of betrayal trauma so early in life, the victim’s personality develops in this context, severely impacting their ability to trust, and leaves a void wherein the sufferer is constantly feeling deep emptiness and loneliness, as well as an instability and disruption in interpersonal relationships.

These forms of trauma have results beyond the symptoms of Post-Traumatic Stress Disorder (PTSD), in that they shape personality development in characteristic ways such as instability in relationships, impulsive behavior and chronic feelings of emptiness and loneliness. These trauma survivors may possess a vulnerability to self-harm (including suicide attempts) and identity disturbances. While these characteristics are often labeled a “personality disorder,” it may be more accurate to attribute them to the type of trauma than a deficiency inherent in the personality.

Alternatives Understandings of BPD

Some have argued for an alternative diagnosis, namely Complex Post-Traumatic Stress Disorder (C-PTSD; Herman, 1997). The proposed criteria for this diagnosis include: history of

subjection to totalitarian control (including domestic physical or sexual abuse) over a period of time, alterations in affect regulation, consciousness, self perception, perception of the perpetrator, relations with others, and in systems of meaning (Herman, 1997). Preliminary research seems to support this diagnosis. For example, in one study of hospitalized patients, many of those who met the criteria for BPD also met the criteria for Complex PTSD and could be properly reclassified under this second diagnosis due to their trauma history (McLean & Gallop, 2003). The inclusion of Complex PTSD in the DSM would thus support recognition of the trauma those with BPD have endured, and the meaning behind the personality development that occurs as an adaptation to these situations.

Another alternative view of BPD from an inter-subjective perspective is presented by Atwood and colleagues (Atwood, Brandchaft, & Stolorow, 1987; Atwood & Stolorow, 1984), who critique the view that BPD is a discrete character pathology solely within the patient. These authors have questioned the clinical evidence for the traditional understanding of BPD as a character structure with faulty object relations due to pathological ego functioning. Instead, the excessive aggression, splitting, and volatile affective states usually attributed to characterological borderline defensiveness is seen as arising from a developmental interference or arrest, usually due to early trauma. Because borderline phenomena are seen to derive from inter-subjective, relational causes, treatment is regarded as being relationally based, with the goal of a more stable self-object bond. More particularly, the client's development can be co-determined with an empathic therapist. The therapist's comprehension of the client's subjective universe and specific needs must be sufficiently extensive to facilitate the client's revision of their self-object needs and their hope for resuming their development (Atwood, Brandchaft & Stolorow, 1987).

Feminist Therapy as an alternative treatment for BPD/Complex PTSD

Feminist theory is an overarching framework and way of making meaning and relating to a client. Brown (2009) broadens the term *feminist*, in relation to therapy, to include a comprehensive multicultural framework that is not only for women, but for everyone. Brown (2009) defines feminist therapy as:

The practice of therapy informed by feminist political philosophies and analysis, grounded in multicultural feminist scholarship on the psychology of women, men and gender, which leads both therapist and client toward strategies and solutions advancing feminist resistance, transformation and social change in daily personal life, and in relationships with the social, emotional and political environments. (p.4)

Feminist therapy seeks to empower a client not only within the context of their environment, but within the therapeutic process and relationship itself. The Feminist Therapist does not view the client as “the other;” “What is inherent in feminist therapy is the radical notion that silenced voices of marginalized people are considered to be the greatest sources of wisdom...in feminist practice, the margins become a new center epistemologically and culturally” (Brown, 2009, p. 2). This sets the stage for the open acknowledgement of a power differential between therapist and client, and how they both may collaborate in the client’s treatment, with shared power shifting back and forth between them as the client develops more self insight and is able to positively influence content in sessions.

The relational stance of feminist therapy empowers the client through the therapeutic inter-being, in which the therapist is engaging in an empathetic healing presence, and the dyad engages in an authentic connection of mutual empowerment and meaning making (Walker, 2009). The core beliefs in feminist therapy practice are that people grow through connection and therefore the purpose of therapy should be bridging a connection rather than separating the client

and therapist through use of power, and that chronic disconnection is the primary source of suffering (Chesler, 2006; Walker, 2009). Feminist therapy practice examines and challenges the schema of both the therapist and the client, and of the open discussion and shifting of the power dynamic within the dyad (Gilbert & Rader, 2005; Walker, 2009).

Application of Feminist Therapy for BPD and Trauma

Feminist therapy has a lengthy history of being used in trauma work and that it lends itself well to the work:

The feminist models attend as well to relational and process components of trauma and then focus on these in the treatment process...feminist therapy is a technically eclectic, integrative practice, a feminist therapist has a range of modalities with which to approach working with trauma survivors (Brown, 2004, p. 4).

Attachment affects personality formation and adult relationships and in turn, the therapeutic relationship. Therefore, the relationship with the therapist becomes both a vehicle and model for healing through the same channel one has been victimized: trusting relationships. Thus this model may provide a responsive approach to the unique relational needs of the trauma survivor, factoring in these attachment adaptations and struggles of these clients. The focus on power sharing and empowerment of the client gives the opportunity for the client to reclaim power by being a partner in her therapy rather than approaches that may reaffirm the client's diminished sense of power in the world and over themselves (Collins, 1998).

The Current Study

The relationship between clients with BPD and their therapists is of the utmost importance in positive treatment outcomes (Bateman & Fonagy, 2000; Van Kessel et al., 2002), and due to the nature of the development of this disorder, this relationship becomes not just

important, but essential for the treatment of BPD. The hypothesis of the current study is that the relationship between the therapist and client would benefit from the egalitarian, empowerment model of a feminist framework. The next section contains the Methodology, which describes the design of the study. The Methodology is then followed by the Findings of semi-structured interviews with 12 participants, licensed clinicians who identify as feminist therapists. These participants share their perspectives on working with clients diagnosed with BPD, and what they consider to be the unique benefits of feminist therapy for this group.

CHAPTER III

Methodology

The purpose of this study is to investigate the perspectives of seasoned clinicians exploring the benefits of utilizing a framework of Feminist theory and the practice of Feminist therapy for the treatment of BPD and discover what treatment approaches are most empowering to this population as well as what is taking place relationally when using this approach. The current investigation was an exploratory, qualitative study, using individual, hour-long semi-structured interviews with twelve seasoned therapists to gain information about the benefits of Feminist theory and practice for both the understanding and treatment of individuals diagnosed with BPD. The participants who were interviewed were licensed Masters or Doctoral level practitioners with at least two years of experience post-graduation as well as experience providing individual psychotherapy with at least three clients in the past two years who have been diagnosed with BPD. This methodology was chosen to elicit insight from seasoned clinicians as to the effects of using a Feminist framework as well as how a trauma informed perspective influences their work with this population. The semi-structured format allowed for flexibility in responses from the therapists, as they were able to both reflect on specific topic areas but not be restricted in their responses, should other themes arise.

Sample

A nonprobability snowball sampling method was used to draw from the researcher's professional network and contacts by identifying therapists who utilize a Feminist framework and work with clients diagnosed with BPD. The researcher contacted these identified clinicians

via a recruitment email (see Appendix A). Clinicians were asked to forward the email to other potential participants in their professional network who may also meet these criteria. To be included in the study, participants had to be licensed Masters or Doctoral level therapists who are fluent in English, had two years post graduate experience, identify as using a Feminist orientation or practice model, have experience working with and be willing to reflect on experiences with at least three clients who meet the DSM criteria for BPD in individual therapy within the past two years. The sample size was 12 participants. While every effort was made to include participants of differing genders, ages, and racial/ethnic backgrounds, the sampling method, small sample size and small population size did not allow for specific recruitment for diversity.

Data Collection

Prior to the beginning of the research, the Smith College School for Social Work Human Subjects Review Committee approved this study (see Appendix B). The participants were given a copy of the informed consent form (see Appendix C), which was reviewed with them prior to the beginning of the interview, and explained the nature, benefits and risks of participation in the study. Participants were informed that they would not be monetarily compensated for their participation in the study though they may benefit from reflecting on and contributing their experience. The participants were informed that their participation in the study will contribute to a body of information for therapists who work with the population of clients diagnosed with BPD on the possible benefits of a power-sharing, feminist framework. Participants were informed that their participation in the study was voluntary and that they could withdraw from the study at any time up until two weeks post interview at which point the information had already be entered into data collection.

The participants were interviewed in person or via telephone in a private location to protect confidentiality. If the participant was not in the local geographic area, the researcher conducted interviews via telephone. The researcher tape-recorded the interviews with the participants' permission, transcribed the recordings with all identifying information being removed in the transcription process.

During the one-hour individual interview, participants were asked ten open-ended questions as well as follow-up questions asking for clarification of responses if necessary (see Appendix D). Participants were asked basic demographic information, including the participants' licensure, age, gender, years of experience, and years of post-graduate experience with clients diagnosed with BPD and whether they have worked with this population in other settings. Participants were asked what Feminist therapy meant to them in their practice of therapy in understanding BPD. They were asked to reflect on their work with this population and what other theoretical frameworks they may draw from to work with this population. They were also asked to reflect on unique benefits and weaknesses of Feminist Therapy to this population.

Data Analysis

The data were transcribed and analyzed by the researcher. The responses to each of the 10 questions were grouped together and coded for themes within each question, including similarities and differences among participants. Responses were then examined across questions for patterns related to understandings of feminist therapy, BPD, trauma, and the therapeutic relationship, as well as any relationship between responses and demographic variables. The findings of this study are presented in the next chapter, followed by a discussion in light of other research and how future studies might further serve to enhance the body of knowledge in this area.

CHAPTER IV

Findings

This study used semi-structured interviews to elicit perspectives from 12 practicing clinicians to explore the benefits and limitations of the framework and practice of feminist therapy for the treatment of Borderline Personality Disorder (BPD). In pursuing this aim, the study sought to elicit from this group of clinicians: 1) their conceptions of what feminist therapy is and how they implement it in practice; 2) how feminist therapists understand BPD; 3) if feminist therapists adapt their approach with BPD; and 4) what the strengths and limits of feminist therapy are for BPD. This chapter contains a summary of the demographics of the study sample, as well as a summation of the themes from the interviews. A more in depth analysis will be found in the discussion chapter that follows.

Sample Demographics

This study consisted of twelve participants (n=12), each of whom had a minimum of two years or more of practice as a therapist, as well as at least that same minimum amount of experience working with clients who have been diagnosed with BPD. In fact, most of the participants in the study have been practicing therapists for over ten years. Using a prepared set of questions, semi-structured interviews with follow up questions were used in obtaining relevant information. Seven (58%) interviews were conducted in person, and five (42%) interviews were conducted over the telephone. Interviews lasted an hour or less. Audio recordings of the

interviews were made. Demographic information for the sample, such as gender, race, age, primary practice setting, and education was gathered.

All (100%) participants in the study identified themselves as female, and none (0%) as male. Two (17%) participants described themselves as people of color, having different multiple heritages. The other ten (83%) described themselves as either Caucasian or white. Participants ranged from 33 to 65 years of age. The mean age was 39. Seven (58%) of the therapists interviewed practiced primarily in the setting of a college counseling center, although they had private practices as well. The other five (42%) participants were primarily in private practice (see Table 1).

Table 1

Participant Demographics

Measured Variables for Participants (n=12)

Participants' Gender	Number	Percent (%)
Female	12	100
Male	0	0
Participants' Ethnicity	Number	Percent (%)
Caucasian/White	10	83
People of Color	2	17
Primary Practice Setting	Number	Percent (%)
College Counseling	7	58
Private Practice	5	42
Method of Interviews	Numbers	Percent (%)
In Person	7	58
Telephone	5	42

The educational backgrounds of the participants include nine clinicians (75%) holding Master of Social Work degrees, as well as one clinician (8%) with a Ph.D. in Social Work, one clinician (8%) with a Doctorate in Psychology, and one MD (8%) licensed in Psychiatry. Thus, clinicians with MSW degrees can be seen to make up three quarters (75%) of the sample and clinicians with advanced degrees beyond the master’s level, including two academic doctorates and one doctor of medicine, can be seen to make up one quarter (25%) of the sample (see Table 2).

Table 2

Participant Education

Educational Background	n	%
PhD, Social Work	1	8%
PsyD, Psychology	1	8%
MD, Psychiatry	1	8%
MSW, Social Work	9	75%
Total	12	100%

After conducting the interviews, reviewing the statements and opinions expressed in them by the 12 therapist participants, and comparing, contrasting, and coding the results, the following themes emerged from the interviews.

