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

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Abstract

This literature review explores the connection between positive therapeutic alliance and treatment success for borderline personality disorder (BPD). Four treatment methods emerge particularly efficacious in treating BPD: dialectical behavior therapy (DBT), mentalization-based therapy (MBT), schema-focused therapy (SFT), and transference-focused psychotherapy (TFP). Based on different treatment philosophies, these four methods are dissimilar in structure and goal emphasis, but similar on one condition: the importance of a positive therapeutic alliance. Research indicates cultivating a relationship that pays attention to the bond, partnership, openness, and confidence that exists between the client and therapist leads to greater outcomes and program retention rates. This report aims to identify crucial elements in the therapeutic alliance that transfer to the effective treatment of borderline personality disorder.

Keywords: borderline personality disorder, therapeutic alliance, therapist effectiveness

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Inappropriate, frantic, abandonment, unstable, intense, disturbance, impulsivity, self-mutilating, paranoid, threats, frequent displays of temper, constant anger, intense anger, difficulty controlling anger. These are some of the words listed in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) describing the symptoms exhibited by people who have borderline personality disorder (BPD). An individual diagnosed with BPD demonstrates persistent behaviors that make interpersonal relationships difficult; they may have affective lability, their self-image and identity may shift dramatically, and their impulsivity may be high (American Psychiatric Association, 2013). Difficulty with interpersonal relationships is the hallmark of those afflicted with BPD (American Psychiatric Association, 2013).

The prevalence of BPD is between 1.6 to 5.9% in the general population, 6% in primary care settings, 10% of people in outpatient settings, and 20% among psychiatric inpatients (Gunderson, 2011). It is thought the BPD diagnosis is underemployed because of the stigma it carries and the perception that individuals who demonstrate the symptoms are manipulative (Gunderson, 2011). Furthermore, studies have found BPD to have a substantial heritable component with 42 to 68% of cases linked to genetic factors (Gunderson, 2011). Misperception persists due to the outward behaviors and interpersonal difficulties of those afflicted with BPD.

The symptoms of BPD can be grouped into three main categories: behavioral dysregulation, affect dysregulation, and interpersonal conflicts (Sinnaeve, Van Den Bosch, Van Steenbergen-Weijenburg, 2015). Behavioral dysregulation is the inability to exercise self-control in certain situations. Affect dysregulation, or emotional instability (e.g., intense paranoia or uncontrollable anger), is a consistent predictor of BPD symptom severity over time (Tragesser,

Solhan, Schwartz-Mette, & Trull, 2007). Of the three symptom groups presenting in BPD, emotion regulation is at the center of behavioral and interpersonal difficulties even though it may be interpersonal problems that cause many to seek treatment (Herr, Rosenthal, Geiger, & Erikson, 2013).

A component of affect dysregulation seems to stem from pervasive thoughts and flawed emotion processing. Neutral and ambiguous stimuli are perceived as dangerous or untrustworthy (Sinnaeve et al., 2015). Selective attention and other maladaptive cognitive processes can impede therapy by creating a client that is distrustful of others, feels helpless and unloved, or perceives neutral or ambiguous situations as troubling (Baer, Peters, Eisenlohr-Moul, Geiger, & Sauer, 2012). Their depressive ruminations can impair concentration, memory, and problem solving (Baer et al., 2012) resulting in ineffective treatment. Of these symptoms, ruminations, or specifically repetitive angry thoughts, are common in people with BPD and significantly correlated with the severity of BPD (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.

BPD has a history of being difficult to treat due to maladaptive cognitive processes perpetuating the emotional instability of the client, but it is not impossible. Dialectical behavior therapy (DBT), mentalization-based therapy (MBT), transference-focused psychotherapy (TFP), schema-focused therapy (SFT) and others have empirical evidence showing a reduction in BPD symptoms over the course of treatment. Brief DBT skills training has also been shown to be effective in reducing acute BPD symptoms for a short amount of time (McMain, Guimond, Barnhart, Habinski, & Streiner, 2017). This suggests once short-term therapy has concluded, and the relationship with the therapist has run its course, the client will eventually return to pre-

treatment thoughts and behaviors without the support of their therapist. A therapist who quickly establishes a connection with the client and teaches short-term symptom relief techniques proves effective until the client's therapy has run its course. Likewise, different therapeutic models that are useful in BPD symptom alleviation imply therapy delivery is a crucial component. Positive therapeutic outcomes are directly related to the quality of the therapeutic alliance, and reduction in BPD symptoms (Goldman & Gregory, 2010). It seems a structured, empirically tested therapy is effective in relieving symptoms of BPD, but a positive therapeutic alliance makes lasting changes over the course of treatment. The importance of studying not only the therapeutic method but also the alliance between client and counselor cannot be understated; to do so would mean each party in the relationship is a separate entity. A strong working alliance may mitigate BPD symptom severity and negative countertransference leading to increased positive therapeutic outcomes, and it takes effort from both the client and the therapist. This report aims to quantify aspects of the therapeutic alliance to outline further research that may be done on each alliance dimension: bond, partnership, confidence, and openness, and how these dimensions affect the treatment of BPD.

