EXPLORING HOW CLINICAL PSYCHOLOGISTS CONCEPTUALISE, MANAGE AND PERSONALLY COPE WITH "DIFFICULT" CLIENTS PRESENTING WITH BORDERLINE PERSONALITY DISORDER

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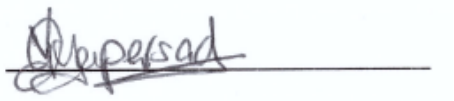
I declare that the above dissertation/thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



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Abstract

Clients diagnosed with Borderline Personality Disorder (BPD) interact with healthcare professionals in compelling ways. By virtue of the symptoms that define BPD, it is likely that the client will challenge the therapist with regards to their theoretical approach or therapeutic style. In addition, clients with BPD are likely to project their need for a therapeutic interaction that is both genuine, empathic and at the same time, flexible. In light of this, it is not uncommon for healthcare practitioners to consider clients with BPD as "difficult" in some way or the other. This study explores how clinical psychologists in Gauteng conceptualise and manage a "difficult" client presenting with Borderline Personality Disorder. Further, coping strategies of the clinician will also be explored. The qualitative study, couched in a social constructionist paradigm, involved interviewing seven clinical psychologists practicing in Gauteng, South Africa. The transcripts of the semi-structured interviews were thematically analysed. The findings of the current study indicated that the difficulties experienced are reflective of the general criteria of the disorder. The picture of the difficult client is painted by personal experience, as well as stereotypes gained from interactions with colleagues and other healthcare professionals. It was further found that management of these patients were viewed and implemented based on the nature of the disorder. In addition, management by the clinician often included supervision and leisure activities.

Keywords: *Borderline Personality Disorder (BPD), boundaries, burn-out, clinical psychologist, countertransference, difficult client, self-harm, splitting, self-care, social constructionism, suicidal risk, transference.*

CHAPTER ONE: INTRODUCTION

1.1 Brief outline of the study

This dissertation begins with an introduction to the study, focusing on the rational for the research and its relevance. Chapter two provides a literature review in which relevant literature focal to this study was examined and discussed. This provides a background of the studies already conducted and evidence within the field. This is divided into GMS and psychiatric studies. Chapter three focuses on the research methodology. This study is rooted within the social constructionist paradigm, and is qualitative in nature so as to explore the subjective experiences of the participants. The participants of the study were seven registered clinical psychologists with exposure to at least one difficult client presenting with BPD. Semi-structured interviews were conducted and the data was analysed using thematic analysis. The findings and discussion chapter follows in which the data gathered is explored. The central focus is placed on the research questions highlighted in chapter one. Chapter five provides a conclusion in which the strengths, limitations and recommendations are explored for future research. A list of references and appendices follows, concluding the dissertation.

1.2 Problem statement

Clinical psychologists have to some degree, encountered clients presenting with BPD which they have perceived as "difficult" in some way. This can be learnt from others, or may be derived from personal experience with clients. Exploring these kinds of clients and how psychotherapists identify, manage and personally cope with them can be greatly beneficial in understanding these clients. Being labelled as a "difficult" client can have implications on both the client as well as the psychotherapist. This negative connotation may bring about feelings of irritation, annoyance and resistance by the therapist (Wilson, 2005).

In therapy, this could possibly translate into a poor therapeutic relationship in which the client may be viewed in a negative light. In turn, the therapist may either become too detached from therapy, or may work harder to counter this "therapy resistant client". As a result, the therapist may experience burnout, excessive stress or displeasure from this relationship. Further, as a result of these stereotypes of being "difficult", inadequate treatment or formulations can be implemented and poor quality of service may be the outcome. These

clients may possibly be avoided, referred onto the next willing therapist, or uncomfortably tolerated within the therapeutic space. Looking at the client, a gloomy future lies ahead because of this. They may be faced with further adverse experiences as a result of this, be it the poor treatment or rejection. The result of this could be additional harm to the client.

This study therefore attempts to explore three aspects of this process. Firstly, it is important to understand what makes these clients difficult. By understanding this, we have a point of departure by which we know what to focus on. Secondly, exploring how these clients are managed can be beneficial so that methods that do make management easier can be explored or tried by other therapists. Lastly, taking into account the therapist themselves, it is helpful to look at ways in which therapists manage themselves, or personally cope after these experiences.

1.3 Rationale for research

It is often found that psychologists find it difficult to define what is meant by the term "difficult" (Quinn, 2002). Thus, I would like to further explore clinical psychologists' personal conceptualisations of the term. Clients with BPD may also receive poor quality or inadequate treatment as a result of being seen as a 'difficult' client (An et al., 2009). On the part of the psychotherapist, there may be a risk of predispositions to burn out, stress, anxiety or other forms of negative physical and emotional ramifications (An, Manwell & Williams, 2013). Therefore I also wish to look at management of difficult clients as well as personal management by the psychotherapist. By doing so, effective mechanisms of self and client care may be identified and utilised by other clinicians.

According to Lieban and Burnette (2013) it was found that less experienced clinicians experienced difficult clients more frequently. In my study, I would like to make a similar comparison with clinical psychologists. Those with less than six years of experience compared to those with six or more years of experience. Skovholt and Rønnestad (2003) have developed six phases of counselor/therapist development. These include: the lay helper, beginning student, advanced student, novice professional, experienced professional, and senior professional.

The novice professional phase covers the first five years after graduation. During this period, there is a sense of being independent as well as certain stages which were found to be evident. Firstly, there is a period in which the therapist seeks to confirm the validity of their training. Secondly, when they are confronted with challenges which they have not adequately mastered, there is a sense of disillusionment with professional training and the self. Thirdly, there is also a period of deeper exploration of both their professional environment as well as themselves. The novice professional also becomes aware that their personality is expressed in their work, which can be experienced either positively or negatively. If the therapist is confident in their abilities, it can lead to a positive outcome. However, if the therapist is doubtful with regards to their suitability for therapy, then this could lead to unfavorable outcomes.

The experienced professional phase includes those who have been practicing for a number of years and who have seen a variety of clients in different contexts. At this phase, the therapist becomes aware of the importance of the therapeutic relationship for client progress. During this stage, there is also flexibility in both their role and working style. It was also found that these individuals are more trusting of their professional judgment, feel more competent and comfortable about their work and are able establish better relationships with clients. At the same time, there is also a sense of "not-knowing" and being open to new learning. Skovholt and Rønnestad (2003) also report that learning comes from direct experience with clients which they are exposed to as well as the therapists' personal life. Therefore, with increased experience, more learning takes place. Sharing their learning also takes through mentoring and supervising younger professionals.

Taking into account Skovholt and Rønnestad's (2003) model of counselor/therapist development, a comparison will be made between the novice professional and the experienced professional. Differences in experiences could therefore be accounted for by differences in the number of years practicing as a psychotherapist. Thus, those with less than six years of experience will be compared to those with six or more years of experience.

Although there are studies done regarding the "difficult" client, this study differs as it deals with clients presenting with BPD and also focuses on clinical psychologists, more specifically in South Africa. Research specifically with clinical psychologists in South Africa is limited as the majority of the research is done with other health care workers such as

medical doctors, nurses and ambulatory staff. By identifying what is regarded as a difficult client, as well as how they are managed and how psychotherapists cope with this, we may be able to use this information to assist other psychotherapists with perceived difficult clients presenting with BPD. In addition, by investigating this specific area, clients could be better identified and assisted. Further studies can also emerge out of this research to generate more information in this particular field.

1.4 Research questions and objectives

For this study, the following research questions are posed:

1. How do clinical psychologists conceptualise difficult clients presenting with BDP?
2. How do they manage these clients?
3. How do they, as clinical psychologists, personally cope having these clients?

The objective of this research is to explore how clinical psychologists conceptualise and identify difficult clients presenting with BPD and how they manage these clients. This study will also aim to understand how these clinical psychologists personally cope after difficult clients. Given the rationale for the study as well as the objectives, relevant research needs to be examined to determine the fund of knowledge within the field already. A literature review highlighting pertinent studies already conducted will be beneficial in creating an understanding of this specific area within the field.

CHAPTER TWO: LITERATURE REVIEW

In everyday human interactions, we find that we get along more easily with some individuals, and struggle with others. This is based on the arrangement of traits that determine whether we can effectively interact with others. Within the profession of psychology, we find that this interaction may also be evident. Despite the overarching theme of empathic connectivity with clients, some clients may be seen as "difficult" by health care professionals (Daberkow, 2000; Koekkoek, van Meijel, Tiemens, Schene, & Hutschemaekers, 2011). According to Koekkoek, Van Meijel and Hutschemaekers (2006), the difficult client is a well-known figure within the mental health care system. It is found that between 15% and 60% of all clients seen by physicians are considered to be difficult (Fiester, 2012).

Even though the acknowledgement of such clients is evident, much of these encounters within psychology are not documented in research. Further, working with difficult clients can be a challenge for most psychotherapists (Softas-Nall & Hanna, 2013). Purves and Sands (2009) reported that clinicians in general report more negative attitudes in working with those clients who have a diagnosis of a personality disorder as compared to other disorders.

In addition, it is reported that a personality diagnosis does impact negatively on the clinical practice with these clients. Many clinicians and mental health practitioners are reluctant to work with those who have personality disorders as they believe that they do not have the skills or training to provide adequate services (Glen, 2005). Looking more specifically at individuals with BPD, Aviram et al. (2006) state that clinicians often describe these clients as "difficult", "manipulative", "treatment resistant", "demanding" and "attention seeking." As a result of such connotations being attached, this could impact negatively upon the clinicians' expectations and image of the client.

2.1 Conceptual definitions

The term "difficult" client can be described in differing terms. The difficult client may be hard to define, however the concept of this term is familiar in many clinical settings (Adler, 2006; Koekkoek et al., 2006; Quinn, 2008). Within the Oxford Dictionary, the term

"difficult" refers to "needing frequent effort or skill to do or understand" (Waite & Hawker, 2009, p. 255).

Individuals presenting with BPD often make frantic efforts to avoid real or imagined abandonment. They experience intense abandonment fears even when met with realistic time-limited separation or unforeseen changes in plans. Efforts to avoid abandonment may include impulsive actions. These individuals also display a pattern of unstable and intense interpersonal relationships. Within these relationships, the individual with BPD may rapidly shift their view of others, for example, from idealising to devaluing a person. An identity disturbance may also be present. There are often sudden and dramatic shifts in the self-image, for example, there may be changes in values, goals and sexual identity (American Psychiatric Association, 2013).

Individuals presenting with BPD may also display impulsivity in at least two areas that are potentially self damaging. Impulsivity refers to "acting without thinking ahead" (Waite & Hawker, 2009, p. 467). These include areas such as gambling, reckless driving or abusing substances. These individuals may also display recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour. Self-mutilating includes acts such as burning or cutting and is also referred to as self-harm or self-injury. These behaviours may be done in a response to threats of separation or rejection (American Psychiatric Association, 2013; Bland, 2003). Many individuals with BPD have lives that can be characterised as being 'turbulent' due to poor impulse control. Additionally, individuals with BPD have a feeling of inner emptiness and aloneness that makes them feel disconnected and hopeless (Goldstein, 1990).

Like dealing with anxiety, individuals may engage in addictive or compulsive and self-destructive behaviours in an attempt to relieve the painful experience. One explanation for the problems individuals with BPD have in controlling impulses, anxiety, and affects is their difficulty in self-soothing (Goldstein, 1990). Goldstein explains that this could be the result of lacking the internalisation of sufficient positive experiences and not being able to evoke the image of a sustaining and soothing caretaker. They can become dependent on others to reassure and soothe them and therefore people with BPD commonly exhibit fears of abandonment. This can lead to a person needing to constantly be with others but also keeping others at a safe distance to avoid losing them. In his or her mind, separation and individuation

is equated with object loss rather than autonomy. Separation or rejection may precipitate crises or suicidal threats and acts.

Affect instability may also be present in individuals with BPD. They may experience frequent dramatic shifts in their emotional states. These emotional states are generally very intense as well as frequent for the individual. This may be present when confronted with interpersonal stress. Individuals with BPD may also experience chronic feelings of emptiness. They are generally unable to express their goals and wishes and may appear shallow and unmotivated by others (American Psychiatric Association, 2013).

