Eclectic Therapeutic Relationship with BPD Clients: Examining the Eclectic Therapeutic Relationship with Clients with Borderline Personality Disorder

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Abstract

Borderline Personality Disorder (BPD) or Emotionally Unstable Personality Disorder (EUPD) clients are characterised by behavioural symptoms of acts of deliberate self-harm, difficulty controlling anger, and instability in relationships, besides others. While specific therapies address specific problem behaviours, an integrated or eclectic approach enables clinicians to adopt a comprehensive therapy plan (Livesley, 2008). Since the therapeutic relationship with BPD clients is characterised by frequent ruptures and fluctuations, it is necessary to understand how the eclectic stance approaches the therapeutic relationship with BPD clients. This study explores these questions through in-depth interviews with seven self-identified eclectic therapists who have worked with BPD clients. Using Thematic Network Analysis, it was found from the interviews that eclectic therapists choose the stance because of the flexibility it offers them, and because of definite client and setting factors. This stance, they suggested, helps in mutual decision-making and leads the therapist to make constant adjustments to the client's level. The process of rapport-building was seen to be an on-going process, where the therapist acts as a facilitator, and often works against resisting traits of the clients. Therapists also talked about

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ruptures in the relationship due to certain factors and identified means through which these can be repaired. Finally, they identified their reactions to BPD clients as consisting of both positive reactions, and negative and unconscious reactions, which require monitoring. The results of this study yield an understanding about the reasons behind the decision to take an eclectic stance, and how it affects the therapeutic relationship.

Keywords: Borderline personality disorder, Eclectic therapy, Therapeutic alliance

Introduction

Our personalities are ingrained and pervasive, and are not merely of a set of isolated characteristics which can be addressed individually. Borderline personality disorder (BPD) is one of the most prevalent, most widely studied, and yet most controversial of the personality disorders described in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). Clients with Borderline Personality Disorder are thought to stand on the border between neurosis and psychosis, and they are characterised by extraordinarily unstable affect, mood, behaviour, object relations, and self- image.

According to DSM-IV- TR (APA, 2000), individuals with Borderline Personality Disorder (BPD) show a pattern of behaviour characterised by impulsivity and instability in interpersonal relationships, self- image, and moods, leading to severe impairment of self- management, social interactions, and goal-achievement (Lieb, Zanarini, Linehan, & Bohus, 2004).

Borderline Personality Disorder clients who come to therapy rarely do so for personality per se, but more so in regard to problems such as depression, anxiety, and relationship problems in their family and work lives. Therapy aimed at clients with Borderline Personality Disorder can go along many different lines, based on the client's needs and the problem which is the priority at that time. Psychodynamic therapy, for example, focuses more on linking the past experiences to the present and then taking on deeper issues like transference, which is interpreted in the course of therapy. The

psychodynamic therapist aims to give the borderline client insight through the linking and interpretation of transference that can bring in change in their behaviour. Dialectical Behaviour Therapy (DBT) integrates behavioural and cognitive treatment principles and strategies with others derived from client-centred and process experiential therapies, Zen Buddhism and Dialectical philosophy (Robins, Ivanoff, & Linehan, 2001). It aims to do so by teaching and encouraging patients to practice mindfulness, that is to cultivate non-judgmental, focused, in-this-moment awareness and to behave in ways consistent with their important goals and values (Robins, 2002). Supportive therapy, which involves reassurance and advice, is helpful when the client is emotionally disturbed and disorganised. Cognitive therapists who work with a BPD client focus on his or her self-defeating thoughts and try to reveal these to the client so it can be modified.

The eclectic approach to psychotherapy. Despite the fact that there exist highly standardised treatments for symptom patterns in BPD client, it still appears that many therapists will adopt an eclectic or integrative framework or treatment when approaching BPD clients. Such a decision is not an easy one, given that standardised treatments, and especially Dialectical Behaviour Therapy, have been seen as highly effective in research literature. This decision to follow an eclectic approach is therefore backed by therapists' own personal preference factors and environmental factors besides others, and these reasons will be explored in this study.