Method

Articles chosen for review were first obtained using the advanced search method available from the Z. Smith Reynolds (ZSR) Library search bar. ZSR Library searches access data from more than 270 databases that include but are not limited to ProQuest, SageJournals, Web of Science, Applied Social Sciences Index and Abstracts (ASSIA), and JSTOR (Denlinger, 2018). Primary search terms were borderline personality disorder, therapeutic alliance, working alliance, working alliance assessment, therapeutic alliance assessment, efficacious treatment, therapeutic qualities, successful treatment, reflective functioning, psychotherapy outcome, and

treatment retention. To focus on most current evidence, time parameters were set for research done within the last ten years during this phase of data compilation. The dynamic nature of research and expanding information in the causes and behavioral breakthroughs of BPD make setting appropriate time constraints important. However, there are several assessment tools used to evaluate aspects of mental disorders that are older than ten years but still prove valid and useful today. An example is the Agnew Relationship Measure used to assess therapeutic alliance dimensions. Published in 1998 to quantify therapeutic relationship elements, this measure of therapeutic alliance was used over other measures, namely the Working Alliance Inventory, because it assesses both therapist and client perspectives.

Peer-reviewed research articles, both quantitative and qualitative, perspective pieces, and meta-analyses were included to provide more in-depth knowledge of BPD and current therapeutic best-practices. Articles were included if they pertained explicitly to borderline personality disorder, therapeutic alliance characteristics, and effective treatments for BPD, and were corroborated by multiple sources.

Results

Although the purpose of this literature review is to focus on the therapeutic alliance, it is essential first to review the diagnostic guidelines for borderline personality disorder. The American Psychiatric Association (2013) outlines nine criteria, five of which must be present in some capacity: (a) fear of abandonment, real or imagined, (b) vacillation between extremes of idealization and devaluation, a pattern of unstable and intense relationships, (c) identity disturbance, (d) potentially self-damaging impulsivity, (e) suicidal and/or self-harming threats or behaviors, (f) intense mood reactivity, (g) feelings of emptiness, (h) intense anger, and (i) transient, paranoid ideation or dissociative symptoms. Any five of these symptoms pose a

challenge for the therapist and may make connection to the client difficult. Many clients who seek treatment have a history of relationship turmoil and enter therapy with low self-esteem (Kramer et al, 2014). A client may behave defiantly or as though they do not care, but this can be a façade. Many clients with BPD have had a history of abuse; pushing people away or holding them too close, or self-injurious behavior may be a result of their low self-worth, or as a means of distraction from intense affective states (Chapman, Leung, & Lynch, 2008).

There appears to be disparity between patient engagement in therapy and therapist perception of the working relationship. A therapist's assessment of their therapeutic alliance has been found to negatively correlate with change in BPD client behavior (Kramer et al., 2014). This suggests therapists inaccurately identify symptoms and severity by allowing the symptoms, themselves, to skew their evaluation of the relationship (Kramer et al., 2014). Clients with more severe affect regulation symptoms who receive lower therapeutic alliance ratings from their therapist may result from maladaptive social skills (Kramer et al., 2014). This does not mean internal motivation to change is low. Conversely, a client who is more pleasant may have adequate coping skills but then rates the therapeutic alliance low, possibly due to the therapist misjudging the severity of the client's disorder. An agreeable disposition may mask other dysfunctional behaviors. Therapist characteristics like gender, years in practice, and theoretical orientation are not significant contributors to therapy results (Lambert, 2013). However, lack of empathy and negative countertransference are linked to adverse outcomes (Lambert, 2013), and it is the strength of the therapist-client relationship that is the most significant predictor of positive therapeutic results (Shedler, 2010). It is imperative the therapist remain aware of their countertransference and tend to the client's needs appropriately.