Expressions of inappropriate, intense or difficulty controlling anger may also be displayed. These expressions may be more intense than is warranted by the situation or provocation and it may be challenging for the individual to restrain this anger (American Psychiatric Association, 2013; Bland, 2003). Paranoid thoughts and dissociative symptoms may occur, however they are transient and are related stress. Dissociative symptoms reflect depersonalisation in which the individual feels a sense of unreality, detachment or being an outside observer with respect to one's thoughts, feelings, actions and body (American Psychiatric Association, 2013). Self-cohesion may also be fragile amongst BPD patients and decompensation or fragmentation can occur under stress or feelings of abandonment.

People with BPD also rely heavily on others for approval and recognition for the maintenance of positive self-esteem. They may lack self-regard that is realistically based. In other words, their conceptions of themselves are either grandiose or devalued and they may often feel entitled or unworthy. Furthermore, many individuals with BPD are sensitive to perceived criticism, disapproval, and lack of appreciation. The result can be self-loathing or self-hate (Goldstein, 1990).

Lastly, the superego development in these individuals is incomplete. This results in an unreliable and inconsistent regulator of behaviour. On one hand one may not experience any guilt or remorse about something; conversely, the guilt felt affects all aspects of one's life. The picture described above results in a pattern of intense and unstable relationships among individuals with BPD. Intimacy can be a struggle, closeness rarely lasts, and fights can occur all too often. Impulsiveness can lead to frequent breakups and reconciliation but at the same

time, separations are extremely difficult, as discussed earlier. Separation may also result in desperate and seemingly manipulative behaviour (Goldstein, 1990).

In taking into account the clinical picture of the BPD individual, the unpredictability in their behaviour, as well as their intense range of emotions are some of the factors which make it difficult for psychotherapists to manage these individuals. Other factors such as intense anger, chronic suicidal ideations, self-injury and suicide attempts have also been found to make the therapeutic process more difficult (Aviram et al., 2006). Further, it is found that treatment is also seen as a slow process which is due to changes in the level of functioning characteristic of BPD. In light of the clinical symptoms that characterise BPD, it is important to explore evidence from medical studies.

2.2 General medical professionals dealing with clients with BPD

A study by Michaelsen (2012) looked at nurses' relations to and feelings about difficult patients in a Danish municipality. It was found that the behavioural and emotional reactions of the nurses can be classified under three aspects. Firstly, persuasion is identified, which refers to attempting to get the patient to adjust to the patient role which the nurse requires. Secondly, there is avoidance which refers to nurses emotionally or physically avoiding the patient. Lastly, there is compromise which refers to the nurse's balance between using persuasion and avoidance (Michaelsen, 2012). Thus it is found that these factors can become evident when a patient is perceived as "difficult". In turn, the quality of care or treatment to the patient can be compromised.

Haas, Leiser, Magill and Sanyer (2005) report that difficulties can be identified in three areas, which are the patient, the physician or the health care system. Patient factors include aspects such as psychiatric disorders, personality disorders, and sub-clinical behavior traits. The physician factors include aspects such as overwork, poor communication skills, low levels of experience and discomfort with uncertainty. Lastly, looking at the factors within the health care system, we find productivity pressures, change in healthcare financing, fragmentation of visits, and the availability of outside information sources that challenge the clinician's authority are evident.

A study by Khalil (2009) looked at nurses' attributions of certain behaviours to "difficult" or "bad" patients in South Africa. According to this study, the most undesirable behaviour which would classify a patient as "difficult" is uncooperativeness. Second to this was rudeness, followed by verbal abuse and then the tendency to always complain. A similar study to the proposed research by Elder, Ricer and Tobias (2006) was conducted which looked at how family physicians identify, manage, and cope with difficult patient encounters in the United States. The types of difficult patients identified were classified under behaviour and medical problems. The findings revealed that behaviour problems included aspects such as stay sick behaviours (ignoring problems, non-compliant, overly dependent), demanding behaviours and other behaviour. The medical problems included multiple problems, pain, drug problems, psychiatric problems and miscellaneous problems. Studies by Khalil (2009); Koekkoek et al. (2006) and Davidtz (2007) have also found these factors as common.

Weight and Kendal (2013) state that negative attitudes among healthcare professionals in England may also be a contributing factor to the stigma surrounding BPD patients. It was found that factors contributing to these negative attitudes include previous negative experiences with clients with BPD, time constraints, low levels of optimism regarding recovery, and a lack of training. Mental health workers further believed that this population was in control of their behaviour, and are actually calculating and threatening.

Miksanek (2008) introduces another element to this in his study in the United States, which is the relationship between the physician and the patient. The problem is not exclusively with the patient, the physician too plays a vital part in this definition. The way in which physicians and patients relate to one another can plays a vital role in determining if a patient is seen as difficult or not. Teo, Du and Escobar (2013) place emphasis on the relationship between the client and the therapist. They state that the focus of change in difficult cases should be the relationship.

Similarly, Breen and Greenberg (2010) state that difficult encounters between therapists and clients with BPD, may also be an indication of inadequate communication between the two parties. Thus, the communication process between patient and physician greatly influence if a patient is perceived as difficult or not. This is also reported by Groner (2009) who states that failed communication between the physician and patient is most likely the cause of a failed therapeutic relationship as per a study in the United States of America (USA). In addition to

this, another study in the USA by Elder et al. (2006) also examined physicians' reasons for perceiving the patient – physician encounter as difficult. The following traits in physicians were identified: clashes with professional identity, personal qualities, time management, levels of comfort with patient autonomy, confidence in skills, and trust in patients.

Personal coping mechanisms are important in dealing with difficult clients as doctors who report many difficult clients were found to be 12 times more likely to report burnout (Baum, 2009). Wilson (2005) speaks of reflective practice in dealing with difficult patients. This is a time where practitioners review their clinical experience, their responses to patients as well as their own ideas on the nature of practice. Activities within reflective practices include journaling, critical incidence analysis, mentoring and supervision. In addition, a study in Ireland by James and Cowman (2007) report that nurses personally manage with difficult patients through supervision and ongoing support.

Hayward, Tilley, Derbyshire, Kuipers and Grey (2005) found that the perceived difficulty of a patient was influenced by factors in the mental health staff such as experience, training, general staff culture, or some combination of these. Breuner and Moreno (2011) have found that the level of difficulty of a patient is influenced by physicians with a lack of experience and those who are overworked. In addition, poor communication as well as an overburdened health care system impacts on the perception of a client as difficult.

Looking at the experience of the physician, Hinchey and Jackson (2011) report that there also appears to be a relation between younger physicians and difficulties with patients. This was based on a study done in the United States. Hinchey and Jackson (2011) also confirm an association between younger physicians and difficulty with the patient. Patient factors that increased difficulty were: having a greater number of physical symptoms and expectations, higher utilisation and a greater number of bothersome symptoms. Clinicians with poorer psychosocial attitudes and less clinical experience found more encounters to be difficult.

Lastly, gender may also be an important factor. In a study conducted by Commons Treloar and Lewis (2008), it was found that female clinicians across mental health in Australia and New Zealand, as well as emergency medical service settings, had more positive attitudes towards patients with BPD. Their ability to empathise more with these patients as compared to males may be due to the "traditional sex role of the female being more able to nurture

patients with significant emotional difficulties" (Commons Treloar & Lewis, 2008, p. 582). The difference may also be accounted for by a higher presentation of female clients with BPD with up to 75% of patients being female.

With regards to attitudes of male and female medical professionals dealing with clients with a Personality Disorder, it was found that female nurses were often found to have more positive attitudes towards patients (Bowers, 2002).

2.3 Psychiatric studies/Biomedical studies

It seems that most of the research on perceptions of BPD patients seems to be located from the perspective of the nurses, mental healthcare workers and medical staff who typically care for them. However, there seemed to be a gap in the literature reviewed. The voice of clinical psychologists regarding their perceptions and experiences working with clients with BPD were not explored in-depth. To support this, Woollaston and Hixenbaugh's (2008) study in London was based on interviews with six nurses about their experiences of working with this client group. Their study indicated that nurses generally saw these patients as manipulative, threatening, and destructive. The participants described BPD patients as having a "demanding and draining presence*"* and they disclosed that they felt "sucked into the world of BPD patients" (p. 705). Woollaston and Hixenbaugh (2008) discuss that nurses developed negative stereotypical perceptions and reactions after working with BPD patient's over time. The researchers propose that the participants' negative feelings are the result of feeling unable to help the patients. More broadly, Koekkoek et al. (2006) views difficult clients are those that do not improve or relapse repeatedly. Koekkoek, van Meijel, Schene and Hutschemaekers (2009) describe a difficult client as those who are interpersonally challenging and those who have a complex character or personality.

A longitudinal, quantitative study by Krawitz (2004) in Australia set out to achieve change in clinician attitudes toward people with BPD after a two-day training workshop. His hypothesis was that attitudes would change from negative to positive if clinicians were better equipped with knowledge, skills and language designed to help clients with a BPD diagnosis. By measuring their attitudes pre- and post-workshop and again at six months, he was able to determine that the training produced statistically significant changes. This implies that many of the negative feelings are the result of not properly understanding the diagnosis.

Deans and Meocevic (2006) found that a large proportion of the 65 nurses in Melbourne, Australia in their survey admitted to feeling like they did not know how to care for people with BPD. The authors perceptively point out that one of the problems facing individuals with BPD is the negative attitudes of those staff that care for them. The data derived from their study indicated that the majority of the participants perceived people with BPD as manipulative, as nuisances, and as engaging in emotional blackmail. Additionally, a high proportion of the respondents felt that people with BPD are responsible for their own actions.

Cleary, Siegfried and Walter (2002) looked at the attitudes of all health professionals towards those diagnosed with BPD in Australia. The majority of the staff was found to have had contact with a client diagnosed with BPD, at least once a month. Although there was a high frequency of contact, two-thirds of the staff indicated that patient management was inadequate. The reasons behind this reflected the belief that those specific clients were difficult to treat, there was a lack of training and/or expertise, and there was a shortage of services available. This study reflects that 84% of the participants had reported that working with patients with BPD was more difficult than working with other patients. It was found that those clients displayed high self-destructive and acting out behaviours which left the staff feeling incompetent and inadequate. Those clients also reject therapeutic care, which also lead to staff feeling frustrated and angry. In addition, further information and training related to service delivery, such as when to refer a client, were found to be a need among the staff. Given that the staff had found those clients difficult, it was important to explore staff support. Those who have had supervision indicated its usefulness in addressing common themes such as boundaries and countertransference. It was found that the structured approach to clinical supervision was suggested to aid staff in better management of clients with BPD.

Ma, Shih, Hsiao, Shih and Hayter (2008) focused on mental health nurses' decision-making patterns on care outcomes for patients with BPD in Taiwan. Five themes were found to emerge which highlights the informants account of their caring experiences for the client with BPD. The first theme describes the shift from the honeymoon phase, to the chaos stage. Participants indicated that in their initial encounter, both the client and participant tried to learn from each other and attempted to be respectful, resulting in a peaceful encounter. This however, was soon followed by the chaos stage in which the client began to display disruptive behaviours such as testing boundaries, manipulating other patients, attempting

suicide and insulting nurses. As a result, the nurses experienced negative feelings towards these clients.

The second theme involved the nurses' expectations for positive versus negative care outcomes, which greatly influenced their decision to interact with the client or not. Expectations for positive outcomes resulted in feelings of empowerment for the nurse, and a willingness to move past challenges faced and to interact with a more positive behaviours. A negative expectation will therefore lead to withdrawal and negative feelings towards the client. The third theme arising focused on practicing routine versus individualised nursing care. Those nurses who had negative expectations were found to practice more routine nursing care.

The fourth theme of Ma et al.'s (2008) study looked at whether the healthcare team members' support was adequate or inadequate. It was found that successful care outcomes for the patient were based on support of the other members of the healthcare team. Experienced nurses with adequate care experiences were found to be active helpers. As a result, the other members of the team are able to learn different approaches and strategies in dealing with clients that present with BPD, leading to lower levels of physical and emotional stress. The final theme looked at the differences in care outcomes. It was found the result of satisfactory care experiences by the nurses were linked to two approaches. Firstly, those with negative expectations for the client with BPD did experience satisfactory care experiences as they felt supported by and sought assistance from other colleagues who had successful care experiences. These nurses began to practice more individualised care and felt more competent. On the other hand, those nurses who experienced positive expectations had utilised individualised care, even during the chaotic stage.