The term eclectic itself, used interchangeably with integrative therapy, was defined by self-identified eclectic therapists, as the practice of using whatever theory or methods seem best for the client, involving combining two or more theories, as no single theory is adequate (Norcross, Karpiak & Lister, 2005). Garfield and Kurtz in 1977 (as cited in Norcross et al., 2005) also mention that such eclectic practitioners are bound by the feelings of dissatisfaction with one orientation of therapy and so select from two or more theories, believing that no single theory could be used to treat all clients effectively. This trend towards eclecticism towards all disorders is believed to be on the rise, even in America, and is the modal theoretical orientation there (Norcross et al., 2005).

Given this global trend towards eclecticism, there are several reasons for why borderline personality clients might especially benefit from more eclectic forms of treatment. In fact, it is a known fact that highly efficacious therapies such as Dialectical Behaviour Therapy (DBT) and Cognitive Analytical Therapy (CAT) are, in fact, integrative in nature, employing a fine blend of theories and techniques. It is possible that therapists can go still further in integrating these therapies with others according to the need of the BPD client. This is especially relevant as BPD clients present with a vast heterogeneity of symptom patterns, as well as a background of genetic, neurobiological and genetic etiological factors (Oldham, 2005). These symptom patterns are most commonly approached through combinations of psychotherapy and symptom-oriented pharmacotherapy (Oldham, 2005), often leaving much up to the therapist in deciding which orientation in therapy should be used to approach the client's unique symptom pattern.

It is considered that eclecticism today is more commonly based on a more deliberate decision—p   eclecticism by design rather than default (Norcross et al., 2005). In using such an eclectic framework, clinicians have the option of following an eclectic approach based on theoretical synthesis of multiple theories; technical eclecticism, which involves the combination of techniques regardless of theories backing these; eclecticism based on common factors seen in all psychotherapies; and finally, assimilative integration which involves selectively bringing together various techniques and concepts by a practitioner   into his own preferred theoretical approach, in which he is trained and experienced (Norcross et al., 2005).

Livesley (2008) puts forward the case that eclecticism is very relevant and necessary for complex personality disorders, Borderline Personality disorder being chief among them. He states that the merits of such an integrated approach come when treatment is specially tuned towards specific domains of psychopathology. He states that:

> Rather than selecting among treatments that are limited in terms of range and scope of problems that they address, a more useful way to conceptualize the

> treatment of complex cases is to select effective interventions from different treatments for each domain of psychopathology. (p. 211)

Understanding that an eclectic approach to a personality disorder could result in confusion and chaos as clinicians choose what they believe best for the client, leading to constant revision of therapy, Livesley (2008) suggests that two ways could be used to counter this sense of confusion. One is the common factor approach, focusing on using common factors seen in all psychotherapies, which include establishing a collaborative treatment agreement, maintaining the relationship in a collaborative manner, maintaining consistency in treatment and validating the client, and motivating the client constantly so that he/she is committed to change. The second approach, suggested by Livesley (2008) is that of viewing the treatment process as moving through a certain series of phases which are well-cut and distinguished, and which include the stages of safety, containment, control and regulation, exploration and change, and integration and synthesis.

The therapeutic relationship with Borderline Personality Disorder clients. Any therapeutic alliance is proposed to be composed of the four elements of the client's capacity to work purposefully, his/her affective bond with the therapist, the therapist's empathetic understanding and involvement, and their level of agreement about goals and tasks involved in treatment (Galloway & Brodsky, 2003).

Such a therapeutic alliance is thought to be especially difficult with BPD clients, given that they often evoke therapist's counter-transference feelings in ways that resist therapeutic change or confronting themselves. Their disorder in itself, with its complexity and chronicity, was suggested by Markham in 2003 (as cited in Wenzel, Jeglic, Levy-Mack, Beck and Brown in 2008) as being one of the most difficult mental illnesses to treat. Such clients make excessive demands of dependency, and are often quick to identify the vulnerabilities of therapists (Galloway & Brodsky, 2003).

The chief term with which BPD clients are described is the adjective 'difficult', as was found by Koekkoek, van Meijel and Hutschemaekers (2006), which refers to the lack of cooperation

between the client and the therapist. Of the three types of difficult clients identified, BPD clients mostly composed the second group of ambivalent care-seekers, characterised by traits of dependency, self-destructiveness and demanding natures, whom clinicians mostly alternate between terming as mad and bad. This therapeutic relationship is also affected by phenomena such as transference and counter-transference, evoking both concern and annoyance in the therapist (Koekkoek et al., 2006).