Descriptions of Feminist Therapy

To orient and give definition to the study at the outset, all of the participants were asked to offer their conceptualizations or descriptions of feminist therapy from the perspectives of their own practice experience. All (100%) of the study participants identified themselves as practicing a feminist model or approach to therapy. Interview questions were designed to encourage participants who identified as feminist therapists to reflect on their work with clients who are

diagnosed with Borderline Personality Disorder (BPD). One therapist (8%) mentioned her training in dialectical behavioral therapy (DBT), but applied that behavioral training and orientation within or “wrapped” in a larger feminist perspective and using a feminist lens.

This study found that in giving descriptions of feminist therapy there was general agreement and consistency in the way the participants conceptualized it. All 12 (100%) of the participants brought up *lens*, *context*, and *power* as the central, defining concepts in describing what they saw as the feminist therapy framework. Within this shared framework participants also offered similar descriptions of its implementation by the use of greater *transparency* in the therapeutic process, *power sharing* between therapist and client in the form of acknowledgement of power differences in therapy, and *collaboration* in the examination of problems and choices for treatment, with the client being regarded as the expert in their own life. The specifically feminist intervention was regarded to be the nature of the therapeutic alignment itself, with an increased focus on the empathetic involvement of the therapist in the therapeutic dyad, and the development of the *therapeutic inter-being* offering a caring and trusting relationship with the client. Participants in the study exhibited more variety in their choices of additional adjunct intervention techniques, as will be further elaborated in a subsequent section of this chapter.

When referring to the feminist *lens*, all (100%) of the participants spoke of it as a conceptual framework or way of viewing, thinking about, or seeing the world based on a multicultural feminist psychology grounded in a recognition of gender and power inequalities in society, useful for treatment of both women and men. Its implementation was seen in terms of a technically eclectic, integrative practice able to embrace multiple treatment modalities if conceived and approached in ways consistent with a feminist framework.

Locating the client within a socio-cultural and psychological *context* seemed central to the construction of the feminist lens. In discussing context from a feminist therapy perspective in response to questioning, all (100%) of the participants used context to mean the social, cultural, and psychic world or environment in which the individual found herself/himself, including how and where they grew up, how they were perceived, and how the larger external world around them impacted them. *Power* was brought up in terms of the power dynamics, power differential, inequality, or even oppression which was experienced by the client in contending with the psychosocial and cultural environment in which she attempted to negotiate her way through the world. One (18%) of the participants expressed her sense that feminist therapy was intended to “liberate” the client from their sense of “internalized oppression.” Others did not put it quite this way, but spoke similarly of both external and internalized power differentials, particularly in reference to race, class, and gender as articulated in the discourses of critical theory and gender studies.

Accordingly, in further delineating their references to lens, context, and power in describing feminist therapy, other concepts were frequently used to further elaborate these themes. In particular, race or ethnicity was specifically brought up by 5 participants (42%), class by 4 participants (33%), and gender or sexual orientation by 4 participants (33%) as being features formative of social identity and determinative of power inequalities whose explicit recognition was part of a feminist therapy framework. Biology or the somatic was brought up 2 times (17%) as being a factor in the biopsychosocial intersection in humans both formatively impacting them and requiring their attention and responses. Teaching was mentioned 2 times (17%), in reference to the feminist therapist’s need to teach some skills to the client at times, and thereby to depart in some degree from a completely egalitarian interaction. This was considered

appropriate if the power differential was acknowledged by the therapist explicitly, and if the teaching was not entered into in a way that the client would find disempowering. Age was specifically mentioned once (18%) relative to the client's traumatic experiences, especially early trauma, and also in terms of a client's present needs. Geography was spoken of once (18%) as a possible feature of context, more in the sense of cultural geography, and the role of differences of place in the formation of a client's personality and experiences, how the client viewed themselves, and how they were viewed by those around them. Cultural mores were also specifically mentioned once (8%) as a contextual feature that helped form a person's values, that differed from group to group and over time, and that provided terms for a person's valuation or devaluation of themselves.

Other concepts used to describe the model of feminist therapy included respectful process, consent, choice, and holistic, mentioned one time (8%) each. In this instance, respectful process implied a greater emphasis on mutual respect in order to facilitate mutual collaboration, pointing to a softer style, and a language of asking rather than telling the client. Following from this softer process the client would be offered choice in interventions or treatments, and ultimately would give consent to any intervention. All of these aspects of the feminist approach to therapy are part of what is meant by collaboration in the feminist sense. The sense of being holistic implies seeing and treating the whole person across the ranges of context and biopsychosocial needs, indeed, seeing the person rather than the pathology. All of these concepts would come up again and again and also be further amplified and shaped by the participants in the context of other questions. These ideas are neither exhaustive of the participants' descriptions of feminist therapy, nor of themselves or their experiences as therapists. Yet in a revealing way these conceptualizations, used in answer to the question of how participants

conceptualized feminist therapy, serve to open the door to the themes elicited from them throughout the interviews.

In thinking about what was essential or foundational to feminist therapy at the outset of the interviews, one of the participants pointed to the importance of the use of the feminist lens in understanding the world in ways that provide meaning both to the therapist and to the client:

I think of feminist therapy as being informed by the lens through which we make sense of everything, not just the work here but the world in general, in that there's a recognition of power dynamics and inequalities and oppression and context that informs people's experience, and that people's pain comes not just from their own psychic experience or history or psychology, but from the world.

A different participant also spoke of the central conceptual role of the feminist lens and how it helps provide context in understanding a client:

I think I view feminist therapy as another lens by which to understand people or view people.... For me, I find it very helpful because it puts the person in a context. And I think that while I strongly believe in the unconscious, and the intra-psychic, and the individual, we are also shaped by what's around us, including class and race, so that's a big part of it [feminist therapy].

In describing her first acquaintance with feminist therapy in social work, another participant felt it flowed naturally from the perspectives of social work as a field of study and practice, and emphasized the explicit use of context in feminist therapy:

I think the first thing that struck me was its overlaps with social work practice especially, and the social work perspective, which for me means looking at the client's entire life and outside world, and not just someone's internal world. So, that while someone's internal

world matters a lot, so does their social context: who they are, and how they are viewed in the world, and what their experiences have been in the world.

This same participant spoke about how the feminist lens was utilized in practice to move some of the socio-cultural context of an individual's life from the background to the foreground:

I think that over time most “good therapists” think about those things, but those are often background, and what's foreground is someone's internal structure. And for me [as a feminist therapist] I think those are all foreground. And maybe they move a little bit at times, you know maybe what's mostly in the foreground. But I think that though the contextual factors in someone's experience growing up in this country, either as female, or a person of color, or gay, or whatever it may be, isn't sort of a back seat to how I would think about or understand them, or my work with them, or how I would understand the feminist model, that it really takes into consideration all those factors.

Yet another participant described her way of conceptualizing her work with clients in terms of her sense of the individual's context or social surroundings, as well as regarding the client as an expert in their own life, and approaching their problems collaboratively:

I think when I meet someone, and during my work with them, I am always thinking about what's inside of them, the intra-psychic. But I'm also thinking, “where did they grow up?” I think collaboration is probably the biggest one, and that I think in a feminist therapy I don't feel that I know the answers. It's really the client and I who together are going to figure this out, and hopefully we're both going to be surprised and learn a lot, 'cause I think when therapists feel like they know more about the patient that's a real mistake, and it kind of closes a lot of potential growth and work that can happen.

Still another participant expanded on the sense of context in feminist therapy, and elaborated it with a view to a larger socio-political awareness she believed could sometimes enhance clients understanding of themselves:

It's just always what we're aware of and thinking about, and the interplay between the presenting problem and our personal experiences as a human being. I like bringing up people's perceptions of what's going on politically, as well, and how that affects their lives. In many ways they may not be thinking in that way, but I'm thinking in that way, and so I try to raise that, and see how the larger scale of things affects their daily lives. I definitely pay attention to all those "isms."

For another participant, the questions provided an opportunity to reflect on some of the ways her view of feminist therapy had developed into a more complex, contextual model with four broad parameters, which she termed the spiritual, somatic, inter-personal, and intra-personal:

For me, it's really about breaking down power in 4 different ways as a feminist: which are the spiritual, the somatic, the inter-personal, and the intra-personal. I try to go into those areas of people's lives and figure out how they can achieve more power.

Asked to elaborate on each of these four areas, she responded that the spiritual has to do with the power of being centered, and connected to something larger than themselves:

So the spiritual is anything you do to worship, to take care of yourself, to feel centered, and so on. It's not necessarily the traditional sense of going to church. People have all these different things that help them feel connected to their spirituality or not connected, and of figuring out what the distress is or coping mechanism can be in that sense of their lives.

She continued with the somatic, which she characterized as a person's feelings of wellbeing and power in the physical side of themselves:

The somatic has to do with your health, your sleeping, symptoms of depression, and how to manage that, how to have your body get to a point where it's centered and you feel well so that you feel power within the physical side of yourself.

The interpersonal was seen in terms of the power context of people's relationships:

The inter-personal is all that social context, and what happens in your relationships.
How are they useful to you?

The intra-personal referred to a person's interior emotive and psychological states and processes, which have been the traditional province of psychology:

And the intra-personal is that intra-psychic stuff. What is all that stuff happening inside you? It is a very different way to think about power and distress than traditional psychotherapy.

It was this wider sense of context that this participant wished to point to as more integrative than traditional psychotherapy:

I think traditional psychotherapy will take you just to the intra-psychic, or to CBT, or to something evidence based, but a feminist approach is really trying to look at all those 4 areas, and how they interact, too.

As can be seen, the description of feminist therapy offered by the remarks of this participant is illustrative of the holistic aspect of the feminist approach to practice.

Collaborative style in the therapeutic relationship: transparency and consent. An acknowledgment of power differences between therapist and client, a collaborative approach to the therapy process, transparency with the client about that process, and gaining the client's

consent for a choice of treatment techniques were all key issues participants commented on as something feminist therapists do differently. These feminist therapists believed they gave greater explicit attention to explaining to the client what was involved in the therapy process than therapists using other approaches. This therapist illustrated this more open and collaborative style in how she talked with clients about trauma, for instance:

I name what I'm doing. If they're talking about trauma, we'll talk about how to talk about it, and what might come up, and what their feelings might be, and whether it's o.k. to talk about it, and how much to talk about it today. So, I don't spring things on my clients. If I talk about something more dynamic I will also sort of say, "well, one way of thinking about this might be such and such."

In this way, collaboration, a central emphasis of feminist therapy, allows the client to be an active partner in deciding where content moves within the sessions and provides a containing structure in which to reflect upon the process in the room as opposed to just the content itself. Transparency about the therapeutic process on the part of the therapist is fundamental to allowing this more egalitarian kind of collaboration in the feminist sense to take place.

Shared expertise and holding multiple truths. Feminist therapists believe they may share expertise with the client by recognizing that the client is the expert in their own life, and by partnering with them in trying to discover and understand that life. In the following remarks one therapist speaks of not imposing an "expert" single formulation of "the truth" on her clients, but in piecing together with the client a more explanative, empowering and healing understanding of the clients' experiences:

But I'm not telling them that that's what I know to be the truth or some expertise that I have that they don't have... I think it's feminist to see the client as the expert in their own

life. They are living this life, and just because I have a degree doesn't mean I know more about their experience than they do.

The client's version of their life, or "truth" about it, is their lived and meaningful experience, including its pain, and this truth may be explored with the therapist as a layer or as multiple layers in a variety of ways to view, construct, narrate, or re-narrate their experiences for different purposes in understanding or transforming it.

Difference from other approaches. As a consequence of their emphasis on collaboration, power acknowledgment and sharing, and greater transparency about the therapeutic process, the participants felt that the feminist approach was different from other therapeutic frameworks in that clinicians bring more of themselves into the therapeutic process empathetically and relationally. This often includes setting more flexible boundaries, letting the clients be the experts in their own lives, and taking a more egalitarian view of the therapy process. This therapist comments on these issues in the following way:

I think when I was in school there was a lot of focus, especially when working with people with borderline personality disorder, on limitations and withholding, which to me seems sort of an anti-feminist model...I think that's a lot of what I was taught, that if somebody is wanting something that I don't feel comfortable doing or I can't do, that it was sort of a boundary problem on their part, or they were too needy or manipulative or whatever it might be, and I just don't generally think about it that way. So I don't particularly care for the words "gratifying" and "withholding," but I think "gratifying" has sort of a bad rap somehow. I think if people need things, they need them.