Nauert (2009) has indicated that BPD patients may be physically unable to regulate emotion. This study, done at the Mount Sinai School of Medicine in the USA, discusses the findings of an imaging study that compared the brains of individuals with BPD against those without the disorder. By using magnetic resonance imaging while disturbing emotional scenes were presented to the research participants, researchers concluded that the area of the brain used to regulate emotion remained inactive in those with BPD. This suggests that there is an underlying biological explanation for why individuals with BPD experience difficulty controlling their emotions or affective responses. More studies like this one could be useful in

disputing the idea or belief that people with BPD are incomplete control of their behaviour. This is not to say that exposing the mental health community to the scientific evidence out there will change how clinicians react.

Treloar (2009) conducted a study in Australia and New Zealand in which 103 mental health practitioners provided comments about their experiences in working with individuals with a diagnosis of BPD. A review of their responses revealed that these patients "generate an uncomfortable personal response in the clinicians" (p. 31). Again, the participants reported that they often feel inadequate, frustrated, or powerless when working with BPD patients. Some of them felt that due to the patients' manipulation, poor coping abilities, and time consumption, the clinicians were unable to see any impact of their treatment efforts. Given this theme, one may suspect that the data from these studies has more to do with the countertransference responses evoked within the clinician, rather than what the clinician thinks or feels generally about individuals who display characteristics of BPD.

A study by Markham and Trower (2003) investigated the idea that a label affects staff perceptions. They examined how the psychiatric label of BPD affects staff perceptions about patient behaviour. Questionnaires with descriptions of patient behaviour and a linked diagnosis were given to 48 nurses. Patients with a label of BPD received more negative responses than those with other labels. They were also thought to be more capable of controlling their negative behaviour and staff reported less sympathy and optimism toward patients with a label of BPD.

Further, 71 mental health nurses completed questionnaires relating to BPD, Schizophrenia, and depression. Results indicated that staff had unfavourable attitudes toward the BPD diagnosis and considered these patients more dangerous than the other diagnoses. It was concluded that a diagnosis of BPD can have damaging implications for patients because of these stereotypical beliefs.

Koekkoek et al. (2011) conducted a study in Netherlands in which they associate the difficult patient with those who are generally unsatisfied with the care they receive and therefore may evoke strong negative emotions in clinicians. Forrest (2012) states that people who do not conform to expectations are sometimes seen in a negative light. As a result of this, some patients may be labelled by health care staff as difficult (Wilson, 2005). Further, these

patients can be seen as difficult to more experienced physicians as well (Breen & Greenberg, 2010).

Viewing such clients as difficult could have possible negative impacts on both the patient as well as the clinician. According to Wilson (2005) negative feelings to these clients could start with a dislike or annoyance and progress into frustration and anger. An et al. (2009) reported that the perception of the client as being difficult could lead to poor care of the client as well as increased stress and burnout amongst clinicians. These symptoms are also reported by Teo et al. (2013) in his study in the USA, who state that difficult patients can be frustrating and time consuming. They may also contribute to professional exhaustion and burnout as well.

Stress is defined as "excess of demands over the individual's ability to meet them" (Atkinson, 1988, p. 58). Cotes (2004) states that stress is perceived in relation to the individual's previous experiences which deal with similar situations. In the same study, it was found that professionals who perceive clients to be a source of stress as well as those who feel uncertain about their professional abilities in dealing with these clients, are more likely to perceive working with clients with personality disorders in a negative way (Cotes, 2004). Applied to this study, having more experiences with clients with BPD could thus have an impact, either positive or negative, on the psychotherapists' stress levels.

According to Koekkoek et al. (2006) psychiatric patients presenting with either psychotic or personality disorders are more likely to be perceived as being a "difficult" patient. Within this study, it was found that these patients fall under four dimensions of difficult behaviours which include "withdrawn and hard to reach, demanding and claiming, attention seeking and manipulating, and aggressive and dangerous" (Koekkoek et al., 2006, p. 796). The first category is found among those with psychotic disorders while the second and third category is found among those with personality disorders. The last category is found among both diagnostic groups.

Importantly, Koekoek et al. (2006) identify four individual factors which were found to be associated with a difficult patient. Firstly, chronicity plays an important role. Chronic patients often present with problems that are more difficult to resolve by the psychiatric system. In turn, this leads to these patients being labeled as difficult. The next factor is dependency on care. Unmet dependency needs can result in the patient projecting a lack of stable self and

trust onto the therapist. This is then perceived by the therapist as demanding and claiming which negatively impacts on the therapeutic relationship. Thirdly, those with character pathology are also seen as difficult. “Psychiatrists mentioned the diagnosis Borderline Personality Disorder up to four times more often than any other diagnosis when asked about characteristics of difficult patients” (Koekoek et al., 2006, p. 797). Within this group, these patients lack a clear self which results in both confusing and negative interactions with the therapist. Lastly, those patients with a perceived lack of reflective capacities are seen to be difficult (Koekoek et al., 2006).

Similarly, a study by Davidtz (2007) in the United States had found that therapists had described patients with certain diagnoses and behaviours which they had found “difficult”. These included BPD, Narcissistic Personality Disorder, Schizoid Personality Disorder, Dissociative Identity Disorder, Substance use disorders, high-risk behaviours and the avoidance of affect. Teo et al. (2013) also report that typically, difficult patients often present with anxiety, depression and other psychiatric symptoms and often express dissatisfaction with care.

According to Fazio-Griffith and Curry (2009), BPD has many negative effects on the individual’s life. It causes strained relationships, instability in important areas of functioning such as work or school, impacts on social activities and may create or perpetuate a negative self-image and self-worth. This could then lead to problems related to treatment as the client may have feelings of incompetency and anger. Having a poor self-worth may aggravate the anger and lead to not advocating for themselves. Within treatment, these are difficult factors to work with. The individual may be unmotivated to work in therapy and the instability experienced can be brought into the therapeutic setting. They may assume this to be an unstable environment as well. Not seeing this as a positive environment may also be a factor related to treatment difficulties. Further, Ruggiero (2012) states that individuals with BPD are both fragile and aggressive, and they are likely to impulsively act out what they are not able to represent. This was drawn from his study conducted in Italy. In addition, it is reported that BPD symptoms may also negatively impact on the therapeutic process which include: self-destructive behaviour, manipulation, impulsivity and fear of abandonment (Fazio-Griffith & Curry, 2009).

Ball and Links (2009) further state that individuals with BPD are likely to have additionally experienced childhood or early life trauma. Further, a large part of these individuals also report a history of some form of personal and social rejection (Holm & Severinsson, 2008). A combination of the above can lead to intense relationships which are marked by conflict. As a result of the history of unstable relationships, the development of trust and rapport is constricted within the therapeutic process as well as with other individuals (Wright & Sloan, 2011).

Moran (2002) states that BPD is the Personality Disorder that people most frequently present with to mental health services. It is often found from previous research that there is a consistent theme regarding the attitudes of health professionals towards patients diagnosed with a BPD. These attitudes experienced are generally negative and derogatory in nature (Bowers & Allan, 2006; Deans & Meocevic, 2006; Potter 2006). Patients with BPD are also regularly stereotyped by health professionals and often assumed to be manipulative and attention-seeking (Brooke & Horn, 2010; Fallon, 2003). It is frequently found that terms such as difficult, attention-seeking and manipulative are commonly used by psychiatrists to describe BPD patients (Weight & Kendal, 2013).

Fonagy and Bateman (2005) report that individuals diagnosed with BPD have difficulties with compliance to treatment mainly because of their maladaptive interpersonal styles. McMurran, Huband and Overton (2010) utilised an electronic search, having found that high rates of termination of therapy are associated with clients with BPD. Therefore, this suggests that a strong therapeutic relationship early in therapy can be beneficial to the therapeutic process. According to Ruggiero (2012), the relationship between the therapist and client is unsteady. This is a result of the patient seeking fusion, which they lack in many relationships, as well as defending themselves against this as "it carries the risk of the loss of the self and of their own boundaries, of confusion and of psychic death" (Ruggiero, 2012, p. 344). Holmqvist (2000) reports that patients diagnosed with BPD are more likely to elicit negative emotional responses in the therapist as compared to patients diagnosed with a psychotic disorder.

Theoretical and clinical literature considers BPD as one of the most challenging psychiatric disorders to treat (Bateman & Fonagy, 2004; Gunderson, 2009). A poor therapeutic relationship can result in difficulties in establishing rapport, high dropout rates as well as

non-compliance (Conklin & Westen, 2005; Paris, 2005). "Pessimistic attitudes regarding prognosis and the failure to maintain a positive approach, and therefore respond therapeutically, can result in the patient feeling critically judged and dismissed" (Commons Treloar & Lewis, 2008, p. 583). Cotes (2004) reports that research has indicated that many professional groups, including psychiatrists, have negative attitudes towards working with clients with personality disorders. It was indicated that this client population group was seen as difficult to care for.

Markham and Trower (2003) state that it is also widely believed that BPD is not an illness. It is seen more as a label for someone who is "bad", not "mad" and is therefore not suited for therapy. It can be seen that stigma occurs from professional medical staff as well, which is equally influential on the client and therapeutic process. This has subsequently resulted in these patients being labeled by medical staff as "attention seeking" and "time wasters" (Snowden & Kane, 2003).

Paris (2007) states that the clinician may not be fully transparent to the client and their family regarding a diagnosis of a personality disorder because they may be concerned about the stigma associated with the diagnosis. A study by James and Cowman (2007) in Ireland reports on psychiatric nurses' knowledge, experience and attitudes towards care received by clients presenting with BPD. Understanding nurses' attitudes towards these clients is likely to result in better care for clients diagnosed with this disorder (James & Cowman, 2007). It was found that clients with BPD were seen to be very or moderately difficult to look after. Despite this however, staff confidence in their own abilities was relatively high. Respondents also reported feeling uncomfortable with the diagnosis of BPD. Further, nurses also did not support the view that inadequate care was the result of the view that clients with BPD are untreatable.

It is found that many of the negative ideas regarding an individual with BPD are linked to the characteristics of the disorder. This may include the intense anger, chronic suicidal ideations, self-injury and suicide attempts (Aviram et al., 2006). In addition, due to the fluctuations in the level of functioning of patients with BPD, treatment is seen to be a slow process. According to Whipple and Fowler (2011), patients who engage in non-suicidal self-injury are difficult to treat. This is due to the fact that these behaviours serve several functions (Nock & Prinstein, 2005). Self –injury refers to acts which involve deliberate inflicting of pain or

injury on one's own body. These include behaviours such as cutting, hitting, picking or scratching, hair pulling, swallowing of objects or any combination of these (Brooke & Horn, 2010; Brown, Comtois & Linehan, 2002; Ross & Heath, 2002). "Non-suicidal self-injury refers to the direct, deliberate destruction of body tissue in the absence of lethal intent" (Whipple & Fowler, 2011, p. 184). Behaviours included are self-inflicted cutting, burning or skin abrading. This behaviour is often triggered by upsetting interpersonal events, emotional disturbances, and misrepresentation of interpersonal interactions (Safran & Muran, 2000a). It was also found that significant relief of negative feelings followed self-injury (Brooke & Horn, 2010).

King (2014) suggests that professionals find difficulty in implementing empathy, congruence and unconditional positive regard when working with clients with BPD. He reports that when professionals are faced with behaviours characteristic of BPD, such as self-harming and suicidal ideation, these evoke negative reactions in the professional. These negative reactions, together with the belief that the client is not really ill can lead to less empathy and less unconditional positive regard towards the client. Similarly, Commons Treloar and Lewis (2008) reported that clinicians generally have negative attitudes towards clients who self-harm as per a study in Australia and New Zealand. When encountering these clients, clinicians experience mixed emotions which leads to distress and inner conflict. As a result, there is an absence or reduction of empathy from the clinician. In addition, Markham & Trower (2003) had conducted a similar study which had compared the attitudes of 50 psychiatric nurses towards patients with various diagnoses. It was found that the nurses had responded more negatively and with less empathy and optimism, towards clients who had been diagnosed with BPD.

One of the assumptions of professionals regarding clients presenting with BPD is that symptoms are within the client's control. For example, acting out behaviors may be seen as a cry for attention as opposed to symptoms of the illness, therefore the clinician may feel manipulated or taken advantage of (Bradley & Westen, 2005). As a result, the clinician may not pay adequate attention to self-harm threats, which could place the client in danger (Liebman & Burnette, 2013).