Therapy with BPD clients is also most importantly characterised by what have popularly come to be known as alliance ruptures, defined as "emotional disconnections that occur between the client and the therapist, which causes a negative shift in the quality of the therapeutic alliance" (Daly, Llewelyn, McDougall & Chanen, 2010, p. 273). These ruptures can further lead to either positive or negative consequences for the client, depending on how the rupture is interpreted. While the negative consequences of such ruptures could include poor treatment outcomes and dropouts from therapy early on, exploring these ruptures can lead to interpretation of the same(Binder and Strupp, 1997 as cited in Daly et al., 2010), as well as to building a stronger therapeutic alliance, greater understanding of the problem at hand, and providing evidence against the client's own negative interpersonal beliefs.

The way in which ruptures are addressed also affects therapy. Structured therapies such as the Cognitive Analytical Model have approached rupture resolution, involving enactment of the problematic relationship patterns seen, as a process of nine stages as stated by Bennett et al. in 2003 (as cited in Daly et al., 2010) which include acknowledgement, exploration, linking and explanation, negotiation, consensus, understanding and assimilating warded off feelings, further explanation, change to patterns/aims and closure.

Difficulties in the therapeutic relationship are also associated with the attitude of the client towards therapeutic change. Wenzel et al. (2008) found, for instance, that BPD clients with higher expectations for improvement and with more positive attitudes about talking with a therapist about their problems showed a greater reduction in psychiatric symptoms like depression and

suicidal ideation 12 months later, while more negative attitudes towards treatment was generally related to previous therapy experiences and feelings of hopelessness.

Keeping in mind these difficulties associated with BPD clients, Koekkoek et al. (2006) suggest that the important step to be taken is to validate the client's experiences, while also being careful to set clear boundaries and limits in the structure of the therapy. They also suggest being conscious of background factors that could affect therapy and about one's own limitations as a therapist. Another possibility is that of therapeutic detachment, suggested by Galloway and Brodsky (2003) as the mirror image of therapeutic empathy. They suggest that this is especially relevant for therapists who may not be able to establish or maintain boundaries in therapeutic relationships such as by personally identifying with clients, or who take the client's continuous mood swings and crises in therapy as personal failures. Such therapists may be able to use the idea of emotional detachment and distancing from the client, which can help the client in taking responsibility for his own actions, and improve the therapeutic relationship as well (Galloway & Brodsky, 2003).

Limited studies are available in India in terms of approaching pure BPD clients, but personality disorders as such, have been researched quite extensively. The rate of personality disorders in subjects who have demonstrated deliberate acts of self-harm or DSH (which is one of the common features of BPD) have varied from 7 % (Banerjee et al., 2007) to 64 % (Chandrasekaran et al., 2003). Nathet et al. used the International Personality Disorder Examination (IPED) to assess outpatients and inpatients in India, who presented with the history of self-harm at any point in their life, in two age groups (15-24 years and 45-74 years). It was found that some number of patients in the younger group was diagnosed with BPD.

The present study takes into account these various research findings which point towards the increasing use of eclectic psychotherapy worldwide (Norcross et al., 2005), as well as the difficulties associated in carrying out therapy with BPD clients (Koekkoek et al., 2006). Such studies indicate that eclectic therapy is a preferred form of treatment because of lack of flexibility in most

standardized therapies. In addition, therapy with BPD patients is characterised by frequent crises and fluctuations in the therapeutic alliance.

This study therefore explores the eclectic stance when adopted with BPD patients, primarily with regard to the therapeutic relationship. It specifically explores this question in terms of reasons backing the decisions of practitioners to take an eclectic stance, and how this stance reflects on the therapeutic alliance with the client. It also explores the nature of the therapeutic alliance in terms of the process of rapport building and the occurrence and nature of fluctuations or breaks in the alliance. Finally, it examines the self-reported reactions of eclectic therapists in India as evoked by BPD clients. It is hoped that the results of this exploratory study will enable therapists in India to understand the difficulties that are associated with BPD clients, as well as the steps that are commonly employed by eclectic therapist to deal with these either in a preventative or restorative manner.