Knowing that a strong therapeutic alliance is imperative to a positive outcome, the next step is to measure facets present in the client-therapist relationship. The Agnew Relationship Measure (ARM), shown to be a valid therapeutic alliance measure (Ardito & Rabellino, 2011), illustrates four unique constructs present in the therapeutic alliance: bond, partnership, confidence, and openness (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998). Bond is the warmth and caring felt by the client, and empathy demonstrated by the therapist; partnership is a collaboration between the client and the therapist, and lays the groundwork for trust in the relationship; confidence is the level of expertise brought by the therapist and the client's belief in the therapist's proficiency about the client's dysfunction; and openness is the client's freedom from judgment or ridicule during sessions (Agnew-Davies et al., 1998). By focusing on bond, partnership, confidence, and openness, a stronger client-therapist relationship can emerge, laying the groundwork for successful treatment.

Dimensions of Therapeutic Alliance

Bond. One of the most studied therapies developed explicitly for BPD, Dialectical behavior therapy (DBT), is a structured, manualized therapy ensuring treatment is consistent. Putting BPD in a favorable light, as done in DBT, has been shown to be associated with a decrease in suicidal behaviors (Bedics, Atkins, Comtois, & Linehan, 2012). Interpersonal psychotherapy (IPT) which focuses on the therapeutic alliance, highlights the affect of the therapist, their optimistic, confident, and warm manner while still maintaining their expert role (Bateman, 2012). Clients who see therapists model correct interpersonal conduct may learn appropriate behavior by seeing appropriate behavior in practice. Those who disengage with their clients, whether it be because of aversive client symptoms or clashing personalities, open the door to reciprocal actions from clients. Clients who disengage with their therapist become

increasingly cynical and irritable during therapy (Chalker et al., 2015) which enhances the risk of negative countertransference. Disengaged therapists also exhibit more confrontational behavior, which seems to be caused by patient personality characteristics and complicated with the BPD symptom severity (Dahl et al., 2017).

Counterintuitively, increased contact can mend a ruptured relationship. When demanding clients were given the opportunity to call the therapists, therapeutic alliance ratings from both the client and the therapist increased, even when the client did not stay within set boundaries (Chalker et al., 2015). Therapists can be apprehensive with BPD clients due to the emotional nature of the relationship. However, when a therapist is adept at thinking in terms of the client thought process, they can buffer the anxiety one feels from dealing with BPD clients. Therapists who have healthy reflective functioning are more effective at building a relationship with demanding clients even when plagued by attachment anxiety (Cologon, Schweitzer, King, & Nolte, 2017). Therapists who successfully set up a positive therapeutic alliance may see a less-demanding client who begins to adhere to set boundaries. It is important to note even with a positive therapeutic alliance, many affective interpersonal symptoms will persist, including intolerance to loneliness (Dammann et al., 2016).

Partnership. Clients are open to change when both parties develop treatment goals. DBT employs commitment strategies in which the client actively participates. These strategies are shown to be effective in behavioral change: non-suicidal self-injury dramatically decreases among clients with eating disorders, many times comorbid with BPD and known for being difficult to treat, when these strategies are employed versus cognitive behavioral therapy (Bedics et al., 2012). CBT focuses on the behavior but does not elicit the same amount of relationship obligation on behalf of the client. DBT highlights the dynamic nature of BPD symptoms and

conveys a spirit of positivity while keeping a firm contract intact. Bornalova & Daughters (2007) outlined techniques used by dialectical behavior therapists to enhance client participation: motivating interviewing, treatment contracting, shared goal-goal setting, and the use of commitment strategies and validation techniques. These all contribute to the success of DBT when it comes to behavior modification. However, focusing on therapeutic alliance by validating the client's feelings and the frequency of client contact may play a larger role in client-counselor satisfaction (Bornalova & Daughters, 2007).

A BPD diagnosis can feel stigmatizing and lower a client's already-depleted self-confidence. Going over diagnostic criteria with the client and asking them if they feel it describes their behavior can mitigate the effects of being diagnosed by giving the client some sense of control over their dysfunction. Clients who are made a collaborator in treatment decisions are more likely to accept the diagnosis (Gunderson, 2011). Dichotomous thinking plagues many sufferers of BPD, and some vacillate between feelings of good and bad, worth and worthlessness. A client can develop self-efficacy in their own decision making if they agree with the therapist. Perhaps small demonstrations of autonomy and ability can build self-confidence over time.

Confidence. A client with BPD will demonstrate one of two forms of attachment when under stress (Bateman, 2012). Hyperactivating strategies are employed when a stressed client clings to a significant person in their life; other clients will exhibit an "attachment deactivating strategy" and push people away to assert autonomy (Bateman, 2012). The therapist is in a unique position to recognize when hyperactivating or deactivating strategies are employed and realize their client is suffering. Having the expertise to be flexible will help mitigate hyperactivating or deactivating strategies and contribute to building trust in the therapeutic alliance. When the therapist adjusts therapeutic interventions and adapts each skill to the client's needs, the client

gets a sense that the therapist is acting in their best interest. When the therapist is flexible, both client and therapist have a sense of confidence imprinted in memory: trust, authenticity, and personal relevance is present in the relationship (Duarte, Fischersworring, Martínez, & Tomicic, 2017).