Whipple and Fowler (2011) have found that those who engage in non-suicidal self-injury display greater expectations of malice from others, have less investment in interpersonal

relationships and display more hostility and aggression in their relationship narratives. As a result, the therapeutic relationship can suffer in this regard. Patients may thus withdraw or have false negative views of the therapist. By being less invested in the therapeutic process, therapy can be more challenging or difficult. Patients engaging in these behaviors also present as challenging to therapists as they lack the capacity to understand the triggers for their actions (Whipple & Fowler, 2011).

A study by Perseius, Kåver, Ekdahl, Åsberg and Samuelsson (2007) conducted in Sweden reports that psychiatric health professionals experience the treatment of clients who self-harm, very stressful. According to Commons Treloar and Lewis (2008) impulsivity, issues with abandonment, poor self-image, and feelings of emptiness are seen to contribute to self-harming behaviours as well as difficulties in treatment. Negative attitudes by the clinician toward the client as a result of the self-harming behaviour can have an adverse effect on therapy. Whether these attitudes of the clinician are overt or covert, patients may sense them through the clinician's demeanour and manner and this could perpetuate further self-harm or suicidal behaviour (McAllister, Creedy, Moyle, & Farrugia, 2002; Commons Treloar & Lewis, 2008).

It is found to be more helpful to look at the person rather than the disorder, thus looking at the reasons behind the patient's self-harming behaviour (Commons Treloar & Lewis, 2008). According to Wright and Jones (2012), it is vital for professionals to remember that not every individual who self-harms has BPD, and every individual with BPD does not self-harm. Individuals who experience depression or bullying for example may also display self-harming behaviours. Further, the self-harming can also be seen as the individual's way of dealing with distress, and as possibly a way of averting suicide.

Cleary et al. (2002) report that insufficient training and supervision regarding self-harm can lead to poor knowledge and understanding of BPD. A study by Patterson, Whittington and Bogg (2007) in the United Kingdom had reflected that there was reduced negativity towards clients who self-harmed after the staff had undergone a training programme on self-harm. This indicates that additional training can aid in creating more positive attitudes towards clients with BPD who self-harm. The tendency to self-harm and likelihood of suicidal ideation has resulted in an overall view of those with BDP labelled as unresponsive in therapy (Snowden & Kane, 2003).

Treloar (2009) reports that various studies indicate that there are difficulties with clinician attitudes towards working with clients with BPD. Clients with BPD are among the most challenging and difficult as it includes aspects of suicide issues as well as intense emotions experienced by both the patient as well as the clinician (Krawitz, 2004).

In a study by Treloar (2009) it was found that clinician attitudes towards clients diagnosed with BPD are indeed negative and derogatory. More specifically, these negative attitudes are related to the personal discomfort of the clinician. Clinicians reported that they were unsure of how to respond to the needs of those clients with BPD. Thus, these clinicians had requested more training and education in working with clients with this disorder. Within this study, it was also found that a common theme of clinician frustration and feelings of inadequacy were evident.

A single clinician working with a client presenting with BPD may soon feel overwhelmed and that ongoing, productive work may be unsustainable (Little, Trauer, Rouhan & Haines, 2010). In addition, a lack of empathy and optimism on the clinician's behalf towards these clients are also evident according to Krawitz (2010). It was also found in this study that many clinicians also experience themselves as having limited or ineffective skills and confidence in dealing with these clients. "These factors could lead to poor outcomes which in turn reinforces negativity, thereby perpetuating the cycle" (Krawitz, 2010, p. 555).

Aviram et al. (2006) add that clinicians may respond to clients' demands in unintentionally damaging ways, for example, emotional withdrawal by clinicians. This may cause difficulties for clients as well as lead to clinicians missing important information regarding the client's subjective experience. "Clinician attitudes are not a black-and-white issue, but rather are a mixture of complex reactions based on both the client's and the clinician's personality and experiences as well as the interaction between the two" (Liebman & Burnette, 2013, p. 123).

Purves and Sands (2009) also report that a possible contributing factor to the overall negative attitudes are that patients diagnosed with BPD are perceived as difficult, as a consequence of their tendency to contest the authority and therapeutic value of clinicians. These clients may reject therapeutic care and engage in behaviors that are considered difficult to manage. In turn this leads to negative staff and clinician attitudes (Cleary et al., 2002). Many individuals diagnosed with BPD, particularly those engaging in self-harm behaviors feel that the health

professionals are reluctant or disinterested in assisting them and becoming involved in their psychotherapeutic treatment (Treloar, 2009).

Studies in England have also found that clients with BPD describe mental health professionals as being unhelpful, negative, hostile, unsympathetic and socially rejecting (Castillo, 2000). Having these attitudes and impressions can have a negative impact on the therapeutic relationship between client and therapist (Swift, 2009). Aviram et al. (2006) stated that individuals with personality disorders are seen to experience powerful and intense feelings, which may then affect the feelings experienced by clinicians. These include feelings of intrusion and manipulation by the client with BPD.

An individual's expectations and attitudes (former) about another person (latter) can cause the former to behave in a manner that induces the latter to act in a way that confirms the former's false perception. This interpersonal situation is described as a self-fulfilling prophecy (Aviram et al., 2006). Stigma and negative expectations about patients with BPD may influence preconceptions by the clinician towards these patients. Clinicians may then defend against emotional demands and certain characteristics. This may precipitate behaviors in these patients which may be confirming of the expectations or stigma. Aviram et al. (2006) add that the factor not taken into account here is the influence of the therapist on the interaction. This could also lead the clinician to think of the patient as manipulative, and as such the clinician may then withdraw to avoid feeling manipulated. Unintentionally, this may exacerbate the self-destructive behaviour of the patient, which heightens the therapist's unresponsiveness, which activates the patient's self-critical tendencies which is followed by the therapist's confirmation of the stigma and their own withdrawal from the patient.

Interaction can be understood as having a series of beginnings and endings, with causes and effects (Watzlawick, Bavelas, Jackson & O'Hanlon, 2011). Within this therapist – client interaction, the assumptions of the therapist influence the nature of the relationship. The stigma and preconceptions brought to the therapeutic relationship impacts on this relationship which in turn, has an adverse impact on the client.

2.3.1 The therapeutic alliance

Freud (1912) wrote about positive transference that enables a patient to maintain motivation to continue working and collaborating with the analyst. Following Freud's introduction to the dynamics between the therapist and client, other psychotherapists have contributed to the current knowledge of the therapeutic relationship. The therapeutic alliance was a term initially written about by the psychoanalyst, Elizabeth Zetzel (1956), to describe the relationship between an analyst and the healthy part of the patient's ego. She asserted that a "sound therapeutic alliance" is a pre-requisite for effective analysis. Zetzel (1956) contended that transferential interpretation, a foundation of psychoanalysis, will only be useful if the interpretations are made at the appropriate time in therapy, at a point in which a positive therapeutic alliance has been established.

Subsequently, Carl Rogers, a prominent humanistic clinician, emphasised the curative ability of the relationship between the therapist and client. Rogers (1957) postulated six essential conditions that need to be present in order for therapeutic change to occur. These include: (1) two people are in psychological contact; (2) the client is in a state of incongruence; (3) the therapist is congruent or integrated in the relationship; (4) the therapist experiences unconditional positive regard for the client; (5) the therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client; and (6) the communication of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

It then follows that one of the most important contributors of successful therapy outcomes is the therapeutic alliance – without which, the client may not find the comfort required to begin the process of change (Martin, Garkse, & Davis, 2000). Cambanis (2012) states that clients with BPD are even more difficult to work with from the general pool of patients, as these clients have high drop-out rates as well as unpredictable treatment outcomes based on a study in South Africa. Further, it is reported that the specific characteristics of BPD patients' can have a negative effect on the therapeutic relationship as well as on the clinician themselves. Bennett, Pary and Ryle (2006) report that those with BPD generally experience greater difficulties than others in making and maintaining a therapeutic alliance.

Ruptures in the therapeutic alliance do occur and may reflect the patients' maladaptive interactional pattern (Safran & Muran, 2000b). The resolution of this rupture allows for the opportunity to strengthen the therapeutic alliance, creating a more positive relationship. Constantino, Castonguay and Schut (2002) contend that there has been insufficient research focusing on the role of the therapist, despite the widespread agreement in the literature that the therapeutic alliance is of vital importance. Questions remain regarding what therapists actually do in their efforts to establish a therapeutic alliance.

In their reviews of numerous studies on the alliance, Ackerman and Hilsenroth (2003) reported on therapist characteristics and techniques, across a range of theoretical orientations, which either negatively or positively impact the therapeutic alliance. Ackerman and Hilsenroth (2003) also believe that attention to the therapist's contributions in the development of the therapeutic alliance is an area of research that has been less developed; they emphasise the significance of investigating the therapist's personal attributes and technical interventions which affect the development of an alliance.

There is evidence that a BPD diagnosis is often not disclosed to a patient because of the stigma associated with it (Lequense & Hersh, 2004). Lequense and Hersh (2004) reviewed medical literature about disclosure to explore why clinicians may or may not disclose the diagnosis of BPD. Their review led them to believe that a BPD diagnosis is disclosed less often than other psychiatric disorders. They examined the barriers to informing clients of the diagnosis and discussed why disclosure is in the patient's best interest. The study found a few explanations for why clinicians do not inform clients of a BPD diagnosis: uncertainty regarding the validity of BPD, the feeling that the diagnosis is too negative, and concern about transference/countertransference.

In regards to the stigma attached to the disorder, Lequesne and Hersh (2004) describe why it may exist. They discuss how the symptoms in the DSM-IV-TR (unchanged in the DSM-5) criteria can be "frightening and frustrating" for clinicians (p. 172). They state "impulsivity, self-mutilating behaviours, recurrent suicidal gestures and threats, affective instability, and inappropriate and intense anger can be intimidating and unnerving for clinicians to treat" (p. 172). This type of symptomology, they report, can lead to countertransference feelings of rage or frustration. Some clinicians may use the diagnosis loosely (and liberally) by ascribing it to any person who evokes these feelings. This has caused the pejorative connotations

associated with the word *borderline*. Further contributing to the stigma is the perception that BPD is untreatable (Lequense & Hersh, 2004).

2.3.2 Transference and countertransference

Freud (1959) first introduced the term countertransference to refer to the analyst's unconscious and defensive reactions to the patient's transference. Within the psychodynamic framework, "difficulties experienced with the client with BPD are understood to be a result of transference and countertransference issues" (Cambanis, 2012, p. 101). If the client projects an image of the therapist as hostile or unhelpful, there is a psychic pull in the therapist to respond to the client's projection. As a result, this confirms the initial projection of the client and reinforces the victim position of the client (Cambanis, 2012). Further, these emotions within the therapist can be destructive for psychotherapy as they distort the view of the client.

Evans (2007) reports that the psychoanalytic theoretical constructs of transference and countertransference are important in understanding the therapeutic relationship between the therapist and the client. Transference describes an unconscious process by which an individual places their own experiences and emotions onto another person (Evans, 2007). "Countertransference is the response of the other person in relation to these transferred feelings and explains the influence that one party has over another" (King, 2014, p. 31). The association between countertransference and BPD are important as there is a strong association between traumatic events and the development of BPD (King, 2014). Countertransference is an important factor as it directly impacts on therapy and may create a block in the therapeutic relationship (Evans, 2007). Liebman and Burnette (2013) state that those diagnosed with BPD are more likely than those presenting with other mental disorders to evoke negative countertransference reactions.

Liebman and Burnette (2013) report that reactions elicited from the therapist are believed to mirror those in which the client receives in their daily lives. Further, negative countertransference reactions are likely to reinforce the client's self-critical feelings of worthlessness and hopelessness (Dinos, Stevens, Serfaty, Weich, & King, 2004; Link & Phelan, 2006). In addition, many clinicians feel that they are not adequately equipped or that they are undertrained to deal with "these kinds of patients". In addition, burnout rates for these clinicians are particularly high (Liebman & Burnette, 2013). These negative

experiences may push clinicians to fall back on stereotypic diagnostic labels that carry connotations of dangerousness and untreatability (Schulze, 2007). These stereotypes, according to Liebman and Burnette (2013) can foster distrust and weaken the therapeutic alliance.