Methodology

For the purpose of the study, seven self-identified eclectic therapists in the city of Bangalore, India, who have had experience in dealing with a minimum of fifteen BPD clients over the course of their career, were chosen. In-depth interviews were conducted based on a semi-structured interview guide exploring the research question. These therapists included six female and one male therapist from both clinical psychology and psychiatric backgrounds. The transcripts of the interviews were analyzed using Thematic Network analysis, which yielded global themes related to the choice of an eclectic stance, how this stance affects the therapeutic alliance, the process of rapport building with the BPD client, breaks in the therapeutic relationship, and the therapists' own conscious and unconscious reactions to the client throughout the process of therapy.

Results and Discussion

The semi-structured interviews conducted with the therapists were analyzed using Thematic Network Analysis, and themes were

derived which point towards the privilege of flexibility and freedom which eclectic therapy provides the therapists with. The major themes were indentified under the broad topic areas of choice of an eclectic stance and the influence of this stance on the therapeutic alliance, the process of rapport building with the BPD client, breaks or ruptures in the therapeutic relationship, and the therapists' own conscious and unconscious reactions to the client.

Choice of an eclectic stance. It was firstly most important to know the reasons put forward by the therapists who self-identify as eclectic practitioners, in choosing the eclectic approach when dealing with BPD clients. Their rationale in choosing the eclectic approach over other standardised therapies, fell into three global themes: the eclectic approach offers flexibility and comprehensiveness in therapy for a therapist; secondly, BPD client factors predispose to eclectic therapy; and finally, the Indian setting naturally elicits the eclectic approach.

Therapists felt that the eclectic approach offers flexibility and comprehensiveness which other standardised therapies may not be able to offer. This flexibility allows them to meet client needs, in terms of prioritising therapy according to current crises, working at the client's level of insight and moulding therapy according to the client's unique family situations. Such therapy, therapists propose, is mostly symptom-oriented so as to maximise the adjustment of the client; this is in line with Oldham's (2005) notion that given the current criteria for BPD, client come with vast heterogeneity in symptoms. Such heterogeneity therefore demands therapy which can be flexibly oriented towards the particular client's symptoms. There is also the flexibility to merge therapies, since therapists felt that no single holistic approach to therapy exists; this was also a popular reason for eclectic therapists in choosing their orientation, as suggested by Garfield and Kurtz in 1977 (as cited in Norcross et al., 2005). A combination of therapies is therefore what is felt is needed for the formulation and action plan, whether through theoretical or technical integration, which are some of the ways of eclecticism as suggested by Norcross et al. (2005).

Secondly, it was proposed that BPD client factors may predispose a therapist to choosing the eclectic approach. Therapists suggest that these clients may make standardised treatments unfeasible, because

they lack structure and therefore cannot be restricted to structured therapies; the disorder itself does not progress in such clear-cut stages as is assumed through many therapies, and therapists felt that as pure personality disorders hardly ever occur, pure therapies are accordingly unfeasible. Because of such client factors, eclectic therapy may be needed to prevent ruptures; for instance, therapists suggested therapy which is intensive and then phased out, which brings in lifestyle changes to prevent crises, brings in environmental modifications, and counter-acts harmful family pathology. In this sense, the design of choice appears to be eclectic by design rather than by default, as was suggested by Norcross et al. (2005).

All therapists identified factors which are specific to India and lead them to prefer the eclectic approach. They suggested the eclectic approach to be necessary environmentally, since there is not much time to deal with a BPD client especially in a hospital setting, and cases may need to be transferred across states when a client shifts base, and the client may also therefore need to adapt to various hospital and private settings. Therapists also found it necessary culturally since 'the Indian self is viewed as more collectivistic and relational' and not suited for westernised individualised therapies, besides the idea that the Indian family mediates over all decisions on therapy which cannot be purely individual. Another India-specific factor suggested by them was that there is no real concept of confidentiality in Indian society setting, which makes group sessions difficult.

Having explored the choice of an eclectic stance, the study then explored how this stance affects the therapeutic alliance. It does so in two ways, by allowing mutual decisions by therapist and client on the next phase of therapy, as well as by compelling the therapist to adjust to the client's level. The eclectic stance necessitates mutual decision-making, since the client is seen as the best judge of what he needs next, being capable, creative and positive, as well as making his own subjective evaluations of progress and improvement. Such mutual decision-making was felt to be essential since therapy has to engage and appeal to the client, in terms of being interesting, with sessions ending on a hopeful note; it also

has to appeal to the clients' curiosity, work at their insight level, and yield quick and observable results.

