The Role of Therapeutic Alliance in the Treatment of Borderline Personality Disorder

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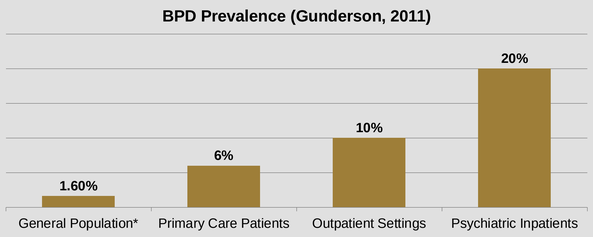
Introduction

These words are used to characterize individuals with borderline personality disorder (BPD): **inappropriate, frantic, unstable, intense, paranoid, threatening, angry**. Traditionally difficult to treat largely due to client interpersonal difficulties, the purpose of this literature review was to identify crucial elements in the therapeutic alliance that facilitates the effective treatment of BPD.



*It is estimated between 1.6 to 5.9% of the general population are living with BPD, 75% of those diagnosed are women (Gunderson, 2011)

Method

The Z. Smith Reynolds (ZSR) Library played a key role in data gathering. ZSR searches more than 270 databases to include Proquest, SageJournals, Web of Science, ASSIA, and JSTOR. Primary search terms were: borderline personality disorder, therapeutic alliance, working alliance, therapeutic alliance assessment, efficacious treatment, reflective functioning, psychotherapy outcome, and therapeutic qualities. Search parameters were limited to the last **10 years, peer-reviewed journal articles explicit to the treatment of BPD, and industry best-practices for the treatment of BPD.**

Materials

The **Agnew Relationship Measure** (Agnew-Davies et al., 1998) was selected to evaluate dimensions of the therapeutic alliance. Published in 1998 to quantify therapeutic relationship elements, this tool was preferred over others because of the equal weight given to both the client's and therapist's perspective. In this measure, the following components make up the therapeutic alliance:

- **Bond** — **Warmth and caring felt by the client, and empathy demonstrated by the therapist**
- **Partnership** — **Collaboration between the client and therapist; this lays the groundwork for trust in the relationship**
- **Confidence** — **Expertise brought by the therapist, and the client's belief in the therapist's treatment proficiency**
- **Openness** — **The client's feeling of freedom from judgment or ridicule during sessions**

Results

BPD has a history of being difficult to treat because the client's maladaptive cognitive processes perpetuate emotional instability. Neutral and ambiguous stimuli are perceived as dangerous or untrustworthy (Sinnaeve et al., 2015) and depressive ruminations can impair concentration, memory, and problem solving (Baer et al., 2012). Building a relationship with a client who is distrustful, who feels hated and incompetent, or sees relationships as threatening will take awareness and finesse on behalf of the therapist to create a healthy connection. The following therapy designs have empirical evidence showing they are effective in reducing BPD symptoms:

- Dialectical Behavior Therapy (DBT)
- Mentalization-Based Therapy (MBT)
- Transference-Focused Psychotherapy (TFP)
- Schema-Focused Therapy (SFT)

Structured, empirically tested therapy is effective in relieving symptoms of BPD, but in order to enact the necessary treatments proven for symptom relief, a strong therapeutic alliance needs to be established first. Positive therapeutic outcomes are directly related to the quality of the therapeutic alliance (Goldman & Gregory, 2010). By paying attention to the **bond, partnership, confidence, & openness** in the counselor-client relationship, a strong working alliance can be quickly established, helping to mitigate BPD symptom severity and negative countertransference.

Therapist characteristics like gender, years in practice, and theoretical orientation do not seem to be significant contributors to therapy results, but lack of empathy and negative countertransference are linked to adverse outcomes (Lambert, 2013). The strength of the therapist-client relationship is the most significant predictor of positive therapeutic results (Shedler, 2010). Defining each aspect in the relationship precipitates therapist awareness to weak elements that may be present in the working alliance.