Ligiero and Gelso (2002) report that countertransference behaviour can have a negative impact on both the working alliance as well as therapy outcomes. Bourke and Grenyer (2010) had conducted a study in Australia looking at psychotherapists' responses to patients with BPD as compared to those diagnosed with Major Depressive Disorder (MDD). It was found that therapists felt less confident in working with clients with BPD as compared to those with MDD. However, it was also found that the most frequent response across both diagnoses was the need of clinician support. It was also found that therapists also reported more withdrawing from patients with BPD.

Another study by Bourke and Greyner (2013) had looked at therapists' accounts of psychotherapy process associated with treating patients with BPD. This echoes the findings of their earlier work as it reports that therapists were found to experience greater emotional distress while working with patients diagnosed with BPD as compared to MDD (Bourke & Greyner, 2013). Additionally, it was found that therapists "experience a push-pull interpersonal dynamic and are under greater pressure to forge a successful therapeutic relationship when working with patients in the BPD group" (Bourke & Greyner, 2013, p. 8).

This speaks to the client with BPD's instability in interpersonal relations as well as the impact this has on the therapist. These individuals find it difficult to be alone as a result of the fear of abandonment, however their inappropriate anger, impulsivity or emotional turmoil often leads to others being pushed away. This oscillation is seen, within the therapeutic relationship, as alternating between pushing the therapist away, but then quickly pulling them back. This can have adverse effects on the relationship as it may be viewed as confusing to the therapist.

Countertransference however, was also found to be beneficial to the therapeutic process (Van Wagoner, Gelso, Hayes, & Diemer, 1991). They purport that when a therapist in aware of their feelings, they are better able to address this before it manifests behaviourally. This therapeutic insight leads to the therapist remaining more engaged with the client. This is

further highlighted by Hayes et al., (1998) who suggest that countertransference can lead to deepened insight. The inner experience of the therapist may often provide a better understanding of the inner experience of the client. Sharing these experiences may also strengthen the working alliance within the therapeutic relationship.

2.3.3 Psychotherapist burnout

Prior to the last decade, there was little research on the topic of self-care. Currently, however, its popularity is increasing in both research and everyday conversations amongst professionals. The available research implies a connection between self-care and burnout but does not provide empirical support for this hypothesis. One can see that the community of psychologists still does not fully embrace the idea of self-care by observing that there is only one code of ethics that stresses the importance of self-care (Carroll, Gilroy, & Murra, 1999).

Psychologists in practicing therapy can experience work with clients with BPD as extremely draining, even to the most seasoned professional. Individually, therapists are becoming aware of the importance of taking care of themselves in order to maintain health and efficacy both personally and professionally (Ungar, Mackey, Guest, & Bernard, 2000). Depression, suicide, substance abuse, sexual misconduct, burnout, and relational problems can all be realistic and serious concerns for therapists who do not effectively care for themselves and cope with the unique occupational stressors they face (Brady, Guy, & Norcross, 1994).

Of the many occupational stressors faced by therapists, BPD patients present with intense symptoms that are often problematic and stressful for therapists; these individuals are frequently referred out and have a history of showing minimal improvements with older treatment formats (Perseius et. al., 2007). Linehan (2000) developed Dialectical Behavior Therapy (DBT), an evidence-based treatment for BPD. Utilising this, a study in Sweden focused on burnout levels in therapists using DBT to treat clients with BPD (Perseius et al., 2007). Results of this study suggest an initial increase in burnout levels as a therapist learns the theory and practice of DBT, a complex and time-intensive treatment model, and begins to implement it with clients. However, longitudinal assessment over the course of treatment shows that burnout levels return to baseline within 18 months with therapists reporting an increased sense of efficacy and hope when treating clients with BPD.

According to Perseius et al. (2007) patients with BPD are known to be difficult in therapy as they are generally unresponsive to therapeutic efforts as well as make considerable emotional demands on psychiatric professionals. It is also found that working with patients who self-harm or who are suicidal can be seen to increase the levels of stress in psychiatric professionals (Burnard, Edwards, Fothergill, Hannigan & Coyle, 2000; Perseius et al., 2007). As a result of increased stress, there is also a heightened risk for burnout as high levels of occupational stress is closely linked with burnout (Jenkins & Elliot, 2004).

In the literature, there are various definitions for the term "burnout". The core elements however include "prolonged stress related to the work-situation, associate with an unfavourable work environment, in initially strongly motivated individuals who respond to the prolonged stress with physical, cognitive and affective dysfunction" (Perseius et al., 2007, p. 636). Further, according to Cotes (2004), burnout can also be used to describe the outcome of chronic stress. More specifically, burnout can be described as "a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that occur among individuals who do 'people work' of some kind" (Maslach & Jackson, 1986, p. 1).

Cotes (2004) further states that the presence of burnout may be associated with negative outcomes for clients. As a result, there are noticed difficulties in developing and sustaining positive therapeutic relationships which in turn could lead to negative outcomes. Overall, Cotes (2004) reports that increased levels of stress or burnout have negative impacts on mental health care workers both in their private and professional lives. It was also found "that negative feelings about one's work with clients predicted negative attitudes towards the PD client group in this sample" (Cotes, 2004, p. 57).

Linehan et al. (2000) report that the negative labels attached to clients with BPD can create a negative bias towards the client even before actual therapy can begin. This can compromise the therapeutic alliance and can lead to emotional exhaustion of the therapist, reduced sense of caring to the client as well as an impairment in self-efficacy in both the client and therapist.

These characteristics, namely emotional exhaustion, negative attitudes and depersonalisation of the other, decreased effectiveness and personal accomplishment, are the main components of "burnout" (Linehan et al., 2000).

A study was conducted by Linehan et al. (2000) in Washington, USA, which examines the reciprocity of burnout between clients with BPD and therapist over time in therapy. It was found that therapists as well as clients become emotionally exhausted from therapy. Additionally, high expectations for the therapeutic success increases the therapist's vulnerability to emotional exhaustion later on. Higher expectations of success may possibly result in more therapeutic work as well, which in turn could lead to emotional exhaustion. Therapists with higher expectations for success are more likely to be disappointed by negative outcomes which could lead to de-motivation and emotional exhaustion over time.

Linehan et al. (2000) have also found that working with clients who were already emotionally exhausted from working with a previous therapist can lead to emotional exhaustion for the therapist. This suggests that clients' previous psychotherapy experiences are very important. Additionally, if clients come into therapy having depersonalised a previous therapist, this could lead to further emotional exhaustion as well as the possibility of the therapist reciprocating and depersonalising the client.

In looking at stress, burnout and coping mechanisms, Edwards et al. (2003) conducted a study in the UK and had found that the most frequently reported coping strategies included: social support, recognising limitations, dealing with problems when they occur, improving skills level, peer support and supervision. In a study by Cotes (2004) which looks at stress, burnout and the attitudes and experiences of mental health professionals working with personality disorders, it was found that professionals dealt with burnout in three main ways. Firstly, informal support at work was mainly used, which focuses on active behavioural coping. It was found that this coping mechanism had been negatively correlated with distress as compared to avoidance coping strategies. The second commonly used coping strategy was relaxation outside of work. Lastly, formal supervision was found to also be very helpful to professionals in dealing with burnout.

2.3.4 Management strategies

With regards to management strategies pertaining to the client, Elder et al. (2006) found that management strategies can be classified into three categories, namely, collaboration, empathy and appropriate use of power. This was drawn from a study conducted in USA. Collaboration with the patient included aspects such as priority setting, the performance of diagnostic skills, decision-making abilities and the use of teamwork and coaching. Essentially, it occurs when the physician and patient work together to define problems and undertake treatment. Empathy involves an emotional understanding and compassion and the appropriate use of power involves setting rules of clinical management, boundaries and limits.

In a study by Ruggeiro (2012), several therapeutic factors were identified in the treatment of BPD patients. These included: the ability to contain as well as "the capacity to share prolonged states of suffering of the self without defensive recourse to interpretations that are premature and inevitably obstructive" (Ruggiero, 2012, p. 359). Additionally, he stated that the ability to tolerate emptiness, negativity as well as countertransferential emotions are important. Lastly, it is also important to be able to deal with discontinuity and to have the desire to safeguard the relationship (Ruggiero, 2012). These factors are deemed important for creating a healthy and positive therapeutic relationship with BPD patients.

Quinn (2002) adds another perspective to coping with or management of the 'difficult' patient. He says that the psychotherapist should act as a container to the patient. Instead of reacting to the difficult patient, the psychotherapist should allow the patient to act out. He states that by not acting out as others may have in the patient's past, the therapist is able to emotionally diffuse the situation. In addition, Knesper (2007) suggests that the initial interview is of vital importance in establishing a good relationship with difficult, unwilling and uncooperative patients. It is during this session that the relationship develops and roles are defined. If there is a power struggle, the nature of the relationship will be grounded in a struggle for the position of authority. If there is disengagement during the first interview phase, there is likely to be an unpleasant power struggle, which is unproductive. Therefore, a positive initial experience allows the patient to feel more comfortable in the therapeutic process.

2.3.5 Clinical experience and training of the clinician

In terms of experience of the clinician, it is found that those with more years of experience are found to foster positive countertransference towards clients. This means that those with more experience react less negatively towards clients with BPD and are also less susceptible to burnout as compared to the novice psychotherapist (Lieban & Burnette, 2013). It was also found that direct exposure to clients presenting with BPD early in clinical training and continuing throughout one's career proves beneficial to enhancing feelings of competence, which, in turn, fosters positive countertransference (Lieban & Burnette, 2013).

Cambanis (2012) states that challenges regarding patients with BPD are often magnified for trainee psychologists. This is primarily due to their lack of experience in implementing treatment plans as well as their lack of understanding of the underlying dynamics. It is found that many trainee psychologists experience feelings of distress or confusion during their training (Stefano et al., 2007). This can be linked to personal feelings of inadequacy, heavy workload, constant evaluation by supervisors as well as pressures to become an expert rapidly (Skovholt & Rønnestad, 2003).

"Although traditionally clinicians equate BPD patients with manipulativity and therefore are reluctant to engage with them, there is emerging evidence that training and education can assist in the improvement of professional attitudes toward working with this patient group" (Commons Treloar & Lewis, 2008, p. 583). Evans (2007) also suggests that specific training regarding the dynamics of the therapeutic relationship with those with personality disorders is vital. This would assist with reducing a destructive transference / countertransference cycle.

A study by Cotes (2004) had found that participants who had received some kind of specialist training as well as those who had felt sufficiently trained to work with clients with a personality disorder had shown significantly more positive attitudes towards clients. Therefore it can be seen that additional therapist training can be greatly beneficial in creating more positive attitudes as well as a sense of confidence when working with clients with a personality disorder, including BPD, which in turn reduces stress and perceived difficulty of these clients.

McHale and Felton's (2010) literature review emphasises that clinical supervision in which debriefing occurs can be greatly beneficial for staff as it can reduce negative attitudes towards clients. Negative attitudes from the clinician can create an obstruction to the therapeutic process, whereas supervision facilitates evaluation and reframing of perspectives (Purves & Sands, 2009). According to Cambanis (2012) supervision is seen to be the ideal context in which novice or trainee psychologists can confront and manage their countertransference issues as well as any further difficulties arising. Findings from Liebman and Burnette (2013) suggest that novice clinicians may benefit from more specialised training focused at clients with BPD in order to minimise burnout, increase competence and to become more aware of implicit reactions. Supervision may also help therapists deal with their countertransference which can be harmful to the therapeutic relationship if not contained and managed (Cambanis, 2012).

"Defenses such as splitting (holding or oscillating between polarised views of self and others as either all good or all bad) and projective identification (projecting unrecognised troubling aspects of the self onto another) may evoke strong countertransference responses in the therapists" (Bourke & Grenyer, 2010, p. 686). Therefore, therapists need to work on developing their personal awareness and insight. It can also be beneficial for therapists to engage in clinical supervision which could assist in avoiding the enactment of patients' transference (Bourke & Grenyer, 2010).