In this way, transparency, collaboration and different conceptualizations about boundaries differ from other approaches.

Are there feminist therapy interventions? In responding to the question of whether there are specifically feminist interventions, all 12 participants (100%) said that all interventions are feminist if done within a feminist frame of reference. Most (83%) participants remarked it was less the intervention and more the frame that was specifically feminist. Many (75%) participants stated that any intervention can be (or be made to be) feminist, and that they move in and out of other therapies within that framework. As one of the participants put it, “Any kind of intervention, you can be a feminist and do it.”

All (100%) the participants stressed collaboration, nurturing, flexibility, and emphasized asking rather than telling, feeling that the language of the intervention was different. Five (42%) participants emphasized that collaboration was a specifically feminist intervention. All (100%) of the participants stated there was an emphasis that the client was the expert in their own life. Many (75%) participants believed an intervention, to be feminist, needed to be less rigid, with more negotiating. All (100%) gave emphasis to transparency in the therapeutic process as creating the environment for collaboration. One (8%) participant offered that she and the client co-created the intervention. Another (8%) participant stressed that a feminist intervention involved not blaming the client, validating trauma, and the therapist owning their subjectivity and what they are bringing into the room. One (8%) participant, referring to theory somewhat in contrast to the others’ emphases, offered that her interventions were framed within feminist and attachment based theory. As can be seen, these viewpoints are in broad agreement, differing primarily in emphasis, but from within the same larger theoretical orientation, worldview, and value set.

The therapeutic relationship. Participants seemed to agree that there is perhaps no more fundamental issue around which the framework of feminist therapy is constructed than that

of the therapeutic relationship. Feminist therapy shifts the emphasis more heavily to the therapeutic relationship than many other therapies. All (100%) 12 participants consistently saw an increased focus on the therapeutic relationship, and its more collaborative and transparent structuring, as a central feature of feminist therapy. The centrality of this relationship is here highlighted by one of the participants:

It is all about the relationship in many ways, so you are dealing with all these issues but you are paying attention to the relationship. And a lot of times that's how we learn. We're in relationships and we learn from those things...I feel like a feminist approach lets you focus more. Thus, feminist therapy makes room for a specific focus on the therapeutic relationship, partnership and collaboration within the therapeutic dyad.

Here, feminist therapy also is described by its practitioners as relationally oriented, beginning with the therapeutic dyad. In this view, if chronic disconnection in relationships is a major (or perhaps primary) source of suffering, then regular and reliable reconnection, beginning with the therapeutic relationship, is an important basis for healing.

Summary of descriptions of feminist therapy. In summarizing the responses of the participants to the question of how they conceptualized feminist therapy, this study found that the central defining concepts of the feminist lens, context, and power differentials were the key terms in which their descriptions were given. These were then seen as implemented in practice through transparency in the therapeutic process, power sharing between therapist and client with the client as the acknowledged expert in their own life, and collaboration within the therapeutic relationship in terms of looking at problems and choosing intervention techniques. Lastly, the therapeutic relationship itself, with its space for containment, and the formation of the therapeutic dyad as constructed within the feminist framework, was a feminist intervention. The

openness and integrative quality of the feminist approach also allowed for feminist therapists to employ other intervention techniques as may be found useful.

How Do Feminist Therapists Understand BPD?

The DSM describes BPD as a pervasive pattern of instability in inter-personal relationships, self image, affects, with marked impulsivity, including extremes of idealization and devaluation, fear of abandonment, chronic emptiness, and self-destructive behavior. It is said to account for 30% to 60% of personality disorders, affect 2% of the population, represent 20% of those seen in inpatient facilities and 10% in outpatient care. Fully 75% of those diagnosed with BPD are women (DSM-V; APA, 2013). There is currently controversy about this diagnosis, with some clinicians suggesting that it unfairly stereotypes and stigmatizes women, and is nearly always connected to trauma, either early, ongoing, or complex trauma, especially in relation to a trusted caregiver (Herman, 1997; Hersh, 2008; Lindblom & Gray, 2010; McLean & Gallop, 2003; Moskowitz, 2001; Zubriggen et al., 2013).

The feminist therapist participants in this study shared these concerns in regards to the diagnosis having stigmatizing consequences, particularly for women, and instead, 92% of participants saw trauma in some form as the most essential feature of the population carrying this diagnosis. One of the participants likened the BPD diagnosis to “Freud’s concept of hysteria” in the history of psychology. These participants tended to treat the trauma of the individual, and the individual needs of the client, from the viewpoint of the feminist lens and its consequent emphasis on collaboration and empowerment. There was also wide employment of other interventional techniques where it was found useful and appropriate to the individual client.

Trauma and BPD. All of the participants in this study felt that trauma was very relevant to this population, and took this into account in their work. More specifically, all (100%) of the

clinicians interviewed identified trauma as integral to people with the BPD diagnosis. Feminist therapists stressed the vulnerability of this population rather than blaming their clients for dysfunctional or unacceptable behavior, and generally offered a gentler, more flexible, collaborative approach to treatment of BPD rather than rigid boundary setting and rule based approaches. One participant put it this way:

This population has typically experienced trauma, and often early trauma. I think in terms of adapting an approach that it's important to be particularly gentle and aware that people are doing the best they can, that they really wouldn't be behaving this way if it wasn't their best way of defending against pain. It's probably maladaptive, which is why they have that diagnosis in the first place, but it's the very best they can do. So, I want to be careful to not inflict further pain. And I think a lot of practitioners have inadvertently inflicted more pain. And I'm sure I have, too. But I want to be cognizant of just how tender people are. They're just so vulnerable.

Another participant commented on the trauma to the self and the lack of control this population feels. In the following quotation she seems to be implying that there is a need for a broader definition of trauma than is often employed:

I don't think it just has to be physical or emotional abuse or neglect, but it can be any kind of growing up situation in which the person ends up feeling out of control and very helpless. I think being overwhelmed and helpless are hallmark reactions to trauma. But I think with this population, I'm always going to see some kind of trauma to the self.

The recognition of trauma in some form as central to clients carrying a diagnosis of BPD provided a basis and direction for the treatment of clients with BPD for the participants in this study. The reflection on the need for a broader definition of trauma by one of the participants

seemed like a response from this viewpoint to the great variety of individual traumas encountered by clinicians in their practices.

Testing, trust and acting out with BPD. Precisely because of their trauma histories, clients carrying the BPD diagnosis have a reputation for being especially distrustful of others, especially caregivers and authority figures, including members of the healthcare community. As a consequence of their experiences, and especially their trust issues, this population may engage in more adamant and suspicious testing of the therapist, and this can lead them to more emphatically aggressive interactions and acting out towards the therapist. One participant generalizes from her experience with these issues:

They do a lot of testing because they've basically grown up not trusting anybody, and that was smart, right? I mean, given what a lot of them experienced in their life, I wouldn't trust almost anybody, either. You know, "are you really going to be there for me?" "Do you really care?" I think for some of these folks, there is absolute terror about getting close to another human being, so they try as they can to get rid of us. I think now I might talk about, 'are you trying to get rid of me?' 'What is this about, you know, not showing up?'

Testing and acting out, including ego assaults directed towards the therapist, and enacting the process of other relationships in their life in their behavior towards the therapist, including moving from therapist to therapist, are some of the issues that cause clients with BPD to have a difficult reputation with clinicians and to be regarded as so difficult to treat. These problems are seen by feminist therapists to be based in relational disconnections consequent to traumas, and the relational reconnection sought in feminist therapy is seen as an essential basis for rebuilding a healing connection.

Boundaries with clients with BPD. Feminist therapy often stresses a softening or relative relaxing of boundaries as one of its tenets in its approach to the treatment of clients with BPD. Eleven out of twelve therapists interviewed (92%) described having more fluid and flexible boundaries when working with clients carrying this diagnosis:

I have a client I've been seeing now for 6 or 7 years who is someone who emails me quite frequently, someone who I do phone sessions with sometimes during the week, and I actually see her reaching out and wanting to do that as sort of a healthy striving. I think it could be pathologized [from another approach], that she needs too much or she's being intrusive. I think that in having the feminist lens on the work, I don't experience it that way. It's not that I might never feel intruded upon or like something's too much for me, but I feel like that's my limitation, then. It doesn't feel like it's the client's.

In reflecting on how her reactions to boundaries with clients with BPD have relaxed somewhat as she has become more experienced in feminist therapy, another participant notes:

I think I used to have the mentality of "you come to me during this time, and if you want to be seen twice this week that is not going to happen." Thinking of this one client, I think I've become more understanding of those needs that she has in spilling over those boundaries. And I don't allow her to spill over them too much but at the same time I try to use them as moments to help explain to her why I can't meet that need in that moment but that we are in this together, so let's try to find a time together when we can meet and let's find a way together for me to help you contain your emotional reactivity and feel like you can hold onto these feelings more... It's not the DBT mentality of every time you need extra from me I'm going to give to you back the skills you need to be independent. There's the relational piece that says you've been deficient - there's this

black hole sort of, and I can't fill it up, nobody can ever fill it up, but I can sit there and look at it with you . . . maybe tomorrow at 2:30.

In contrast to this general view of relaxing boundaries, one (8%) participant actually spoke of her sometimes more defensive reactions with clients diagnosed with BPD, although the larger context of her interview indicated she was coming from an approach of more relaxed boundaries to begin with, and so her tightening of them was a relative matter:

when I think of clients diagnosed with BPD I do adjust what I do at times because I do become more hyper-aware of how someone with BPD may use our relationship to manipulate me, and so I do in some ways sort of buckle up a little more, maybe. I feel a little more on the defensive. . . . I feel like I am very naturally maternal, also, in my style, but with someone with BPD I may get a little more authoritative. I realize that is a way of protecting myself and making sure the boundaries are observed.

A further elaboration of reasons for flexible boundaries and “gratifying” in the feminist approach as they relate to the diminishing of testing, intrusiveness, and “neediness” in clients carrying the diagnosis of BPD is given voice by this participant in what follows:

Are we going to be empathic and compassionate and co-gratifying, or are we going to be boundaried and withholding and following the rules? I actually think for many clients, maybe not all, that that latter kind of approach, being that rigid, can stir the client up more than the more gratifying, empathic response. So for some clients to say “I'm not reachable between sessions” can increase the longing and the need for communication, whereas saying “I am reachable between sessions” can actually be all they need. Some of the clients initially call me, and will call me a lot, and then that sort of decreases.

Sometimes a participant found disagreement from a colleague coming from a different approach to therapy, which used firmer boundaries in working with clients with a BPD diagnosis:

The couples' therapist said to me "I don't know about her calling you so much. I think she needs to learn to be able to depend on herself." And I said, "well, that would be nice, if she could, but right now she can't". And the therapist and I had a different view of that. I think the therapist thought I was enabling her. I think this is where the feminist approach really is important, and I think a more dynamic approach. I knew the person, and I knew that she hadn't needed to call me for years and years, so there was something different about what she was feeling and couldn't manage now. And yes, my boundaries are more fluid. But I see that work, telephone work outside the session, as therapy, too. I don't see it as breaking the frame, or something extra. I mean, if I could have seen her every day, that's probably what she would have needed, and I couldn't do that.

This study found that the practice experience of the participants tended to agree with the sentiments echoed by the speaker above in terms of the reactions of BPD clients often being stirred up by a harder, more authoritarian, rule-based approach to treatment. The relaxing of boundaries with this population was employed by nearly all (92%) of the participants as a response to their increased needs, and was found by these participants to actually be helpful in reducing the level of demand for the therapist's attention after the client's opportunity for testing.