Occasionally, there is a disparity between patient engagement in therapy and therapist perception of the working relationship (Kramer et al., 2014). This suggests therapists inaccurately identify symptoms and severity by allowing the symptoms themselves to skew relationship evaluation (Kramer et al., 2014). It is imperative the therapist remain aware of their countertransference and tend to the client's needs appropriately.

Borderline Personality Disorder Diagnostic Guidelines (APA, 2013)
Fear of Abandonment (real or imagined)
Unstable and intense relationships
Identity disturbance
Potentially self-damaging impulsivity
Suicidal and/or self-harming threats or behaviors
Intense mood reactivity
Feelings of emptiness
Intense anger
Paranoid ideation or dissociative symptoms

Discussion

Bond. A therapist who possesses an optimistic, confident, and warm manner, traits stressed in interpersonal psychotherapy, while still maintaining their expert role (Bateman, 2012) model appropriate interpersonal conduct. This modeling facilitates client learning correct responses and behavior in social situations. Clients with therapists who disengage from the relationship, whether it be because of aversive client symptoms, fear of not keeping boundaries, or clashing personalities, invites reciprocal actions from clients. Clients who disengage with their therapist become increasingly cynical and irritable during therapy (Chalker et al., 2015), enhancing the risk of negative countertransference. Disengaged therapists exhibit more confrontational behavior (Dahl et al., 2017) further complicating the treatment process.

Partnership. Clients are open to change when both parties develop treatment goals. Conveying a spirit of positivity while keeping the client involved in their own therapy through the use of motivating techniques, contracts, shared-goal setting, commitment strategies and validation techniques all contribute to behavior modification success (Bornolova & Daughters, 2007). Clients who are made a collaborator in treatment decisions are more likely to accept their diagnosis; small demonstrations of autonomy and ability can build client self-confidence over time.

Confidence. Flexibility on behalf of the therapist can enhance a client's confidence in their therapist's ability. When the therapist adjusts therapeutic interventions and adapts skills to the client's needs, the client gets a sense the therapist is acting in their best interest. It is essential the therapist think holistically when it comes to problem-solving, and not mirroring the client's fervent affect when exhibited to further enhance the client's confidence in the therapist's skill. Also keeping abreast of best-practices as it pertains to BPD not only eases client anxiety, but the therapist's anxiety when it comes to dealing with an adversarial client.

Openness. Creating an environment that is unthreatening and supportive cultivates trust and positive regard. When a therapist is open to seeing the world through their client's eyes, they are more likely to create a nonjudgmental atmosphere. Conversely, taking an authoritative stance out of fear or misconception of BPD clients leads to deleterious consequences for the therapeutic alliance. Reasons therapists may be apprehensive to treat BPD clients include fear of litigation, possible enmeshment, and the difficult nature of the disorder. An overly structured and militant environment does not instill a sense of autonomy or freedom for the client to express authentic feelings, and may even cause early therapy termination. The therapist may inadvertently contribute to the client's feelings of worthlessness and self-critical cognitions (Link & Phelan, 2006).

Suggestions for Future Research

- Behavioral aspects, particularly strategies to increase self-control, have been extensively examined. However, more research could be done on the cognitive issues of BPD relating to lack of awareness and symptom denial.
- BPD occurring comorbidly with other disorders can further complicate diagnosis and treatment. Symptoms of other disorders can also impede treatment and contribute to a flawed therapeutic alliance. It would be beneficial to look at how the the therapeutic alliance and counselor role varies depending on the disorder presenting.
- Publication bias is a source of concern for empirically proving certain treatment aspects of BPD. Claims of borderline-relevant symptom alleviation and improved retention rates were not confirmed when accounted for risk of bias (Cristea et al., 2017). Additional research on therapeutic alliance across all modes of treatment would be helpful in further advancing the bond, partnership, confidence, and openness constructs.

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