Splitting is found to be a central defence in BPD (Akhtar & Bryne, 1983). Akhtar and Bryne continue that splitting refers to the separation of mutually contradictory, alternatively conscious self and object representations in order to avoid painful ambivalence and anxiety. The use of splitting results in five clinical manifestations. Firstly, there is an inability to experience ambivalence. The individual will therefore split external objects into all good or all bad parts, with an inability to hold a combination of the two. As a consequence, there is often extreme idealisation and devaluation of others, with a shift between these two poles. Splitting therefore leads to unstable interpersonal relationships and a difficulty in managing these. Secondly, impaired decision making is found to be another area highlighted as a result of splitting. Viewing external objects as mutually exclusive leads to hasty and impulsive decisions based on the goodness or badness of the object at that particular moment. At a later stage, these choices may be regretted due to the impulsive nature of the decision (Akhtar & Bryne, 1983).

Thirdly, the self may also be split which is influenced by environmental cues. This resultantly causes intense fluctuations in the individual's self-esteem as they view the self as all good or all bad. Any setback may therefore lead to feelings of worthlessness and any positive experiences may leave the person feeling superior and outstanding. These views of the self are exclusive and a blend of good and bad parts are extremely difficult, or impossible to hold at the same time (Akhtar & Bryne, 1983).

Fourthly, impulsive actions are also found to be ego-syntonic, producing little subsequent guilt. This differs from neurotic compulsions which are ego-dystonic and anxiety provoking. Lastly, the poor integration of libidinal and aggressive drives as a result of splitting, leads to the dissociation of their corresponding affects. An incorporation of these two drives is therefore difficult, responses to stimuli are therefore situated on either pole, for example, severe anger in response to frustration (Akhtar & Bryne, 1983).

A later study by Bourke and Greyner (2013) had also reported supervision had played an important role for therapists to maintain a positive therapeutic frame towards the patient with BPD. Evans (2007) also suggests that clinical supervision is essential so that the therapist with the client is able to address difficulties, including exploring unconscious processes which may occur.

Most research on BPD treatment focuses on describing the client and the less on the professional. Looking more at the management or coping of psychologists, is not as widely documented (Elder et al., 2006). As a consequence of the lack of focus on the therapist's experiences working with 'difficult' clients, the impact on the professional is left under-explored. The resultant output from this is a lack of understanding of the influence a 'difficult' client may in fact have on the therapist ability to perform psychological functions as intended. This study attempts to address this gap by exploring clinical psychologists' perceptions and experiences working with 'difficult' Borderline Personality Disorder clients within the South African context.

The literature review conducted provides a more detailed look at the studies conducted pertaining to this current research. From this we find that there is indeed the label of "difficult" attached to the diagnosis of BPD as well as the adverse impact of this on both the client and therapist. Further, the management thereof as well as therapist self-care, is found to

be an area which is of great importance. This study therefore explores these relevant areas. To do so, the research methodology is outlined in the following chapter to provide a detailed description of the current study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Epistemology: Social constructionism

"Epistemology is theory of knowledge" (Carter & Little, 2007, p. 1317). It can further be seen as focusing on how individuals come to know the world. Auerswald (1985, p. 1) defines epistemology as "a set of imminent rules used in thought by large groups of people to define reality." The epistemology to be used for this research is social constructionism. According to Fouche and Schurink (2011), constructionists do not believe in a single truth. Rather, reality can only be known to those who personally experience it. The social constructionist approach thus challenges the idea of a single truth (Gergen, 1985).

Terre Blanche and Durrheim (1999, p. 148) define social constructionism as "the research approach that seeks to analyse how signs and images have powers to create particular representations of people and objects – that underlie our experience of these people and objects". Additionally, social constructionism refers to an approach that is "concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live" (Gergen, 1985, p. 266). This approach allows for an exploration of the ways in which meaning and understanding are created through social interactions (Lock & Strong, 2010). Therefore, people experience and understand their world through social processes.

Within this approach, the focus lies on the interaction between individuals by which language is created, sustained and abandoned (Gergen, 2001). Language is seen as an important tool within social constructionism. Human life is constituted in language and therefore language should be the object of study (Anderson & Gooloshian, 1988). In addition, they further add that there are no "real" external realities which can be truly known.

Further, Doan (1997) adds that social constructionism aims to break down single truths and promote multiple truths or realities. In addition, "through language, we assimilate and influence our world as it is expressed in cultural norms and values" (Bhana, 2009, p. 54). Freedman and Combs (1996) suggest that the act of speaking is not a neutral process and societies construct their realities in language. Further, they state that language directs individuals as to how to see the world around them as well as what should be seen in it.

The social constructionism paradigm "locates meaning in an understanding of how ideas and attitudes are developed over time within a social, community context" (Dickerson & Zimmerman, 1996, p. 80). Dean and Rhodes (1998) state that in addition to not subscribing to a single truth, social constructionism also affirms that it is not possible to make objective observations from a neutral position. Therefore all observations and experiences are subjective and different across individuals.

Social constructionism also holds that the act of observation can be seen to change that which is observed. Further, knowledge is seen as created within a particular context (Dean & Rhodes, 1998). Anderson and Goolishian (1988) state that people understand life through social constructions in the form of narratives which gives meaning to their individual subjective experiences, therefore an understanding of reality is socially constructed. This epistemology was deemed suitable for this study as the nature of the study focuses on the subjective experiences of the clinical psychologist participants. It also takes into consideration multiple realities and uniquely personal stories. Thus, their understanding and conceptualisation is valued, which resonated within the social constructionist paradigm. Each participant's experience is unique and there is no single truth to be sought. The social constructionism approach allowed for the participants' individual realities to be explored in great detail and remained respectful to the idea that each participant's experiences are different depending on their social and cultural contexts as well as to the meaning attached to their experiences of difficult clients.

3.2 Qualitative research approach

According to Denzin and Lincoln (2005) qualitative research attempts to attach meaning to and interpret phenomena, according to the way people view them. In addition, Merriam (2009) states that qualitative researchers are interested in how people make sense of their world and the experiences they have in it. Together with this, Nkwi, Nyamongo and Ryan (2001) state that qualitative research can be described as any research which uses data which does not reflect ordinal values. Further, the "qualitative research interview provides the opportunity for the researcher to understand the experiences and perceptions of the participants in their own language" (Kallenbach, 2012, p. 50).

Kallenbach (2012) reports that qualitative research interviews involve themes which are derived from the participant responses. These include the participants' subjective experiences and views. Within this study, this approach was utilised to explore how clinical psychologists conceptualise a "difficult" client presenting with BPD, as well as how they manage these clients and cope personally. It was therefore important to extract their subjective experiences of this process. Coupling a qualitative approach with the social constructionist epistemology was apt for this study. They work together to understand the human experience within different contexts, as well as how the social, historical and linguistic aspects of life has contributed to meaning making (Polkinghorne, 2005).

The main objective of this study was to capture the experiences of the participants. It was vital to gain their understanding and worldview of the difficult client and their conceptualisation of this. Therefore, it was important to understand the participant within the context of their individual experiences.

3.3 Sampling

According to Gravetter and Forzano (2012) a sample refers to a set of individuals from a given population. Bailey (1987) further defines a sample as a portion of individuals selected from a larger population for a specific study. The sample population is the group of selected individuals with whom the study is based upon. In this study, the sample population comprised of seven clinical psychologists from Gauteng, South Africa. The inclusion criteria included being registered as a clinical psychologist and that they had experienced at least one "difficult" client who has a diagnosis of BPD.

The number of years of experience was also looked at. This was classified as "less than six years of experience" and "six years or more experience". This did not include clients seen during coursework years as these years of training are predominantly theoretically based, but did include the internship and community service years which are predominantly focused on working with clients.

The required participants were obtained using purposive sampling. According to Grinnell and Unrau (2008) this type of sample comprises of elements which contain the characteristics which the researcher seeks to explore in the study. De Vos (2004) further describes purposive

sampling as a way of sampling by which the researcher obtains a sample according to specific characteristics which is defined by the researcher. Therefore purposive sampling was utilised to gain a sample population of clinical psychologists in Gauteng province whom have had contact with a difficult client presenting with BPD. Purposive sampling was beneficial as a specific group of participants were needed for the study. In-depth interviews and the open-ended nature of the interviews are accounted for by the small sample size which aimed to elicit rich, detailed data.

Individuals were sought through contacting clinical psychologists directly via telephone. Contact numbers were obtained from the internet through websites such as therapistdirectory.co.za, medpages.co.za, psychotherapy.co.za and the psychologist register from the HPCSA which is a public document. Within these mediums, the essence of the study was described and interest in the study by prospective participants was sought.

3.4 Data collection: Semi-structured interviews

The researcher is the instrument for data collection. Therefore I have personally conducted the interviews for the study. By using the qualitative approach, it was possible to gain rich, descriptive data of their experiences through interviews. Bickman and Rog (1998) suggest that it is appropriate to use structured, semi-structured or unstructured interview when the study uses descriptive and exploratory approaches. It was beneficial to use the approach of semi-structured interviews, in the current study, as this explorative method is able to provide more detailed insights into this area of enquiry of clinical psychologists' subjective experiences.

According to Polkinghorne (2005) in a qualitative study, information is collected with the aim of uncovering the unique experiences of the participants. In the current study, semi-structured interviews were used to acquire data from participants. According to Greeff (2011) semi-structured interviews are utilised to gain rich data from participants about a specific topic. Denzin and Lincoln (2003) also state that an interview allows for the reciprocal conversation between the participant and the researcher. This method also allowed for flexibility of the researcher and participant which was useful in gaining the subjective experiences which are unique to individuals.

With semi-structured interviews, the researcher has a set of questions. These questions however, need not be rigidly followed (Patton, 1990). Rather, they guide the conversation taking place. This method was best suited to the current study as the experiences of the participants were able to be explored in detail. Further, aspects which I have not thought of in the interview schedule were able to be freely introduced by the participant and I was able to explore these further. This allowed for rich information from the participants' experiences.

A semi-structured interview guided the interview held with each participant (Appendix D). Kvale (1996) states that an advantage of using a semi-structured interview questionnaire is that it builds rapport between the interviewer and the interviewee. As a result, deeper information can be sought from the participant. The nature of the semi-structured interview, which is open-ended, allowed for the participants to freely elaborate and express their experiences without being constricted to specific answers (Kvale, 1996; Rossouw, 2003).

Upon contact with prospective participants, I introduced myself. The study had then been proposed to the prospective participant, explaining the purpose. If the participant required further information, a brief outline of the study was forwarded to participant. Any questions were also answered via the telephone. If the prospective participant agreed to the study, a meeting was set up where I met with the participant at an agreed upon time at their consultation premises.

During the visit to the participant, the aims and purpose of the study were explained to the participant once again and any further questions were answered. The participant was then required to sign an information letter (Appendix B), and an informed consent form, agreeing to participate in the study as well as for the session to be audio-recorded (Appendix C). The participant was then informed of any limits to confidentiality, as well as what will happen to the information after it is transcribed. Further, the participant was informed that no foreseeable harm to them was identified. A copy of the study, once completed, will also be available to the participants through UNISA's institutional repository which is available online.

After the consent form has been signed, the interview took place. The interview was conducted by myself and had taken approximately 60 minutes on average to complete. Questions from the interview schedule were proposed and further prompts in relation to

responses were asked to gain more depth. All of the interviews were audio-recorded and later transcribed verbatim by a professional transcriber who signed a confidentiality agreement (Appendix E). The names, as well as any other identifying information of the participants were changed in order to protect the participants. After data was collected, the transcripts were analysed, by myself, utilising an appropriate and suitable method, namely, thematic analysis.

3.5 Method of analysis: Thematic analysis

The data from the semi-structured interviews was analysed using thematic analysis. According to Braun and Clarke (2006), thematic analysis is a method which identifies, analyses, and highlights patterns within the data. The data set was divided into appropriate themes and by doing so, was neatly organised and analysed.

This method was useful in this study as qualitative methods elicit rich data. In addition, this study draws on the experiences and makes interpretations from this data. Thus, analysing themes from the data was useful in gaining an understanding of the participants' experiences. The aim here was to extract the views of the participant, while at the same time, trying to place it under broader themes describing the data collected. From this, it was possible to identify commonalities as well as differences in the identified themes from all participants. It was important to go through this data a number of times to be able to keep the essence of it while still being able to compare similar themes which had manifested in other areas of the same study. By highlighting these themes, it became easier to organise and view the gathered data. It also aided in viewing similarities and divergences in the data.