Reactions to the BPD diagnosis: stereotyping and stigmatizing women. All participants had a reaction to the use of the diagnostic label "Borderline Personality Disorder." What came up in discussions was that it was used stereotypically almost exclusively to apply to women, in a stigmatizing way, and had extremely limited usefulness in understanding the causes or treating the symptoms. One participant interviewed said:

As a feminist therapist I don't tend to use the diagnosis of borderline personality disorder [BPD] even though I have a lot of patients who would fit that criteria of symptoms. But I think I've only once in about 35 years heard a man diagnosed with borderline personality disorder. So, I am very reticent to use it because I think it's been used in psychiatry in a pejorative way, and only towards females, and I tend to think of borderline personality disorder more like Judith Herman as a complex trauma issue, or complex PTSD. A lot of people just throw it around and don't think twice that, hmm, why is it only women? It's a little bit like "hysteria" was, right, 40 or 50 years ago or more, in that only women were diagnosed as "hysterical," and not men.

All (100%) of the feminist clinicians interviewed saw the diagnosis of BPD as pejorative and stigmatizing to women. Most (83%) clinicians did not prefer to use the term. In contrast, one clinician tried to see the positive intention of the original concept in the DSM apart from the subsequent stigmatizing application of it for women. Trying to see value in the original formulation of it, she said:

If people just took the diagnosis as it's written and wanted to help people from suffering, versus characterizing them as difficult and not fun to work with, the diagnosis wouldn't have the stigma. It's just how it's written in the DSM isn't as damaging as how it's perceived and used and misused.

Another participant pointed out the different reactions of professional healthcare workers to a client given the diagnosis BPD versus PTSD:

When you present to a team "I'm referring this person with borderline personality disorder" you get a very different response than if you say "I'm referring this person who has PTSD," and their symptoms may be quite identical. But I think that our

immediate feeling about meeting with that person, how we enter the relationship, is often very different depending on the diagnosis someone carries, and I think that communicates something to the client.

Different diagnoses may also labor under the burden of different stigmas, leading sometimes to inadvertent shaming. A different participant spoke out about her concern for the way she feels therapists and the mental health community at large can unintentionally shame clients with BPD:

When I say “we” I mean all mental health practitioners, can inadvertently shame our clients, identify undesirable behaviors, and question them. I think this population is very tuned in to emotional nuance and judgment, and we let it seep out. They feel our judgment. So we have to work extra hard to be compassionate.

Many of the clinicians were concerned about the stigma that goes along with the diagnosis, both for the individual who carries the diagnosis, and the perceptions of clinicians working with this population:

There’s a lot of stigma attached to that diagnosis and I think a lot of people bring that into their work with people who carry that diagnosis. I prefer not to use a diagnosis, but rather, to think about the person’s experience of their life and relationships and difficulties and struggles and symptoms that they want to work on - look at the function of the behavior because we all do things that serve a purpose. I really don’t like labeling and try to set that aside.

For feminist therapists who are concerned about the stereotyping of women as well as the stigmatizing effect of the BPD diagnosis, one may well ask how do they approach their work with clients carrying the BPD diagnosis that they regard as less stereotyping and less stigmatizing? This participant attempted to explore her approach with that in mind:

I try to help people to see that it's not strictly something within them, and to have them look at the society that we live in and the environment they grew up in and helping people to understand it's a way they've developed of functioning in the world, not this illness that's within them. I think society in general, female stereotypes, dynamics in families, often a history of trauma, are all factors that lead to these ways of coping that people develop to survive in the world. I try to look at it as nothing more than a label that someone has given them.

Another participant addressed the issue important to feminist therapy of the therapist owning responsibility for their own discomforts and limitations, rather than seeing everything in terms of the limitations of the client alone:

It's easy to pathologize clients when we're uncomfortable with something, but it may mean we just haven't done enough of our own work on it, or it may be that we have some limitation in what we can provide.

This study found that for these participants looking at each client as an individual in terms of their individual needs, seeing the person behind the diagnosis, identifying the traumas but addressing the present needs as well as the past traumas as seem to be most urgent to the client's distress, and owning up to the therapist's limitations transparently as part of the therapeutic process, are all part of what feminist therapists seem to mean when they talk about not "pathologizing" the client unnecessarily.

BPD or Complex PTSD? All (100%) of the participants viewed trauma as the central feature in the lives of people who had been given a diagnosis of BPD, and nearly all (83%) saw chronic disconnection as primary to the client's source of suffering. Many (58%) explicitly mentioned PTSD as more descriptive of the BPD population than a pervasive personality

disorder. Several (25%) mentioned Complex PTSD as elucidated by Judith Herman (1997) as a preference in the way they thought of and spoke about BPD. One (8%) participant brought up the work of Linehan (1991) in regards to increased sensitivity and vulnerability as informing her view of BPD. Another (8%) participant spoke of the relational work of Atwood and Stolorow (1984), who maintain that a person may exhibit borderline symptoms with one person and not another, implying that it is a relational diagnosis and not a personal one.

All (100%) of the participants shared a perception that the BPD diagnosis as it was most often applied was stigmatizing and primarily assigned in a pejorative way to women. One (8%) participant felt the BPD diagnosis in the DSM was well intended and not theoretically pejorative in conception, but agreed with the others (100%) that it was routinely misapplied and stigmatizing to women. This same participant spoke of her own frustrations that misunderstanding and misapplying the BPD diagnosis often obscured the central role of trauma, and that this had negative implications for treatment.

Do Feminist Therapists Adapt their Approach with BPD?

In this study, most of the participants initially said they did not adjust the feminist approach to therapy with clients diagnosed with BPD. This was most true in reference to the overarching framework of feminist therapy: the feminist lens, psychosocial context, and location of the client in terms of various power differentials affecting their life. With further discussion, however, what emerged was a realization that there were differences in the way the therapy was implemented with clients with a diagnosis of BPD. More particularly, boundaries were often relaxed. The reason for this loosening was because this population typically had more unmet needs, was more volatile, and more challenging towards the therapist, and this adjustment was seen to be helpful in reducing neediness and facilitating relational healing.

Adjunct therapies with BPD. Feminist therapy has been described as a flexible, integrated, eclectic approach that easily integrates other modalities or interventions. Most (92%) of the participants interviewed reported that they integrated other types of therapy into their approach with this population, including Dialectical Behavioral Therapy (DBT; 58%), Cognitive Behavioral Therapy (CBT; 42%), Eye Movement Desensitization and Reprocessing (EMDR; 33%), Family Systems Therapy (17%), Narrative Therapy (8%), and Motivational Interviewing (8%), often through the utilization of other specialists or in groups. One of the participants who utilizes DBT in her work with clients with BPD pointed out that this intervention can be adapted and made feminist if it is presented within the feminist framework, in a collaborative manner. She describes her adaptation of traditional DBT through a feminist lens:

I think I'm a little less rigid with the boundaries I set with people—I do more negotiating. I really do a lot in choice and recognizing if something is my own personal limit, and whether clients want to accept that or not. I think sometimes other clinicians would accuse me of being more lenient, but I really don't see it that way. I see it more as that we are collaborating. I really work hard to make sure that [DBT] doesn't appear punitive, while still trying to hold someone to the treatment guidelines.

DBT is widely used to help in the treatment of BPD, and tends to be more boundary and rule based than the feminist therapy approach. It is especially interesting to note that it may be used effectively by feminist therapists who are able to adapt it through a balance between relaxation of boundaries, transparency in communicating its requirements and potential benefits to the client, and gentle but continued focus on its guidelines. As has been previously stated, it is reported as utilized by 58% of the participants, mostly as an additional adjunct therapy, but also, as in the case of the speaker above, by a feminist therapist also trained in DBT.

A team approach with BPD. Feminist therapists generally felt that due to the immense needs of this population, a truly feminist model would also include professional collaboration with other therapists in coordinating adjunct therapies to meet these various needs. One of the participants touched on this point:

I guess in terms of adapting my approach to address a trauma, I do at times bring in adjunct therapies [such as DBT], 'cause I think that can help. I think the other thing that can be helpful in working with people with complex PTSD is it's really often important to have a team, cause these folks have almost always never gotten their needs met. So there are a lot of needs that they have. Sometimes we don't have enough to go around as a therapist, but if we can spread out the wealth a little bit it can be helpful. That may be another reason to include other therapies or therapists if it seems important or helpful.

Reflecting on clients with a BPD diagnosis who may also be helped by incorporating and adapting other therapies, one participant emphasized the positive recognition of clients' strengths, which feminist therapy encourages:

I might think about trauma theory. I might think about a very basic kind of CBT or DBT model more around helping people contain. So when I say CBT or DBT I just think more of strategies to help people manage in their lives. I think I try to support and help shore up their capacities in that way rather than kind of tap into or pull too much on their vulnerabilities . . . particularly when I can only see someone once a week or sometimes twice a week that just feels like an important balance to me.

Participants who spoke of utilizing other adjunct therapies with their clients diagnosed with BPD all expressed that feminist therapy provided them with great flexibility not only to integrate other

techniques but to interact collaboratively with other therapists in a team approach as well while retaining their distinctive lens

Alliance/Ruptures with clients with BPD. Issues of building trust and creating a therapeutic alliance as well as the inevitable ruptures came up with every (100%) therapist interviewed. Many of the therapists felt that developing trust often could be longer, harder, and slower with people with a BPD diagnosis, and consequently ruptures, when they occurred, could be larger and more difficult for this group. Speaking to the issue of developing trust, one therapist said:

It's a slow process. I think it's a really slow process. People have a lot of reasons not to trust. So we just have to hope that we can earn it. And it goes both ways. People have a lot of reasons to not be completely forthcoming, so we don't know how much truth we're getting. Clients don't know how much they can trust us to stick around. So, we have to be truthful about how much we can offer and not offer, and hope that that alliance can build despite ruptures. There are going to be ruptures. And I think we can be forthcoming about that, too. We can't pretend to be all things to all people. We're not going to be perfect.

Another participant spoke about the seemingly larger ruptures with clients diagnosed with BPD:

It always feels to me like the ruptures that happen are on a grander scale sometimes than someone who doesn't have a BPD diagnosis.

A different participant spoke about utilizing the feminist style of therapeutic alliance to assist in replacing dysfunctional "drama construction" with more positive ways of regulating emotional states in clients with a BPD diagnosis:

There's a certain earnestness in this population, constructing drama to get their needs met. I think they are tired. I see the loneliness...I try to attenuate the shame around it, and

[in the case of one client] get her to recognize that she is part of a community of support, and that there may be better ways to use that community of support, and alternate ways to meet those needs... sublimating it into something that can be a little more constructive instead of destructive, and psychodynamic in the healing of the deep and early injury. The job is to try to help her find more positive ways of regulating her emotional states and relating to herself and others - all through a feminist lens.

Cooperatively establishing a therapeutic alliance and weathering the inevitable ruptures while continuing to maintain a genuinely caring attitude and collaboratively seeking positive interventions were described by the participants as significant among the challenges surrounding the treatment of clients diagnosed with BPD.

Use of power/power sharing. All (100%) therapists interviewed talked about the open discussion of the power differential and use of power within the dyad as integral to a feminist approach to therapy. One therapist commented on the use of power underlying the development of trust among clients carrying a BPD diagnosis:

Trust around not wanting to live is a big one, I think, for this population, because at some point you're going to get to those feelings. Again, are you going to be a therapist who abuses the power and hospitalizes them? Sometimes that's needed [hospitalization]. But sometimes if it's safe to be with them through these feelings, and they know that they can have the feelings and nothing's going to happen – it's always a judgment call, but that's another example of trust. “Can I trust that my therapist will make this decision *with* me?” And that is sometimes really hard to do as a therapist. ‘Cause they can so easily feel that our concern is actually being used against them. That's what makes it tricky.

As the foregoing comments show, the idea of power sharing and its potential use between clinician and client in therapy is not an ordinary, much less a trivial, matter. This power sharing may even be profoundly burdened not only with issues of trust, but with issues of life and death itself. In this place, experience and intuition interplay deeply with familiarity with the client, client history, and knowledge of the diagnosis and the way it expresses itself for a particular client. In the feminist sense, being present *with* the client in joint decision making even at these most delicate and profoundly disturbing moments is an important ideal to strive for, although one necessarily always tempered with pragmatic clinical experience.

Therapist as Container. One participant spoke about containing the affect or emotions of her clients diagnosed with BPD, although it might be quite different for different clients, and spoke of the containment process in therapy as perhaps one of the biggest challenges for therapists:

I often feel with these folks that I carry them around with me all the time. And as a therapist you have to be willing to be able to do that, and feel o.k. with it. And I think some people can do it and others can't. And as part of that I have a few folks that will call me a lot, or there might be periods of time where they can't be alone with what they're feeling, so they're going to call me, and they need to use me in a certain way. You've got to be able to let yourself be used, and not all therapists are o.k. with that. You've got to know yourself, I think, pretty well. That's the whole process of figuring ourselves out, right? What can we do and not do? And what are we comfortable with?