It is essential the therapist think holistically when it comes to problem-solving with the client, to avoid dysregulating the client, and not mirror the client's fervent affect when exhibited (Bateman, 2012). Client commitment is imperative to ceasing self-injurious behavior, many times present in BPD clients (American Psychiatric Association, 2013). Furthermore, using behavior extinction strategies along with the expert role of the therapist proved effective in stopping self-injurious behavior (Bedics, Atkins, Harned, & Linehan, 2015). DBT therapists have specialized training in neutrality: to respond in nonenforcing ways to aversive client conduct (Bedics et al., 2015). Keeping up-to-date on treatment approaches may ease a therapist's anxiety when it comes to treating challenging clients, and clients benefit by trusting their counselor's expertise in their disorder.

Openness. Schema-focused therapy (SFT) emphasizes trust in the client-therapist relationship through an environment that is unthreatening (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). The therapist focuses on having a supportive attitude to cultivate mutual trust and positive regard (Spinhoven et al., 2007). Theory regarding BPD etiology places emphasis on early childhood experiences. The first phase of a schema mode model may facilitate client understanding and empathy on behalf of the therapist (Spinhoven et al., 2007). When a therapist is open to seeing the world through their client's eyes, they are more likely to create a nonjudgmental atmosphere.

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 to include additional energy and time spent with problematic clients (Jiminez, 2013). An overly structured and militant environment does not instill a sense of autonomy or freedom for the client to express authentic feelings and may cause early therapy termination. Not only does this place a burden on the client, but the tense atmosphere may set the stage for negative countertransference. The therapist may inadvertently contribute to the client's feelings of worthlessness and self-critical cognitions (Link & Phelan, 2006). Individuals diagnosed with a personality disorder are not more susceptible than individuals who have been diagnosed with other disorders to early termination of therapy (McMurran, Huband, & Overton, 2010). A therapist who takes this into account may be more likely to devote time and energy to clients who need their help the most.

Discussion

Treating clients with BPD can be exhausting due to the nature of their symptoms, symptoms of which the client may not be fully aware. Patients might be silent during sessions, not knowing what to talk about, or they may be confrontational and blaming, or overly passive and yielding; how the therapist reacts may be more critical to therapeutic effectiveness than the model of therapy they ascribe to (Lambert, 2013). Six aspects of emotion regulation have been particularly challenging: lack of awareness or clarity of emotional responses, nonacceptance and limited access to strategies intended to help mollify impulsive responses, and difficulties controlling impulses when experiencing stress or intense emotion (Gratz & Roemer, 2004). Behavioral aspects like strategies to increase self-control have been extensively examined, but

more research could be done on the cognitive issues of BPD relating to lack of awareness and symptom denial.

Notably, client attrition rates may be due to variables other than the quality of the patient-client relationship. BPD can be comorbid with an array of other disorders, including severe depressive disorder, other personality disorders, substance use disorders, and identity problems (American Psychiatric Association, 2013). Poor overall functioning, difficulty concentrating and fatigue (particularly when due to a comorbid disorder), and demographic factors may also contribute to treatment withdrawal (Hom & Joiner, 2017). Symptoms of other disorders impede treatment; worsening symptoms of other disorders have been shown to contribute to poor general functioning, lessen treatment effects, and contribute to a flawed therapeutic alliance (Jarvi, Baskin-Sommers, Hearon, Gironde, & Björgvinsson, 2016). The effectiveness of short-term cognitive-behavioral therapies in treating individuals with multiple disorders including BPD (McMain, Guimond, Barnhart, Habinski, & Streiner, 2017) indicates targeting comorbid disorders during the onset of treatment is necessary to create an atmosphere that is conducive to treatment efficacy.

Publication bias is a source of concern for many treatment models of BPD. Claims of borderline-relevant symptoms alleviation and improved therapy retention rates were not confirmed when accounted for risk of bias (Cristea et al., 2017). Additional research on therapeutic alliance needs to be conducted independent of treatment theory to account for inflated claims of program efficacy. It may not be the treatment method that explains improvement in BPD symptoms, but the distinctive therapists that utilize effective interpersonal skills. More inquiries into comparing the similarities as well as the differences of BPD treatments where therapeutic alliance is a significant focus would be helpful in isolating useful

techniques. These techniques may generalize to other therapies that are tailored to the needs of individual clients. Employing best practices that prove effective could lead to stronger client-therapist alliances and ensures BPD symptom improvement, the true goal of therapy.

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