In analysing the data, several steps were followed. In the first stage of the data analysis process, the interviews were transcribed verbatim of each participant. According to Braun and Clarke (2006) one of the initial steps of thematic analysis involves making a note of sets of themes or patterns as they arise. The process involves a constant movement between the data and the themes which you have formulated. I had read through the transcripts and immersed myself in the data. Repeated reading was also necessary. Phase two involved generating initial codes. This involves organising the data into meaningful groups (Tuckett, 2005). This was done on the transcripts in the left hand margins.

Phase three involved searching for themes. Once the initial codes or groups had been formed, I had organised them into themes. At the end of the transcript I had gone over the groups jotted down in the margin, and organised them into larger themes on the right hand margin. Sub-themes also arose which was also useful to explore related ideas.

Phase four then required a review of the themes. This required refinement of the themes created. According to Braun and Clarke (2006) some themes may not actually be themes. For example, some themes are not really themes, as they may be insufficient data to support them, while other themes may need to be merged. For example, two separate themes which can be joined as one theme. Further, other themes needed to be broken down into smaller sub-themes to better capture and understand the data.

Phase five comprises of the identification of themes. According to Braun and Clarke (2006), within this phase, the essence of what each theme is about is highlighted. Here, I had looked at what is interesting about each theme and why. It was also important to define why a theme was important and how it fits within the research being conducted. With regards to naming the themes, it was important to provide names which clearly reflected what the theme is about.

Lastly, phase six involved producing the report (Braun & Clarke, 2006). This occurred when the themes had been compiled and the final report was written up. It is important that the themes accurately and concisely reflected the data obtained. In this stage I had also made use of verbatim extracts from the transcripts to strengthen the themes.

3.6 Trustworthiness of data

In looking at the trustworthiness of qualitative data, Shenton (2004) uses four criteria proposed by Lincoln and Guba (1986) in compiling a trustworthy qualitative research study. These include credibility, transferability, dependability and confirmability.

According to Shenton (2004) credibility seeks to find out how harmonious the findings are with the social realities. Having credible data reflects accurate recordings of the data and findings. In order to increase credibility, all participation was voluntary, thus accurate reflections offered by the participant regarding the research topic was produced. Having

participants freely participate in the study had also increased the credibility of responses as they were not forced to participate. To further increase trustworthiness, the questions used in the semi-structured interview have been derived from previous questionnaires in studies dealing with experiences of difficult clients. Further, the audio-recorded interviews were transcribed verbatim. By doing so, the responses of the participants were accurately traced.

Transferability, according to Shenton (2004), talks about the application of the findings in one study, to the wider population. In terms of this study, the context was described in detail so as to give the reader a clear picture of the setting in which the study has taken place so that aspects of the study can be potentially transferable. It is not necessary to ensure replication of this qualitative study as aspects such as situations, events, individuals and their interactions are unique and cannot be identically replicated. Further, the researcher is seen to be central in generating the data from participants, therefore this method of gaining data is unique, making replication difficult.

The next factor is dependability. According to Shenton (2004), having dependability means producing the same or similar findings to an original study, if the study was repeated in the same way in terms of context, method and participants. The context, method and participants of this study were highlighted in detail. This included the design, data-gathering procedures as well as methods of interpretation of the data.

The last factor is confirmability. Shenton (2004) states that it is important to ensure that the findings reported are a product of the participants' subjective experiences, as opposed to preferences of the researcher. In order to attain this, I have used a semi-structured interview. Although there are a few guided questions, the participants were free to express themselves and talk about subjective experiences without being restricted to a rigid structured questionnaire. By allowing the participants this freedom, my personal influences or interests did not dominate the findings. In addition, my self-reflexivity journal was used as a way in which to separate and distinguish my personal experiences from that of each participant. The findings are thus a trustworthy reflection of the participants' experiences.

3.7 Self-reflexivity

I had started this study as I had encountered a "difficult" client whilst still training. Upon further enquiry, I was informed that this individual had a diagnosis of BPD. At that point, my supervisor had shared her experiences of such clients, including the great difficulty that came with. My discomfort, frustration and confusion were labelled as "normal" when dealing with these clients and that those feelings can be a subtle indication of a possible BPD diagnosis. That encounter had intrigued me and had sparked my interest in this field. Before carrying out the research, I dreaded encountering another client with BPD as I felt incompetent, however still curious as to why this particular diagnosis had carried these stereotypes.

Having started this research, I find that I had carried some of those stereotypes with me. Through my honours degree internship as well as into my Masters degree training as a clinical psychologist, I have picked up assumptions about clients with BPD as well. Firstly, there was a general negative attitude towards these clients. I had observed other professionals sigh at referral letters which indicated a BPD diagnosis or joke about future or current clients. Although I had seen just one client with BPD, my views were already rigid. I had experienced a sense of dread, as I perceived these clients as requiring years of therapy which was more challenging on the therapist. I had also viewed these clients as treatment resistant and emotionally draining. In addition, I recall thinking that I stand no chance against these clients.

Having started with my initial interview, I had found myself anxious and determined. I knew that I had valuable information to gather however at the same time, uneasy about my abilities as this was the first interview. After this interview, I had learnt that I needed more clarity on some questions in order for my participant to better understand what information I was looking for. As a result of this, I had added more prompts under each main question so that this could be addressed. I found that this had worked well with the future participants. Looking at myself through the interview process, I was somewhat nervous and worried initially. The uncertainty of myself made me question if my interview protocol was adequate to answer my interview questions. In retrospect, I view myself as somewhat mechanistic in my interviews which may have limited the information received. The lack of "flow" in the conversation therefore, may have been received as restricting by the participant. In order to address this, I had reviewed the tape and transcript and looked at the points at which I had felt

stuck (where I had felt a pause in the conversation and I had felt that I needed to rush off to the next question to break this). At these points I found that I had either not had enough probes, that my nervousness / anxiety had interrupted my ability to follow the participant accurately, or that I was worried about the time constraints.

Feedback from my supervisor after her reviewing the recording and transcript had made me more confident in that valuable information was present. In addition, adding the probes and having the first interview done had also helped me become more relaxed. Further, I had reframed the process of data collection. Initially, it was seen as a mechanistic process of which pertinent information needs to be gathered. If not done properly, it would be seen as a waste of a valuable participant. However, viewing this as more of a conversation, introducing genuine curiosity in addition to the main questions had greatly assisted me. I found that this stance had helped me become more relaxed and genuine. Valuable information from this stance was also obtained as I had followed the participants more closely and engaged more deeply. This, in turn, was found to help participants divulge more information and freely explore the content.

As the interviews progressed, I started to get an idea of common themes as well as challenges to my own assumptions. For example, I had assumed that every participant had been guarded and wary against Borderline clients, however this was not the case. In some instances, these clients were found to be "interesting". I was then able to use this with future participants, for example "some participants found X while other participants found Y" which I had felt gave the participants a wider array of alternatives, possibly alternatives in which the participant was not aware of.

This had also influenced the way in which I had approached participants. I was more aware of my own assumptions and tended to be more neutral in my interaction so that the participant felt comfortable in disclosing their views, be it more positive or negative.
New concepts such as problems relating to boundaries had also come up frequently. I found that using this also helped my participants to express themselves. Introducing this to clarify as well, had also assisted as a probe in my questions. It was also important for me to read more about these concepts in order to better understand them. By doing so, I was able to more actively engage with my participants when they had mentioned these concepts or ideas. Looking back, these were also points at which I had felt stuck as I had not fully understood

the content. Asking the participant to explain these may have also restricted their flow as they may feel that I would not fully understand this. In addition to this, allowing the participants to use their own clients (anonymously) has also assisted in explaining, highlighting and clarifying processes which emanated.

Nearing the end of the data-gathering process, I became confident in the information that I had collected. Checking back with my interview questions as well as reading over the literature review chapter had aided me in keeping focused on the information I required as well as to remind me of previous findings so that connections could be made between that and my participants information. This assisted in developing themes as well as highlighting new information which may differ from that of previous research. In turn, these findings also encouraged me to find additional research regarding areas I had not included initially in my literature review.

As a developing therapist, I have found great benefit from this research undertaking. I have noted my preconceptions coming into this study and the development thus far. As a result, it has shaped my approach in some way. I find that I am more aware of how my assumptions impact on the way I approach a client. I have found that I too had assumed every "Borderline client" is seen to be difficult and thus, actively avoided. My questions had also indirectly hinted at this, for example (what makes clients presenting with BPD difficult?) thereby assuming they are indeed difficult. Learning from this, I am more aware of my assumptions about both the diagnosis as well as the individual themselves. The way I conduct interviews now, takes cognisance of the client and my assumptions. I find myself checking with myself, if I am "leading on" the client into a specific direction.

This research has resultantly shifted my frame of reference. My first encounter with a client with BPD had left me feeling incapacitated. I felt inadequate and feared seeing another. At the same time, I was curious as to why this happened, and not just with me, but with others as well. Having the opportunity to explore this further has helped me grow as a clinical psychologist and in conducting therapy. My greater understanding of these clients has made me more confident in my approach. I have moved away from seeing them as "difficult" and therefore "avoided" the further along in the study I had gone. Now, I find myself more intrigued, curious and somewhat keen in my therapeutic encounters with these clients. Having gained a deeper picture about their dynamics, presentations, the differing ways in

which they are managed as well as greater self-awareness, has positively reframed the client with BPD for me.

3.8 Ethical considerations

Ethics refers to "preferences that influence behaviour in human relations, conforming to a code of principles, the rules of conduct, the responsibility of the researcher and the standards of conduct of a given profession" (Strydom, 2011, p.114). Great importance is placed on research ethics as well as the areas of which the researcher should be aware of and avoid in order to stay within the ethical boundaries (De Vos, 2004).

Within this study, the following ethical aspects were considered and are relevant. This study has been approved by the ethics committee of the University of South Africa. In addition, the sample population had voluntarily participated and were made aware that an honorarium of R300 would be awarded for participation, as a gesture of valuing their time.

3.8.1 Avoidance of harm and voluntary participation

Doing no harm to the participant is of vital important in social research (Babbie, 2007). This refers to physical, metal as well as emotional harm. It is the responsibility of the researcher to protect the participant from potential harm, within reasonable limits, during the research process (Creswell, 2003). The participants were treated in a fair and just manner at all times. No known harm was done to any of the participants during this study. All information furnished by the participants was not and will not be used against them. This was ensured by removing any identifying information from the transcriptions or any other traces of identifying information so that the data cannot be linked to participant. The identity of participants is limited to my supervisor and myself only.

In terms of voluntary participation, the participants were not forced or coerced into the study. In this study, the participants had the option to participate or not. Further, they had the option to leave the study at any time without any consequences. Measures were also taken to make sure that the research was conducted fairly. This includes fair selection of participants, therefore no participant was excluded unreasonably, unfairly or discriminated against.

Participants were not exploited in any way and they were appropriately remunerated for their participation.

3.8.2 Ethical clearance and informed consent

The research proposal was submitted to the University of South Africa for ethical clearance and the study had been approved. The participants were informed of the study, its procedure, aims, methods, use of findings and any foreseeable consequences to the participant (Strydom, 2011). According to Grinnell and Unrau (2008), the participants should be given the opportunity to choose what can and cannot happen to them within the study. I had therefore sought informed consent in writing before the study could continue.

Additionally, the aims, methods, purpose, use of findings, possible harm to the participant were discussed with each participant. The duration of the interview, which had lasted approximately 60 minutes on average, as well as the option to withdraw at any time without any consequences were made explicit. Additionally, any further queries or concerns were addressed. Once the participant was comfortable with the information, the informed consent form was handed to them to sign. The participants as qualified clinical psychologists were all able to fully comprehend the nature of the study as well as the risks involved and had made a voluntary decision regarding their participation.

3.8.3 Confidentiality

Every individual has the right to privacy (Strydom, 2011). Therefore the participants of the study were informed that their privacy will be protected. Information by the participant about their clients could be potentially harmful for both the participant and their clients; therefore confidentiality was of great importance to protect these individuals. In reporting the findings, pseudonyms were used in place of participants' names, for example, "Participant A". Any identifying details or names reported by the participant during the interview were also changed to pseudonyms. Access to identifiable information of the participants was limited to my supervisor and myself only. This restricted access applied to all raw data of the study. If any names or identifying information had been mentioned by the interviewee, the details were removed in order to protect the individual. Furthermore, all raw data, including audio-

recordings, will be destroyed after five years. In the interim period, the physical and electronic data is being kept securely in a locked filing cabinet.