Reflecting from a feminist perspective, one of the participants, who preferred to use the phrase complex PTSD for clients carrying the diagnosis of BPD, spoke about the role of the therapist as being a container for the unprocessed feelings these trauma clients have:

You know, I think lots of times with these folks they can engender feelings in us that feel very uncomfortable...For example, one of these people has been separated, and all of the feelings it really feels like I have to contain. So, it's very different from another patient I have who's separating. I don't contain any of her feelings. I'm here to kind of help her understand and clarify, and make sense of it all, but I'm not carrying them around. And often, I think, people with complex PTSD, as a therapist, you have to be able to carry their feelings around that they can't feel, that they can't manage themselves yet.

In feminist therapy, the more empathetic and relational demands of the approach reach a kind of high tide not only with the therapy as containment, but more particularly with the therapist as container for the intolerable affects of clients diagnosed with BPD. The participants who broached this subject were candid that not every therapist might feel able to meet this demand, or not at all moments in their own lives. Self knowledge and supervision were used to form honest self assessments.

Strengths and Limitations of Feminist Therapy for BPD

The findings in this study include those challenges most expressed by the study participants in working with clients diagnosed with BPD, and their thoughts about the rewards. After that, a summary of the strengths and limitations of feminist therapy for the treatment of BPD according to the practice experience of the 12 participants will be offered as a contribution to thinking about the topic.

Challenges with clients diagnosed with BPD. When questioned about the special challenges that feminist therapists faced when working with clients diagnosed with BPD, the study participants identified 5 special challenges, as follows: 1) the client's behavior can be off-putting: distrustful, critical, rejecting and provocative; 2) the client's behaviors are more

aggressive than many other clients; 3) therapeutic ruptures tend to occur on a grander scale; 4) clients with BPD often direct ego assaults against their therapists; and 5) therapists need to be able to be a container to hold the often intolerable affects of these clients. Although participants were not specifically asked as part of this question how they thought it best to meet these challenges, their responses elsewhere that touched upon these same challenges disclosed that they regarded self knowledge through all its avenues and professional supervision to be essential in being aware of personal limitations and keeping on a healthy professional course.

Although a number of the participants interviewed were reluctant to speak about challenges specific to this population in ways that might further stigmatize, others exhibited a professional transparency during interviews and spoke about it more openly:

I think their way of learning how to be in the world is off-putting. It can be very off-putting. So that's hard to continue to want to be around sometimes when it's critical and rejecting and provocative, and all those things. Sometimes it pushes my buttons.

Considering the interplay of the chronic demands of clients with BPD and the changing personal needs of the therapist, one participant reflected on these kinds of challenges:

I think another challenge for me has been that it does feel harder to do the work in the way I would want to now that I'm a parent and have evening responsibilities. I think it would be harder for me to have a number of clients right now who had borderline personality disorder and needed me to be flexible. So that's a challenge.

Another participant addressed the problem that the behaviors of clients diagnosed with BPD can strain the therapeutic relationship, which is especially challenging to feminist therapists because they draw so much more on the relationship compared to more behavioral approaches, such as DBT:

I think this population has become infamous because they're most powerful at getting under our skin and knowing how to use exactly the right constellation of words to keep me right at the edge of my seat. They're brilliant. The challenge is to not be rattled along with her and still be empathetic and caring to the point where I can still do the relational work without becoming exhausted, and I think that's why people developed non-relational therapies to deal with this population, because relating is straining.

One other participant indicated that the effort involved in the work with clients with BPD was uniquely challenging because of the intensity of the raw, unprocessed emotions. She put it this way:

I think the biggest challenge is being able to really be a container and hold the affect for these folks, and again that's why sometimes you're going to have other people work with you. A lot of the feelings that people bring in have not been processed, or metabolized, or integrated, so that's our job, to help them do that. But doing that can be scary, and painful, and overwhelming for the therapist, too, because often you're going to sit with some pretty raw feelings and emotions.

Still another participant spoke of the challenges logistically and financially concerning the increased needs so often encountered in treatment of clients with BPD:

The 50-minute hour once a week may not be what's helpful. I mean it might be, but it might not be. And I think there are a lot of constraints these days in terms of insurance, and that impacts people in terms of being able to get long-term treatment and get all the treatment they need.

Far more attention was given in this study to inquiring into the nature and the unique challenges presented by clients diagnosed with BPD than to the notion of rewards for the therapist in

treating these clients, not only in the specific question about challenges and rewards, but in all the other parts of the study. Despite this, insightful responses were offered about the rewards in working with clients with a BPD diagnosis which perhaps reveal more about the therapists than the clients, as will be seen in the next section.

Rewards of working with clients with BPD. Although rewards for any therapist are a personal matter, there was a pattern among feminist therapists to look at the work of growing and healing for the client as the ultimate satisfaction. Included in this were often mentioned empowerment of the client, learning of new skills, the client's relief from or ability to find a way to live with pain, and sometimes also the therapist's own satisfaction in entering into the client's world and making a difference. One participant addressed more especially this last point:

I think the reward is that if you can do that work, and get in there with someone, I personally find it much more engaging. Demand for me to be on my toes and be engaged in kind of what's happening in the room between us makes me feel more part of a process; it feels more interesting to me, and compelling.

Another participant felt that the struggle often brought a depth or intensity of reward proportional to the effort when achievements were finally reached:

It's also really rewarding, because when you help that person be able to integrate a feeling or an emotion or you do a piece of work that you process it's incredibly rewarding.

Most participants regarded it as a privilege to see their clients in their life journey and witness their clients' growth. Using their professional skills to help a client integrate an emotion or do work they processed together was felt to be deeply rewarding. Even given all the problems and

human limitations encountered with such work, the attitude expressed was that seeing progress was very satisfying.

Benefits of a feminist approach to BPD. The participants of this study spoke of 9 unique benefits of a feminist approach to therapy with clients diagnosed with BPD, as follows: feminist therapy 1) allows more focus on the therapeutic relationship, encouraging therapeutic reconnection; 2) diminishes pathologizing of the client as much as possible; 3) encourages seeing a client's adaptation to trauma; 4) views clients resilience in positive terms important to their identity and wellbeing; 5) uses and models collaboration to empower the client, rather than reinforcing the client's diminished sense of power in themselves and the world; 6) uses transparency, which removes a veil and helps remove fear and build trust; 7) acknowledges power differences in the therapeutic dyad, creating some sense of safety; 8) offers a place to contain or leave intolerable feelings for the client; and 9) uses collaborative techniques to create tools for managing pain. One participant spoke of the benefits of feminist therapy for clients with BPD in the following manner:

Well, I think in a nutshell it's an approach that diminishes pathologizing or pathology as much as possible, and really encourages looking at the patient through their adaptation to trauma, and what resilience they have, you know, what their resilience is, what they've got inside. And some of the stories are amazing, what people have gotten through, and it's important they can feel that way. So, I think those are the two benefits of the feminist approach. And then I guess just collaboration. I think we can all benefit from having more collaboration in our life, and hopefully teaching our patients how to do that and carry that with them.

Speaking of feminist therapy as a positive and non-pathologizing approach, one participant said:

I think a feminist approach also highlights people's strengths and capacities. We're kind of focused on people's growing, and just not on their deficits. So I think that's a really helpful model. I think it's a non-pathologizing model. I think it sees people in context, and seeing ourselves in context is a really helpful piece of the work. I think there's some freedom in it.

When the benefits of feminist therapy for clients with BPD were coded and tabulated for the group of 12 clinician participants in the study, seven themes emerged that were most often cited by the participants as most beneficial to these clients, as follows: emphasis on relationships (100%), collaboration (92%), transparency (83%), empowerment of the client (83%), therapeutic containment (58%), a non-pathologizing interaction with the client (42%), and positive highlighting of the client's capacities (42%).

Limitations of a feminist approach to BPD. All (100%) of the participants felt that there were no limitations to a feminist approach to therapy for BPD, and that it was extremely flexible, integrative, and eclectic in being able to embrace other useful techniques. Like all therapies, however, they felt it required 1) the opportunity for use in the practice setting, 2) an understanding of its theoretical framework, and potential for applications, and 3) clinical experience in applying its lens and perspectives to clients. One participant pointed out:

The feminist approach doesn't have to be limiting in any way. You can do anything and do it from a feminist point of view, so [it's] not necessarily [limiting]. The limitation could be if the clinician misunderstands what it means to be feminist, and thinks it's all about making everybody equal and not ever having to use power. Then I think it could run into trouble. But since it's not about taking away power, it's about naming it, and

talking about it, and talking about what gets in the way for us, no, I don't see that it has to have any limitations.

The participants viewed feminist therapy as essentially without practical limit as a model or approach, because it was both a lens or perspective and a flexible, eclectic, integrative practice able to embrace other modalities and adapt to adjunct therapies in the treatment of BPD. The limits foreseen were essentially the personal limits of individual therapists in their ability to understand and apply it effectively.

Conclusions

The purpose of this study has been to examine the perspectives of a sample of 12 practicing feminist therapists about the benefits of utilizing feminist therapy for the treatment of BPD. The hypothesis of this study was that the client diagnosed with BPD may greatly benefit from the enhanced therapeutic relationship in this more collaborative, egalitarian, empowerment model of therapy. What emerged from the discussions evolving out of the interview questions was a gradual shaping of a response to the study's hypothesis. The enhanced therapeutic relationship in the feminist therapy approach was seen by the participants to offer both specific and unique benefits to this population. These benefits were viewed potentially to include: seeing the client's adaptation to trauma, their resilience in positive terms, a diminishment of pathologizing, their building of trust, creating a sense of safety, containment of intolerable feelings, creating tools for managing pain, empowerment through collaboration, and therapeutic reconnection.

Not surprisingly, the feminist therapist participants who agreed to be interviewed for this study all were enthusiastic about feminist therapy, and all reflected positively on the benefits to clients diagnosed with BPD in their practice experiences. It should be noted they responded to

the questions very searchingly, sometimes recalling an early incidence of their own inexperience, and freely praising other techniques which they integrated or adapted to their own feminist framework.

The interviews were richly woven tapestries of both clinical experiences and women's experiences. At many points these interviews were also deeply moving, as living, breathing, human documents of suffering, loss, and recovery. The attitudes exemplified throughout these remarkable interviews were ones of personal humility and profound empathy. Despite their enthusiasm for feminist therapy, the participants were self reflective and questioning rather than doctrinaire in tone. Their responses enriched the scope of the questions asked. Together, the perspectives expressed by the participants comprise a valuable body of clinical experiences on both feminist therapy and the treatment of BPD. It is hoped the summation and account of them in this study may make some measure of contribution to social work thinking on this topic. In the next chapter these findings will be re-examined and discussed in light of the relevant review of the literature, significant interpretations of these findings, and implications for social work practice, policy, and further study.

CHAPTER V

Discussion

By engaging licensed clinicians who practice feminist therapy with clients carrying the diagnosis of BPD in a dialogue about how the feminist model impacts their work with these clients, this study hoped to increase our understanding of what benefits or limitations there may be in the treatment of this population using feminist therapy. The ultimate goal was to contribute to the understanding of BPD itself, and its more effective treatment. As a consequence of this, the nature and characterization of the BPD diagnosis and the role of trauma, the rethinking of it by Judith Herman as complex PTSD, as well as its stigmatizing application primarily to women, were examined.

Interview participants shared in-depth experiences of practicing therapists employing the feminist model in their work with clients diagnosed with BPD, and their assessments of its benefits and limits in treating BPD, as well as their reflections on the current DSM diagnostic concept of BPD, and how they view it and approach it in their practices.

Biases

This study will be better understood and evaluated in the context of the author's theoretical biases and the study's methodological biases, so that the contribution it has to offer may be more knowingly compared to the findings and conclusions of other studies. Awareness of these biases may, as well, supply a basis for further studies to improve upon, challenge, and refine.