The second major effect the eclectic stance has on the therapeutic alliance is in terms of adjustments the therapist has to personally make, on two levels. On a professional level, the therapist moulds therapy to client's level of understanding to convince the client of his own symptom pattern, thereby approaching the client with realistic expectations and understandable language. The therapist also seeks to convey to the client that her feelings are not absurd or out-of-the-world. On a personal level, adjustments are made in terms of the invasions to her privacy that may occur, the threats to her reputation and practice, the fear of crises from the client such as suicides threats, and having to deal with and balance the client's suspiciousness and dependency.

The process of rapport-building. Rapport-building is considered to be a common factor in all therapies, but eclectic therapists suggested differences in the process rapport built with BPD clients in eclectic therapy. The first theme which emerged was the idea that rapport building is an on-going process. Therapists suggested that this is because of therapists' constant efforts to prevent ruptures by dealing with clients' suspicions and by re-establishing clients' trust in the profession; the latter may be especially important as BPD clients are known to wander from one therapist to another and face different treatment from each. Therapists also viewed rapport-building as on-going because of the processes which continue throughout the rapport journey, like normalising the client's feelings, allowing for catharsis and venting, providing "You Alone Time" to clients and working towards goals which are set mutually. In addition, throughout the process of therapy, the nature of rapport depends on the setting of boundaries and limits, through limiting number of sessions and respecting therapists' privacy. This setting of limits is considered essential to therapy with 'difficult' clients, as Koekkoek et al. (2006) suggests, and therapists in this study as well emphasised its importance to rapport building throughout therapy.

Secondly, the therapist was viewed as a facilitator in rapport building. As a facilitator, he is expected to have humanistic qualities such as being reassuring, validating the client, being

willing to spend time with the client and being non-judgmental. These humanistic characteristics correspond to the notion of the therapist as a transitional object for the client (Gregory, 2004) in establishing the therapeutic alliance, considered to be the first thematic stage of recovery for a BPD client according to Gregory (2004). Therapists also have to be dialectical in the sense of being free from prejudices and gender stereotypes. One of the therapists in the study stated, for example, that "Bold and risky behaviour for women is (usually) diagnosed as BPD, but for the males it is diagnosed as Anti-Social Personality Disorder"; therapists were assertive that such stereotypes should be avoided. The therapist has to have valuable experience which can facilitate rapport building, which can allow him to compromise with the client at present for long-term benefits, provide a structure, be prepared for interpretations of what comes from the clients, monitor his or her own body language and interpret the nonverbal cues from the client. Along with the experience, the therapist should have good facilitating clinical skills such as cautiousness and formality in establishing rapport, and skill in exerting authority and in applying knowledge appropriately.

The third theme which arose is that BPD client factors resist healthy rapport building. Such resistance occurs because of clients' extremes in perception of the therapist. BPD clients were also proposed to have dependency features, suggested as part of the core conflict for BPD clients of dependency versus autonomy by Gregory (2004). This dependency is buoyed by their lack of social support, their extreme idealizing of the therapist, and a tendency to perceive the therapist as a friend rather than as a professional. The BPD client was also said to resist a healthy rapport because of their poor 'psychological mindedness' in terms of low ego strength, poor frustration tolerance, an inability to confront core issues and poor insight. All these factors collectively make them part of a 'difficult' clinical population, which Koekkoek et al. (2006) define as the lack of cooperation between the client and professional. Koekkoek et al. (2006) state that although such clients are willing to seek help, they are less willing to accept the help offered. All this then appears to leave the onus of responsibility on the therapist to build up rapport with the client and overcome the barriers put up by them.

Ruptures in the alliance. With the knowledge that the therapeutic alliance with BPD clients is often characterised by breaks and ruptures or periods of emotional disconnection (Daly et al., 2010), the study questioned therapists with regard to ruptures in alliance they have encountered, and how they have dealt with these. Two significant global themes emerged in this regard.