This study was conceived after an 8 month internship in social work at a department of inpatient psychiatry at an urban hospital in a metropolitan center, where the author's interest had been drawn to the experiences and problems of patients diagnosed with Borderline Personality Disorder, and the reactions of medical, psychiatric, and social work staff in response to their treatment. Additional study at Smith College School for Social Work and a review of the current literature on BPD and feminist therapy led to the formulation of the hypothesis that the relationship between therapist and client, which was seen as key to the improvement in the life of the client with BPD, may benefit greatly from the collaborative, more egalitarian, empowerment model of a feminist approach. Furthermore, the arguments by Herman (1997), Brown (2009), Walker (2009) and others that trauma was at the center of the problem seemed cogent, persuasive, and worthy of exploration. A second year internship was arranged at an institution with a group that practiced a feminist therapy team approach, and eight months were spent as part of the same institutional context working alongside some of the participants in this study. It may well be seen that this was essentially an internship in feminist therapy, where its theory and implementation were learned not merely by reading and thinking, but by daily operational application with clients and the team of practicing feminist therapist clinicians. While this opportunity provided greater depth to the learning experience, it undoubtedly increased the biases of the researcher, in this case by demonstration of the theoretical approach, and further confirmation of the belief that feminist therapy held an important key to helping clients diagnosed with BPD. In this context, this study was designed and carried out to further explore the articulated hypothesis.

Moreover, the design of the study, to interview feminist therapists about the benefits of the approach they believed in and followed, may be seen as a biased examination, or at least one

that would most probably confirm the hypothesis, particularly in the hands of a researcher who shared their outlook. However, there is another way to look at it. When attempting to understand human social phenomena, there is often no better way than to go as a participant observer. If, from a certain point of view, the method risks losing something in objectivity, which it frequently does, the observer may yet be compensated with a wealth of immersion in a lived reality, and a robust reaction to that reality, and a richness of substance, feeling, nuance, and detail, which may provide insights worthy of the investigation, as well as clues for future study and thought. The present study, with its biases made more transparent, tenders its results in that hope.

Demographics

A unique factor of the demographics of this study was that seven (58%) of the twelve participants knew each other, had trainings together, and worked at or were connected to the same institution. One might think this shared experience would give this cohort opinions that were similar, if not almost uniform; but, in interviewing them for this study there were found to be quite a range of differing nuances and emphases in their answers, though all of them shared the use of an overarching feminist framework and lens. Rather than simply expressing homogenous beliefs or viewpoints, they seem to have challenged each other to inquire more critically, sharing their differences, responding to one another's individual insights, and to have become more rather than less inspired to think more deeply about their own use of the feminist approach and its implementation in practice. As a result of their regular collaboration, all seven of this cohort had developed complex, subtle, nuanced views of feminist therapy, sometimes with differing emphases.

The other five (42%) individual participants, some of whom knew members of the first seven, reflected wide general agreement with the overarching framework of feminist therapy as well. Their answers were often shorter and less rich in nuance and detail, however, and noticeably less illustrated by cases or personal revelations. These differences frankly cannot be fully evaluated, but the last five interviews were conducted by telephone instead of in person, and were held with participants who did not previously know the interviewer. The first seven interviews, in contrast, were conducted in person, and all of the interviewees knew the interviewer. This greater familiarity, as well as the face to face setting, could also have given greater incentive to the first seven participants to offer more detail and illustrations in their answers, as well as to spend more time in the interview. Despite this, the variety of emphases in the responses of the first cohort of seven, as well as occasional references to one another's views, especially when they differed, showed that there had been a stimulating dynamic of interaction between members of the group.

One unintended consequence of these interviews was an appreciation that the collaborative approach to therapy, which is such a hallmark of the feminist model, is not limited to the relationship between therapist and client, though that is its central therapeutic purpose. In addition, it may extend to the interactions between professional colleagues, more deeply informing their shared thinking and treatment where a primary practice setting enables feminist therapy practitioners to collect and collaborate professionally. In a therapeutic approach where the therapist collaboratively models and co-creates the intervention with the client, the advantages of professional collaboration from this point of view merit further exploration.

Hypothesis and Findings

The hypothesis of this study was that the relationship between therapist and client diagnosed with BPD may greatly benefit in a unique way from the collaborative, more egalitarian, empowerment model of feminist therapy. The findings of this study have provided an opportunity for the views of a sample of practicing feminist clinicians to emerge, giving voice to their clinical experiences reflecting the benefits of feminist therapy in the treatment of BPD. Their viewpoints principally offer strong confirmation of the findings of other clinicians who have alleged the importance of the enhanced therapeutic relationship provided by feminist therapy in the treatment of BPD (Bateman & Fonagy, 2000; Brown, 2009; McLean & Gallop, 2003; Van Kessel et al., 2002; Walker, 2009). The findings from the participants also emphasize the role of trauma as perhaps the central feature informing the constellation of symptoms which have been diagnostically described as BPD, lending strong support from clinical experience to the work of other clinicians who have examined trauma causally in relation to BPD (Atwood & Stolorow, 1984; Herman, 1997; Lindblom & Gray, 2010; McLean & Gallop, 2003; Moskowitz, 2001; Seese, 1997). Consequently, the participants have shown substantial agreement with the view that chronic disconnection as a result of trauma is the primary source of suffering for clients diagnosed with BPD (Herman, 1997; McLean & Gallop, 2003; Walker, 2009).

Correspondingly, their experience supports the idea that the enhanced relationship with the therapist in feminist therapy becomes a key relational vehicle for healing through the same channel the client has been victimized: that of trusting relationships (Walker, 2009), and that empowerment through collaboration gives the client the opportunity to reclaim power by being a partner in their therapy (Brown, 2009; Walker, 2009). The experience of the participants in this study gives marked support and encouragement for elements of treatment of BPD by feminist

therapy as identified in the literature, including the necessity of a strong attachment between client and therapist (Bateman & Fonagy, 2000; Brown, 2009; Herman, 1997; Walker, 2009), and in reducing blame and treating clients as capable rather than fragile, while emphasizing hope and recovery (Brown, 2009; Linehan et al., 1991; Van Kessel et al., 2002; Walker, 2009).

Describing and Implementing Feminist Therapy

The first part of the study dealt with describing feminist therapy as the participants saw it, and then with its implementation in terms of intervention strategies. Central to feminist therapy in the viewpoints of all of the participants was the concept of the feminist lens, which, as they explained it, included consideration of context, power and inequality, based on a feminist psychology recognizing various gender and power inequalities within society. The implementation of feminist therapy was regarded as a technically eclectic, integrative practice, embracing multiple treatment modalities, applicable to both women and men. These descriptions of feminist therapy by the participants were in accord with the views of feminist therapy outlined by Brown (2009). The participants also felt that feminist therapy gave increased focus to the therapeutic relationship, and emphasized a collaborative style using transparency, consent, and power sharing to empower clients, allowing each client to be the expert in their own life, echoing the importance of the therapeutic relationship as emphasized by Bateman & Fonagy (2000), and further developed by Brown (2009) and Walker (2009).

More particularly, viewing the client as situated within a sociocultural and psychological context was integral to the participants' employment of the feminist lens. In a feminist perspective the context of the client's life in terms of power differentials and inequalities, including gender, sexual orientation, class, race, and ethnicity, among others, or even oppression as experienced by the client, was placed in the foreground as equally important as the intra-

psychic processes and events of the client's life. This was seen as perhaps a hallmark difference between feminist therapy and more traditional psychodynamic approaches, where primarily the intra-psychic is examined, and the socio-cultural context is ordinarily in the background, if considered at all. This description of feminist therapy would appear to be substantially in accord with leading feminist viewpoints offered by Brown (2009) or Walker (2009).

From a feminist therapy perspective, sometimes it has been regarded as problematic, especially for clients diagnosed with BPD, if therapy masks acknowledgment of power differentials and their impact on the client. As has been said, with BPD the client's trauma is often thought to be based on a relational disconnectedness arising from victimization by a trusted caregiver, resulting in a damagingly diminished sense of self worth and loss of power (Walker, 2009). The client with BPD tends to enact this sense of powerlessness in other relationships, including the therapeutic one, alternately by feelings of worthlessness and by acting out, and eventually often abandoning the relationship (Moskovitz, 2001). The removal of power from the client in therapy, as in a doctor/patient or expert/dependent relationship, may tend therefore, to reinforce the client's overwhelming sense of helplessness and disconnectedness, in effect inhibiting elements relationally necessary for healing, improvement, and growth (Walker, 2009), as opposed to merely acquiring more externally acceptable behavior, as may be the focus in more behavioral approaches.

The collaborative, feminist approach attempts to reverse this pattern of helplessness, and to empower the client, emphasizing co-decision making that encourages the client's strengths and abilities, thereby contributing to actual healing and internal development (Van Kessel et al., 2002; Brown, 2009; Walker, 2009). The intention is to build a relationship based on trust in the therapeutic dyad that will allow the client to re-establish empowerment rather than self

diminishment in a trusting relationship. From this perspective, if chronic disconnection in relationships is a major or primary source of suffering, then regular and reliable reconnection through the therapeutic relationship becomes a basis for healing (Brown, 2009; Walker, 2009).

Implementing feminist therapy. The participants agreed that if the framework of feminist therapy is constructed around the feminist lens, context, and power, then the therapeutic relationship is the foundation of its implementation. By focusing centrally on the therapeutic relationship, feminist therapy is also seen by its practitioners as relationally oriented, beginning with the therapeutic dyad. More than many other approaches, feminist therapy places an emphasis on shared power, collaboration in understanding and decision-making regarding interventions, and transparency in the therapy process: “The core beliefs in Feminist Therapy practice are that people grow through connection and therefore the purpose of therapy should be bridging a connection rather than separating the client and therapist through use of power, and that chronic disconnection is the primary source of suffering” (Walker, 2009). All of the participants in the study viewed the emphasis on relationship as a central feature, as well as a primary benefit of feminist therapy.

If the therapeutic relationship is the basis of implementing feminist therapy, then the methods of that implementation are the uniquely collaborative style between therapist and client, transparency with the client about the therapy process, and gaining the client’s consent in a choice of treatment techniques, or even “co-creating” interventions with the client, as one of the participants phrased it. The therapist participates in modeling collaboration and power sharing for and with the client. In the feminist process of collaboration, as opposed to other less egalitarian models of therapy, the client becomes an active partner in deciding what content arises and where it moves between sessions. This empowers the client to become a co-shaper of

the containing structure in which to reflect both upon the content and the process itself (Brown, 2009). For some clients, this is their first experience of this kind of power and decision-making, and the process itself can be in some measure reparative: “Recovery can only take place within the context of relationships, it cannot occur in isolation” (Herman, 1997, p.133). Thus, in addition to a contextual view, feminist therapy employs a relational style of collaboration, power acknowledgement and sharing, and transparency about the therapeutic process as implementations of treatment.

Nearly all of the participants spoke about collaboration as a central intervention as well as a benefit of feminist therapy. Most of the participants also spoke of transparency as integral to the feminist approach. This relational and more egalitarian treatment approach involves the therapist both more empathetically and relationally in the reparative work of the therapeutic process within the therapeutic dyad, termed “therapeutic inter-being” in feminist theory (Walker, 2009), although not spoken of by that name by any of the participants. The significance of therapeutic inter-being is that, in connecting with the therapist, clients may experience healing relationally through the same channel by which they became victimized – a trusting relationship (Walker, 2009). It is thought that in this way feminist therapy may offer a more responsive approach to the unique needs of trauma survivors. The concentration on empowerment of the client helps the client regain power rather than reaffirming the client’s sense of diminished power in themselves and the world (Brown, 2009; Walker, 2009).

Feminist interventions. A paradox appears to arise for many in thinking about and discussing whether or not there are specifically feminist interventions. Are all interventions feminist, or are none feminist? Can they be made feminist? All of the participants said that all interventions are feminist if done within a feminist frame of reference. Most participants

remarked it was less the intervention and more the frame that was specifically feminist. Many of the participants stated that any intervention can be (or be made to be) feminist, and that they moved in and out of other therapies within a feminist framework, such as DBT, CBT, or EMDR.

Interpreting these remarks in light of the whole body of the interviews as well as the literature of feminist therapy in general, it may be seen that feminist therapy is first a larger viewpoint, or lens. This lens or organizing viewpoint utilizes context, including power differentials (Brown, 2009). Because it is a larger organizing viewpoint other therapies or techniques may indeed be utilized within its frame (Bateman & Fonagy, 2000). Sometimes some additional therapies may need to be adapted in terms of joint decision making about intervention techniques, client treatment preferences, more egalitarian language, or some other client empowering emphasis.

Feminist therapy is secondly a relational interaction which models collaboration or power sharing (Walker, 2009). All of the participants stressed collaboration, nurturing, flexibility, and emphasized asking rather than telling. Also, many of the participants believed a feminist intervention was less rigid. Collaboration in the feminist manner demands less rigidity in both roles and boundaries, and asks greater flexibility relationally. A feminist therapist must cede some power in order to share power, and in sharing power so empower others, as well as model the power sharing process. Five participants maintained that collaboration was a specifically feminist intervention. Because feminist therapy is both a viewpoint and an interaction, collaboration is both part of the frame or lens, and an essential part of the interaction. Therefore, collaboration also may be seen quite appropriately as a specifically feminist intervention (Brown, 2009).

For the collaborative effort to do its job of modeling and power sharing, it must also be transparent. All of the participants emphasized transparency. The nature of the power sharing in feminist therapy is the recognition that the client is the expert in their own life. The study participants agreed with that view. The therapist hopes to contribute training, experience with similar problems, a safe place to examine the client's problems together, and hopefully empathy, respect, kindness, and humility.

Beginning with the feminist lens as an organizing viewpoint, moving into the therapeutic relationship as a central focus, and modeling collaboration and power sharing through transparency as the core of a relational interaction or intervention which extends empowerment to the client, is all taken together as the central implementation of feminist therapy, to which other intervention techniques may be applied if offered within the feminist frame. In the feminist frame the therapist is the foundational intervention (Walker, 2009).

How Feminist Therapists Understand BPD

In understanding BPD, what emerged from the study was a perception of trauma as the central underlying feature of clients with a BPD diagnosis. More specifically, all of the participants interviewed identified trauma as integral to people carrying a diagnosis of BPD. Speaking from her own practice experience, one of the participants suggested there was a need for a broader definition of trauma as not just physical or emotional abuse or neglect, but any kind of situation where a client has felt profoundly "overwhelmed and helpless." She referred to this kind of experience as "trauma to the self." Another participant suggested from her experience that the trauma clients with BPD had experienced was often, although not always, early trauma, resonating with the work of Seese (1997) and Moskowitz (2001).

Because of their trauma histories, clients with a BPD diagnosis were described as highly distrustful of others, especially authority figures. This frequently may include members of the healthcare community. As a result of these trust issues, clients diagnosed with BPD may engage in more hostile and suspicious testing, which can lead to more aggressive interactions and acting out towards the therapist. These observations were supportive of remarks offered by Moskowitz (2001) and reaffirmed by Lindblom & Gray (2010). In response to this, feminist therapists often stressed a relative relaxation of boundaries as part of the process of regaining that trust. Eleven of the twelve participants interviewed described having more fluid and flexible boundaries when working with clients carrying a diagnosis of BPD. This might mean extra phone calls, emails, or additional sessions during the week as a response to meeting the client's need for additional connection. Participants felt that the way they approached boundaries would differ not only from one client to another as individuals, but also within differing socio-cultural contexts with different norms. In general, the eleven participants who reported a relaxation of boundaries also explained that they felt this approach helped to diminish testing, intrusiveness, and neediness in clients with BPD. In contrast to this general approach, one participant spoke of her sometimes more defensive reactions with clients diagnosed with BPD. Yet, the larger context of her interview suggested her feminist approach involved more relaxed boundaries from the start, so tightening them for her was a relative matter. One of the participants also spoke of her relaxed boundaries leading to a disagreement with a couples therapist colleague whose therapeutic approach used firmer boundaries in working with clients diagnosed with BPD.

All of the participants also indicated that, as feminist therapists, they stressed the vulnerabilities of clients with this diagnosis rather than blaming them for dysfunctional or unacceptable behavior, consistent with the findings of Linehan et al. (1991) and Van Kessel et al.

(2002). In treatment, clients were generally offered a gentler, more flexible, collaborative approach, in contrast to more rule based treatment approaches with more rigid boundary setting. The treatment approach was also very tailored to the individual, and non-conforming in regards to choices of adjunct or additional therapeutic techniques, as described by Bateman & Fonagy (2000). The modalities of adjunct therapies utilized by the participants in this study included DBT (58%), CBT (42%), EMDR (33%), and Family Systems Therapy (17%). Combined with earlier observations about the relational and interactive nature of the process of feminist therapy, this part of the study confirms Brown's view of feminist therapy: "The Feminist models attend as well to relational and process components of trauma and then focus on these in the treatment process...feminist therapy is a technically eclectic, integrative practice, a feminist therapist has a range of modalities with which to approach working with trauma survivors" (Brown, 2009, p. 4).

Reactions to the Diagnosis: BPD or Complex PTSD

All of the participants had a critical reaction to the use of the diagnostic label "Borderline Personality Disorder." In fact, all of the participants interviewed saw the diagnosis of BPD as pejorative and stigmatizing and almost exclusively applied to women, supporting the assertions of Hersh (2008). Most of the participants preferred not to use the term BPD. The reality of this perception is supported by information from the DSM itself, which reports that "women represent 75% of those diagnosed with BPD" (DSM-V; APA, 2013, p. 666). The participants felt the diagnosis offered limited usefulness in understanding the causes or treating the symptoms, supporting views offered by Lindblom & Gray (2010). In contrast, one participant tried to see a positive intent in the original concept in the DSM apart from the subsequent stigmatizing application of it for women. This same participant also spoke of frustrations that the diagnosis

was often misapplied and obscured the central role of trauma, with negative implications for treatment.

Many expressed concern for the stereotyping and stigma attached to the diagnosis both as it impacts the individual who carries it and the perceptions of clinicians working with this population. One participant expressed concern that the mental health community at large, including therapists, can unintentionally shame clients, with harmful consequences due to the extreme vulnerability of this population to even inadvertent shaming. This fits in with the research about the stigma of this diagnosis by Hersh (2008), that “Borderline Personality presents as a controversial and often stigmatized diagnosis that is not well understood by the public and is a challenge for clinicians in diagnostic accuracy and creation and implementation of treatment as well as affects the clinician’s willingness to treat people carrying this diagnosis” (p. 13). Bourke and Grenyer’s 2010 study also points to the general dissatisfaction with sessions and a more negative view of clients with this diagnosis on the part of clinicians, despite their genuine earnestness in wishing to help them.

Although all of the participants viewed trauma as the central feature in the lives of people who had received the BPD diagnosis, nearly all (83%) saw chronic disconnection as primary to the client’s source of suffering. Many (58%) explicitly mentioned PTSD as more descriptive of the BPD population than a pervasive personality disorder. Several (25%) mentioned complex PTSD as described by Judith Herman (1997) as a preference in their way of thinking and speaking about BPD. One participant referred to the work of Marsha Linehan (1991) in regards to the increased sensitivity and vulnerability of this population as informing her view of BPD. Another participant brought up the relational work of Atwood and Stolorow (1984), who maintain that a person may exhibit borderline symptoms with one person and not another,

implying that it is a relational diagnosis and not a characterological one. Issues of trust building and alliance as well as ruptures were identified by every therapist interviewed, recognizing that trust could be longer and harder to establish and ruptures larger and more difficult with clients with BPD, largely supporting the work of Moskowitz (2001). In reflecting on all the raw, unprocessed and uncomfortable emotions brought out by clients carrying the diagnosis of BPD, the majority of the participants spoke of the important role of the feminist therapist and the therapy as being a container for all of the feelings these clients cannot process or manage themselves yet.

Benefits and Limitations of Feminist Therapy for Clients with BPD/Complex PTSD

Participants in the study identified five special challenges in working with clients with a BPD diagnosis. The first four challenges identified by the participants were that, first, the client's behavior often can become critical, rejecting, distrustful, and provocative; second, the client's behaviors are more aggressive than many other clients; third, therapeutic ruptures tend to occur on a grander scale; and fourth, clients with BPD often direct ego assaults against their therapists. All of these challenges strongly supported Moskowitz's (2001) description of patterns of behavior often associated with clients carrying a diagnosis of BPD. In addition, the participants identified as a fifth challenge: that therapists need to be able to be a container to hold the often intolerable affects of these clients.

One of the participants expressed the problem as one in which the therapist on some human level may become offended by a client who acts in these ways, particularly with ego assaults, but must still remain centered enough to find the capacity to continue to care for the suffering client in order to do the job of therapy. In discussion, some of the participants felt that the therapist's self knowledge about their own strengths and weaknesses provided a key to

understanding to what extent each therapist might extend themselves towards these special challenges. Ongoing supervision and/or therapy for the therapist was seen as an important, if not indispensable, resource in facilitating the ongoing process of knowing oneself.

Conversely, in thinking of special rewards in working with clients diagnosed with BPD, there was a pattern among the participants to regard the work of growing and healing for the client as the ultimate satisfaction. Often mentioned was the empowerment of the client, the learning of new skills, and the client's relief from or ability to find a way to live with pain. Sometimes the participants expressed their own satisfaction as therapists in entering into the client's world and making a difference.

In the findings chapter of this study the participants identified nine distinct benefits of a feminist approach to therapy with clients diagnosed with BPD, or complex PTSD. First, it was felt that feminist therapy allowed more focus on the therapeutic relationship, encouraging therapeutic re-connection, which fits in with the research of Bateman and Fonagy (2000), Brown (2009), and Walker (2009) that a powerful attachment between client and therapist is the most effective element of treatment with clients diagnosed with BPD. Secondly, the feminist approach diminishes pathologizing as much as possible; thirdly, it encourages seeing a client's adaptation to trauma; and fourthly, views clients' resilience in positive terms important to their identity and wellbeing. All of these benefits confirm the research of Linehan et al. (1991), and Van Kessel et al. (2002), asserting that treating clients as capable and emphasizing hope and recovery are essential and powerful treatment elements in BPD. The fifth benefit observed by the participants was that feminist therapy uses and models collaboration to empower the client, rather than reinforcing the client's diminished sense of power in themselves and the world, which supports the writings of Brown (2009) and Walker (2009) on the purpose and effects of the feminist

approach. The sixth benefit, that the therapy uses transparency, which removes a veil, and helps remove fear and build trust, confirms the research of Bateman and Fonagy (2000) about how vital clarity is when working with these clients. The seventh benefit, that feminist therapy acknowledges power differences in the therapeutic dyad, creating some sense of safety; the eighth benefit, that it offers a place to contain or leave intolerable feelings for the client; and the ninth benefit, that feminist therapy uses collaborative techniques to create tools for managing pain, are all viewpoints confirming or supporting the work of Brown (2009) and Walker (2009) on the central importance of the therapeutic dyad and the empowerment of the client in achieving reconnection and healing. Seven themes emerged from these benefits in feminist therapeutic practice: emphasis on relationships, collaboration, transparency, empowerment of the client, therapeutic containment, a non-pathologizing interaction with the client, and positive highlighting of the client's capacities.

Remarkably, and after time for reflection, none of the participants felt that there were any limitations to a feminist approach to therapy for this population. They saw it as simultaneously an overarching framework or organizing perspective and a way of interacting with clients. It was seen as extremely flexible and integrative in being able to embrace other useful techniques and adapt to adjunct therapies in the treatment of BPD, or complex PTSD. Like all therapies, however, they felt it required three things for successful implementation: first, the opportunity for use in a practice setting; second, an understanding of its theoretical framework and potential for application; third, clinical experience in applying its lens and perspectives to clients. The limits described by the participants were essentially the personal limits of individual therapists in their ability to understand and apply it effectively.

Implications for Social Work Practice, Policy, and Further Study

Perhaps the first issue of interest for further study is one which arises from the demographic data. As had been observed at the outset of this discussion, the association of the cohort of seven professionally connected participants in a practice setting where feminist therapy was a shared approach had led not to homogenous views, as might have been supposed, but instead their regular professional collaboration had led this group to have complex, subtle, and nuanced views about feminist therapy with individual emphases. In an approach which elaborates and models collaboration, and where the practitioner co-creates the intervention with the clients, does the generalization of special or enhanced collaborative techniques extend to the interaction between professional colleagues, with a benefit of more deeply informing their shared thinking and treatment of clients?