Firstly, therapists felt that there is a high probability of ruptures in the therapeutic alliance with BPD clients. This was supported by the idea that clients have certain inherent traits which predispose them to ruptures in the alliance, which include having lofty ideals, a constant sense of victimisation, their over-reactiveness to minor stimulation which 'others find normal', their tendency to misinterpret situations, and their high levels of defensiveness and mistrust. Clients also seem to have had a number of experiences in their past which predispose them to alliance ruptures, such as negative experiences in their formative years, family pathology, biases of previous therapists against them which could also lead to labelling in public spheres, their experiences of going through multiple therapists (through doctor shopping) and the resultant possible contradictions, and their fear therefore of connecting emotionally. Also relevant are therapy-specific factors which raise the risk of ruptures, which include their feelings of transference and the fact that their real relationships are projected onto the therapeutic relationship, which is in itself threatening. BPD clients are also constantly being confronted by the therapist, have little or no control over the session, and often communicate at vastly different levels from the therapist. All these contribute to ruptures in the alliance, and Daly et al. (2010) quote studies which suggest that such ruptures, if left unaddressed, can lead to ineffective treatment or early termination of therapy.

Therapists also expressed their opinions that such ruptures are repairable. Repairing the ruptures, therapists suggested, can come from noticing indicators to potential ruptures, such as the body language of clients and other signs which indicate their lack of motivation and participation in sessions. This can come about through their missing sessions, or participating passively by making excuses and refusing to take responsibility for actions. The therapists appeared to suggest that skilled therapists can pick up

on such indicators, which can prevent ruptures altogether. They also suggested the use of reactive/immediate repair mechanisms, such as naming the client's feeling while reducing any chances of physical danger or suicide, reassuring them and providing a 'holding environment', which is a means of intervention suggested by Koekkoek et al. (2006), as well as reminding them of mutual goals and obligations, and using the advice of supervisors.

On the other hand, repairing the alliance may also require more deliberate and long-term measures, the therapists suggested, such as garnering family support or modifying the environment, bringing in cognitive restructuring for the client, and preparing the client for potential further changes, i.e. termination of therapy and life transitions. Such long-term measures to repair the alliance may actually contribute to further therapeutic change, as Safran, Muran, Samstag, and Stevens in 2002 suggested (as cited in Daly, 2010).

Eclectic therapists' reactions to the client. The participants suggested that therapists face both positive and negative reactions to a BPD client. There are positive reactions, on the one hand, which ought to be enhanced, such as feelings of sympathy. Similarly, there are negative reactions to the client which should be monitored, such as frustration, emotional attachment, a judgmental attitude, anger, panic and the like. For instance, one of the therapists in the study stated, "I sometimes don't feel like picking up the call (from the client). It is very irritating and annoying". One of the key negative reactions therapists suggested was that of over-involvement and emotional attachment, a danger which Galloway and Brodsky (2003) suggest can be overcome by what they term 'therapeutic detachment' from the client, through the process of distancing.

Secondly, therapists suggested that unconscious reactions towards the client must be monitored. Such monitoring ought to be done on two levels. On a personal level, therapists ought to review sessions, keep track of files to monitor emotions and so on; however, they noted that such ways are more feasible in private clinic setups. On a more interactional level is supervision which is done through peer discussions, case supervision and personal therapy, all of which are more feasible in hospital setups.

Conclusion

This study explored the views of eclectic therapists who work with clients with Borderline Personality Disorder (BPD) in India. Significant opinions given by the therapists relate to their view that the eclectic stance is both necessary and preferable when dealing with BPD clients, and more so in an Indian setting. This is a consequence of the flexibility and freedom the eclectic stance affords them in adjusting to constraints of the client, setting and time. In addition, it was felt by therapists that at each stage of therapy, both the client and the therapist have the freedom and personal responsibility of taking mutual decisions regarding therapy. They also noted that the therapist has the constant need to be present-oriented, in terms of meeting the client at his present point of need and thus reducing crises. He also has the personal responsibility, in addition, of monitoring his own feelings, either through supervision or personal efforts. Given these facets of eclectic practice suggested by therapists in their work with BPD clients, it could be significant to note in future research, the specific means of integration followed by such clinicians, the manner in which they practice eclectically, and the efficacy of such therapy.

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