Perhaps it would be fruitful in a further study first to compare the seemingly more egalitarian nature of the collaborative professional relationship between feminist therapists in a cooperative practice setting with feminist therapists either in individual or mixed practice settings in order to see if there was a greater elaboration of their views and techniques, particularly in the treatment of BPD. An unanticipated suggestion arising from this study is that a richer, subtler understanding and perhaps application of feminist therapy may occur in a more supportive, all feminist group practice that might well have benefits to the population diagnosed with BPD. This might have implications for social work education in directing thinking toward this possible benefit, and for practice in implementing feminist therapy. Secondly, a feminist therapy group practice setting could be compared with non-feminist practice settings to contrast the collaborative style and to observe differences in outcomes in the treatment of BPD.

Other demographic considerations might lead to other implications for social work practice and future questions for investigation. For instance, ten out of the twelve participants were self-identified as Caucasian or white. It is beyond the scope of this study to identify what the make-up of the wider population of feminist therapists is. Perhaps white women are in the majority. If so, does feminist therapy reflect more the outlook and concerns of this group than of other women? Is it able to reflect effectively about gender and empowerment contexts across different sectors of class and ethnicity? Does it have limiting biases in this connection, and if so, what are they? It might be of value to gather a more diverse sample of clinician participants to see if and how this demographic variable might have an effect on the outcome of such a study.

Also, all of the participants were female, and although this may have value to a study concerning feminist therapy, nevertheless, it could be informative to hear from male clinicians who embraced the essential tenets of feminist therapy, though this might become quite a different study. Additionally, as all of the participants focused on the stigmatization of women clients with a diagnosis of BPD, which indeed makes up the majority (75%) of those so diagnosed, it might be of comparative interest to learn more about the experiences of stigmatization with the use of a BPD diagnosis among male clients, and if the BPD diagnosis is used differently for that group. More broadly, it would be valuable to continue to look at how gender may play a role not only in the diagnosis of BPD, but for the survivors of trauma, including early trauma, complex trauma, and especially complex PTSD.

In thinking about the benefits of feminist therapy for BPD, or for complex PTSD, or for trauma generally, this study strongly points up the value of a more relational method of healing than is so often used in treatment of individuals or populations who often exhibit socially challenging behaviors. There often has been a tendency to construct less relational modalities

because it is easier on the therapist or other provider engaging in the treatment. There is also the question of whether the feminist therapist is more drained by engaging in a style of therapy which is so heavily relational, compared to therapists utilizing those approaches that are less relational, and perhaps more behavioral, such as DBT. DBT is well regarded in the treatment of BPD. In fact most of the feminist therapists in this study found value in DBT, and 58% utilized it in conjunction with their own work, although none would regard it as a replacement for feminist therapy.

It could be a focus of possible further research to inquire into whether a relational approach, such as feminist therapy, places a substantially greater demand on the therapist than a less relational one. Is age a factor in the ability of therapists to engage in intensely relational therapies? How about personality type? There may be a clue provided by something one of the participants stated in regard to the idea of the therapist as a container for the client's unprocessed feelings, which she said she carried around with her. She said not everyone was able to be used in that way. Maybe that is the key: it is a quality of mind and emotional outlook. Perhaps we might think of it as personality, but it undoubtedly involves learning, and perhaps also personal suffering – enough to form an enhanced empathy.

There may be a deeper ethical question involved in this as well. Some therapies help in regulating behavior, which certainly has social benefits for the client by making them more acceptable to the world. Perhaps, however, such therapies, by their more external focus simply cannot be deeply curative internally. Perhaps they may be easier on the therapist, although this remains a subject open to investigation, rather than an axiomatic conclusion. If, however, more internally healing therapies arise that may be more intensively relationally focused, even if they do place a greater emotional or psychological demand on the therapist, can the therapist forgo

employing them for the benefit of the client if the benefit is greater? Or forgo at least referring clients to those practicing a more reparative form of therapy for clients with particular problems? Can social work policy endorse offering a less reparative therapy if there is a more reparative one available? Perhaps these are questions that could be more fully addressed and developed in a further study with a different focus and scope.

Another point of departure for further research, or perhaps a number of departures, resides in the problem about which there is so much current debate: is BPD actually better described and its treatment better advanced by regarding it, as Judith Herman (1997) and the majority of the participants in this study have done, as a form of complex PTSD? Many clients who have met the criteria for BPD also meet the criteria for complex PTSD (McLean & Gallop, 2003; Herman, 1997). But the implications for treatment of a pervasive disorder are different from those for a complex trauma. Although beyond the scope of the present study, it would seem that a resolution to this debate ought to be forthcoming. The resolution of this matter has implications not only for a great many clients who suffer, but for the efficacy of the approaches to treatment in social work practice. Moreover, there are implications for social work policy toward a disproportionately victimized and stigmatized group of trauma survivors.

Conclusion and Future Prospect

This study has occasioned the opportunity to listen to some voices in clinical practice on a subject about which they are passionate: feminist therapy. All of the participants who made up this study adamantly believed in the intellectual validity and the clinical efficacy of feminist therapy. Their passion for it was an expression of a hunger for distributive justice in this society and in the world. Within the world, they saw the ramifications of power and the inequities of its social distribution. From their perspectives of praxis, their experiences in the world, they saw a

feminist stance as resistant to and transformational of systemic injustices. Feminist therapy was likewise seen as both transformative and reparative to the individual, and resistant, re-directing, and transformative of the society as well, benefiting both women and men. These were regarded as laudable, desirable goals for clinical practice and social work policy alike. In this study of the benefits of feminist therapy for BPD, the benefits must be situated within these goals and this view of the world. In the feminist view, the client is not regarded as “other,” not unnecessarily pathologized, but seen along with ourselves as in different places perhaps on a continuum of relationship. This helps the therapist to recognize inter-subjectivity, the seeing of ourselves and others both as subjects rather than seeing others as objects. The benefit of this way of thinking is it combats the objectifying and de-valuing of others, especially others in whom we feel there is some kind of difference. All of this comes into play when BPD, or complex PTSD, as essentially a trauma based problem, is treated by feminist therapy.

There is, however, a great difference in both conception and treatment of the problem, depending upon whether we regard it as pervasive, as in the BPD diagnosis, or whether we regard it as a trauma inflicted on a victim. As one of the participants indicated, it is about saying to a trauma victim that there is not essentially this illness inside them which they are responsible for, a form of blaming the victim. Instead, there are real and deep injustices based on inequities of power out there in the world, and they have real impacts on people, often whole categories of people, who occupy a subordinate or oppressed place in our or any society structurally and systemically. Women regularly occupy such a place in human societies around the globe, and as such, along with children, are routinely offered less in the way of psychic and even physical defenses to retain their natural psychic integrity against the predatory onslaughts or unbridled

angers of those more powerful than they. If they are both female and children, protection may become minimal or at times non-existent.

The opportunity for the abuse of women and children is both structural and systemic. It may be that the providers of mental health care must redirect themselves in policy orientation as well as clinical focus towards efforts to empower and heal those suffering from the excesses of an essentially systemic social problem where the most vulnerable among us are subject to being deeply traumatized, often at defenseless times in life, by caregivers, and then re-traumatized by a system of mental health care providers who classify the problem as originating within them, rather than recognizing the harm that has been done them as the victims of others. In the social work field, one richly populated with women, perhaps the awareness of these structural inequities should be more widely appreciated, and perceptions of their manifestations more keenly observed.

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Appendix A

Recruitment Email

Dear Colleague:

I am a second year MSW student at the Smith College School for Social Work and would like to invite you to participate in a research study I am conducting for my MSW Thesis: A Feminist, Relational Approach to the Understanding and Treatment of the collection of characteristics and behavioral traits that the DSM currently identifies as Borderline Personality Disorder. I am looking for participants who are licensed Masters or Doctoral level therapists with at least two years of experience post graduation, who utilize a Feminist model or approach to therapy, and have had at least three clients with Borderline Personality Disorder over the last two years. If you meet these criteria, and are willing to reflect on your work with these clients in an hour-long interview at a private location of your convenience, or by phone, please contact me at the email below to learn more about participating in this study. Please also forward this email to any of your colleagues who may also fit the above criteria.

Sincerely,

Abigail Moore
XXXXXX@XXXXXXXX

Appendix B

Human Subjects Review Committee Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 8, 2013

Abigail Moore

Dear Abigail,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

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

Maintaining Data: You must retain all data and other 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).

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett'.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: Natalie Hill, Research Advisor

Appendix C

Informed Consent Form

Dear Participant,

I am student in the Master in Social Work program at the Smith College School of Social Work, and I am conducting a research study exploring the advantages and disadvantages that that Therapists perceive in applying a Feminist model/therapy for clients diagnosed with Borderline Personality Disorder. The purposes of this study are to explore 1) Does the questioning of dominant cultural values and assumptions lead to unique or valuable treatment benefits for the client with Borderline Personality Disorder, 2) what are the relational benefits to the therapeutic dyad by utilizing a Feminist framework for therapy, 3) To explore if a less authoritarian, more egalitarian power sharing approach to therapy as characterized by Feminist Therapy may result in a more generalizing reparative behavioral benefit to the client. Data from the study will be used in my MSW thesis, and possible presentation and publication.

To participate in this study, you must be a licensed Masters or Doctoral level therapist fluent in English, identify as practicing feminist model or approach to therapy, have two years of experience in psychotherapy post graduation that includes work with individuals who meet the DSM criteria for Borderline Personality Disorder, provide individual psychotherapy to a population that has included at least three individuals diagnosed with Borderline Personality Disorder within the past two years, and be willing to reflect on these experiences in the context of an hour-long, audio recorded interview. Participation will consist of an hour long, individual interview. The interview will be audio recorded. I will transcribe and analyze the interviews.

Minimal risk from participation is anticipated, although you may experience some discomfort when reflecting on challenging therapeutic experiences. You may benefit by gaining new insight into your work with clients diagnosed with Borderline Personality Disorder by engaging in a deeper reflection on this work, and by sharing and learning from other participants' insights following the completion of the study and writing of the thesis. The information gained from these interviews will add to a body of information for therapists who work with Borderline Personality Disorder, and to an understanding of a feminist approach to therapy with this population. Compensation will not be provided.

Your identity will be held in confidence outside of the interviews. When recordings are transcribed, any identifying information will be removed. Transcriptions will not contain any names or identifying information and will be shared with my Research Advisor only after identifying information is removed. Data used in any related presentation or publication will be presented as a whole, and any illustrative quotes or vignettes will be carefully disguised. Email exchanges with participants will be kept in a file within my password protected computer system. Data, recordings, notes and consent forms will be kept secure in my files for a period of three years as stipulated by federal guideline after which time they will be destroyed; should materials still be needed after this time, they will continue to be maintained securely and destroyed when no longer needed.

Participation in this study is voluntary. You may withdraw from the study at any time during the interview by stating that you would like to withdraw, and may refuse to answer any question. You can also withdraw your responses following the interview by emailing me at xxx@xxxxx within two weeks of your interview. There is no penalty for withdrawal from the study. If you choose to withdraw, all materials related to you will be destroyed immediately. You may also contact me by email with any questions or concerns about this study, before or after the interviews. If you have questions or concerns about your rights as a participant, you are encouraged to contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at xxx-xxx-xxxx. Thank you for your participation in this study. Please keep a copy of this document for your records.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant _____ Date: _____

Signature of Researcher: _____ Date: _____

Abigail Moore

Appendix D

Interview Questions

- 1.) How do you think about and conceptualize Feminist model or approach to therapy in general?
- 2.) How do you implement a Feminist model or approach to practice?
- 3.) Are there interventions that you attribute to this approach?
- 4.) Thinking about clients that you have worked with who are diagnosed with BPD:
- 5.) Is a Feminist approach reflective of your work with these clients? How do you change or adjust your approach?
- 6.) (If you do something different) why? How is the adaptation of your normal style helpful in these cases?
- 7.) Do you specifically utilize any other theories and/or interventions for working with this population?
If so, do you find them any more or less effective than the feminist approach?
- 8.) How do you perceive the role of trauma with this population?
Is it particularly relevant?
Do you adapt your approach to specifically address trauma?
- 9.) What do you see as being any specific, unique challenges to the work with this population, or special rewards to it?
- 10.) What do you see as the unique benefits of a Feminist approach to working with to this population?
- 11.) Do you see any limitations to a Feminist approach to working with this population?