The study was conducted according to the research design outlined above. In doing so, the data was gathered, transcribed and analysed. The findings of this are provided in the following chapter. A discussion is further included so as to integrate the findings of the study more comprehensively.

CHAPTER FOUR: FINDINGS AND DISCUSSION

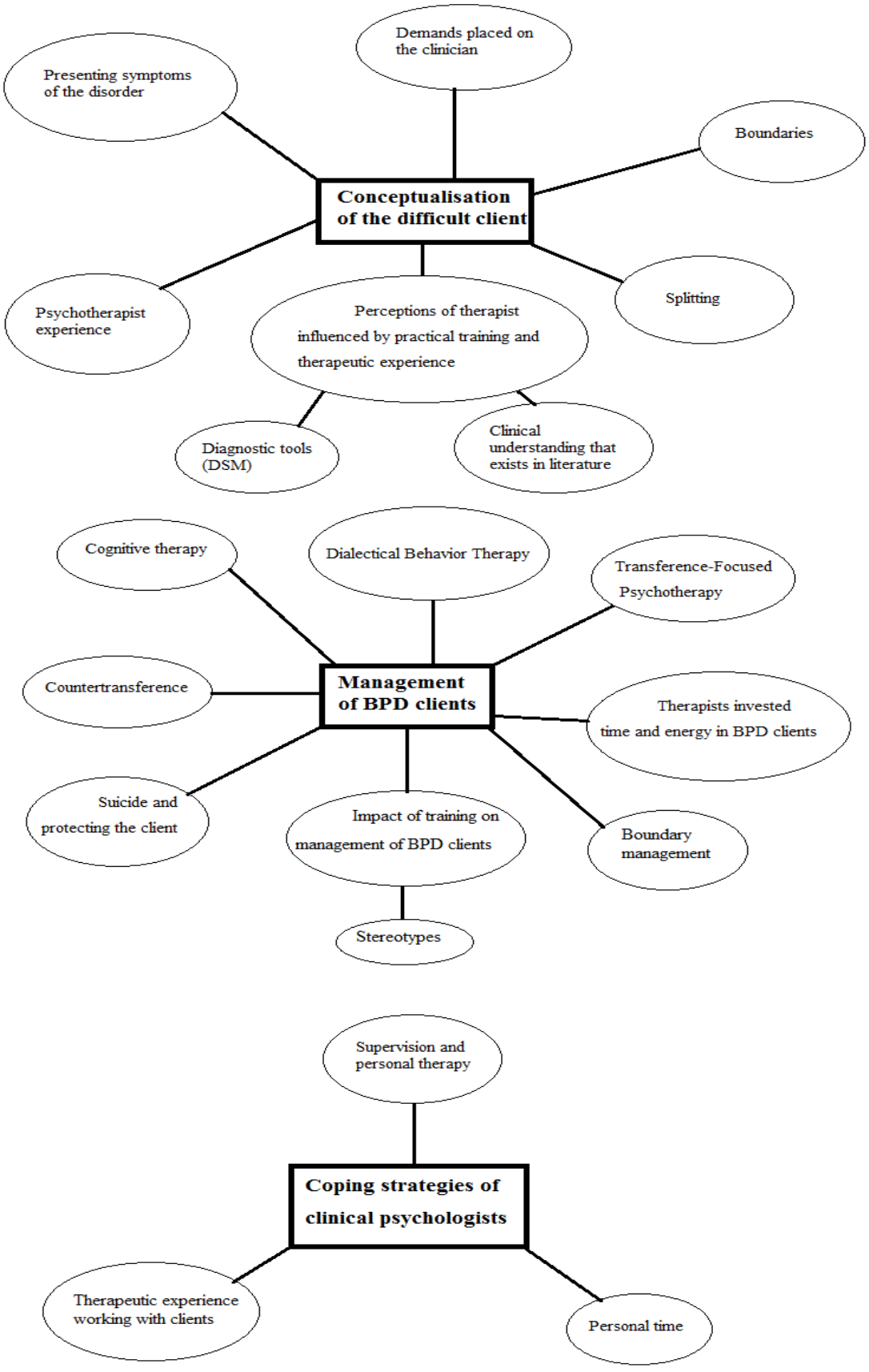
In this study, clinical psychologists' therapeutic experience with clients with BPD was explored. Current evidence provided the basis for the exploration, indicating in one study, for example, that 84% of participants reported clients with BPD as more difficult than other clients (Clearly et al., 2002). The difficulty, it seems, stems from the pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity that is indicated by the presence of very specific symptoms (American Psychiatric Association, 2013). In lieu of these symptoms, a client experiencing BPD becomes a challenge as their behaviour may be as unpredictable as their intense range of emotional experiences. The resulting interaction between the client with BPD and the practitioner, may face various challenges and the client may be labelled as 'difficult'. The problem with a client being regarded as 'difficult' is as Wilson (2005) states, that 'difficult' clients may be treated in specific ways, given the negative feelings to these clients that may develop. Initially, this may be expressed through annoyance or dislike but can escalate towards frustration and anger. It is needless to say that the therapeutic relationship may be affected.

This study explores clinical psychologists experience working with BPD, specifically how they identify, manage and cope. Studies have also reported that burn-out, stress, anxiety and other forms of negative physical and emotional ramifications may be experienced on the part of the psychotherapist (An et al., 2013). This study is therefore deemed relevant and important as it will enable the development of an understanding that can improve the clinical relationship between client and clinician. Additionally, a comparison between what Skovholt and Rønnestad (2003) term the 'novice professional' and the 'experienced professional' will allowed us to determine whether experience of six years or more of clinical practice influences the therapeutic relationship with clients with BPD in any way.

Seven clinical psychologists participated in the study and the interviews were recorded and transcribed. Thematic analysis was the chosen analytical tool and three themes were highlighted. These are 1) conceptualisation of difficult clients; 2) management of clients with BPD; 3) coping strategies of clinical psychologists. The interview transcripts were also compared according to number of years that the participants had, practicing as clinical psychologists. It was considered important to understand if there was any difference in working with difficult clients with BPD, as the more years of clinical experience gained,

may influence the therapeutic interaction. In this regard, participants were categorised in two categories, namely, those with one to five years' experience and those with six or more years of experience. This is aligned with Skovholt and Rønnestad's (2003) work, which indicates that number of years working with clients may influence the therapist's interaction.

Figure One: Summary of themes and sub-themes



The findings and discussion of the current study have been integrated as this will allow for a more comprehensive and detailed understanding of the experiences of the participants in working with difficult clients with BPD. The themes identified will be discussed in relation to the literature reviewed. This will be followed by a discussion on the participants' experience working with clients.

4.1 Conceptualisation of difficult clients

The diagnosis of BPD has very specific criteria (nine criteria of which five must be presented by the client for a diagnosis to be made) as set forth by the American Psychiatric Association (2003). Some of the criteria include unstable and intense interpersonal relationships, identity disturbance, affective instability and inappropriate, intense anger, or difficulty controlling anger. Aviram et al. (2006) states that clinicians often describe these clients as "difficult", "manipulative", "treatment resistant", "demanding" and "attention seeking" and this is essentially a reflection of the nature of the disorder.

The participants of the study broadly indicated that working with clients diagnosed with BPD is difficult in two ways. Firstly, it is the presenting symptoms of the disorder itself and secondly, the demands placed upon the therapist.

In light of this, participant 1 stated that:

> *if you describe it as Borderline, it immediately puts it in the context of Psychiatry. That immediately puts it in a context of the DSM…I mean, ja(yes), the diagnosis fall(s) within that context. In itself, for me, it is where the first challenge lies, because, obviously, the DSM works on a medical model, and… Then the difficulty, or the disorder is to see within a medical model. It is seen as an illness which for me is the first difficulty. If you see it in that context it limits the potential possibilities of what to do with it.*

This in itself becomes difficult, as the diagnosis of a client results in a particular perception of their behaviour and emotions.

The main difficulty highlighted for this participant is the actual label of BPD within

the context of the DSM. Viewing an individual within the context of a disorder may therefore view the individual as a diagnosis. With it, the person is no longer seen as a person, rather, as a set of criteria. The individual is therefore labelled as "sick" or "abnormal" and by default, the problem is located within the individual.

Participant 7 stated that clients with BPD "*are labour-intensive"* and that "*you find yourself doing more work with them...than with most of the patients. Not only in a practical [but also in a] pragmatic way like having to arrange things or give them reports to an officer at work or a school principal or whatever".*

This participant experiences difficulties regarding time constraints. More specifically, clients with BPD are experienced as more labour intensive, thus requiring more time from the clinician. This takes the form of working harder in the session, planning more structured sessions as well as additional work outside of the therapy room, such as liaising with third parties. These demands therefore require more attention from the clinician, making participant 7 view them as more difficult than other clients. The consequence of this could lead to poor management of the client. This is further reflected by Teo et al. (2013) in which their study revealed that difficult patients were found to be both frustrating and time consuming.

Participant 5 could not describe a difficult BDP client given that he "*love[s] the borderline patient"*. He indicated that,

> *what people in general describe as a difficult patient is someone who has high express(ed) emotions, high defensive behaviour and lots of acting out. So, there is lots of emotional acting out and self-harm behaviour and… I think what also sometimes is difficult* in *the therapy is the intense need of the Borderline patient for you to please him…*

Participant 5 does not find clients with BPD difficult. He does indicate, however, that certain behaviours may make a client difficult. These include increased acting out, high expressed emotions and increased defensive behaviour. These elements were found by Koekkoek et al. (2006) in their study which highlighted difficult behaviours of clients. These symptoms may therefore lead to negative countertransference by the clinician,

negatively impacting on the therapeutic relationship.

From the above excerpts, it can be stated that the impression created in the mind of the therapist based on the diagnosis, will in ways, influence whether a client is perceived as being difficult or not. Further, there appears to be different aspects which influence what makes a difficult client. With one participant, clients with BPD are not seen as difficult at all. As is the current standard for diagnosis, the DSM must be utilised and has set criterion for every diagnosis. This in itself may create the impression to the therapist that the client may be difficult. Khalil's (2009) study informs mental health professionals that undesirable behaviour, rudeness and verbal abuse as well as the tendency to complain may result in the client being viewed as difficult. This is similar to many other studies (Koekkoek et al., 2006; Davidtz, 2007) which also reported similar findings. Even though Haas et al. (2005) indicate that difficulties are identified in three areas, namely, the physician, client or health care system, Miksanek (2008) rightfully states that the relationship between the physician and the client is paramount and that the physician's interaction with the client may determine the extent to which a client is considered difficult.

In this respect, it must be noted that all seven of the participants interviewed indicated that working with clients with BPD presents difficulties, beyond the actual diagnosis (This includes participant 5, who despite indicating his 'love' for clients with BPD, was able to describe the difficulty they present). The participants specifically, were referring to the therapeutic relationship, which clearly links to Miksanek's (2008) assertion. For example, participant 3 stated that the difficulty working with clients with BPD is "*the way that they present"*. The participant was referring to the arrangement of their symptoms that places them in a very confined way of interacting with themselves and others. This essentially implies that "*they don't present like any other client. They present with a kind of intensity that is very difficult to deal with"* (Participant 3).

This intensity, referred to by participant 3, was also reflected upon by participant 2 who said that clients who "*provoke emotions within me….very often of frustration and when I get a cue from within that I am frustrated, then I would regard that as a difficult patient"*. What is important to note here, is that difficult clients are not only

clients with BPD, as participant 2 said, "*I wouldn't say that it is only Borderlines that provoke that within me. I have had Borderline patients that didn't provoke that within me at all. I have had Borderlines who did provoke that within me".* This is important to keep in mind, as all clients present with a particular arrangement of symptoms that may be perceived in a particular manner. Therefore it is important to be aware of the arrangement of symptoms and the impact which it has on the clinician as this influences the therapeutic context.

However, it seems that all the participants have aligned their understanding of working with clients with BPD as being difficult to varying degrees. This might be linked to the general perception that exists regarding clients with BPD that the participants may have been exposed to during their training. For example, participant 7 stated that, "*if you are inexperienced as a therapist, then I say Borderline no oh no, you know. But in time, and it is not dependent on your conceptualisation and your understanding all of these things, but for me at this time I will take them any day and work with them".*

This notion is further supported by Lieban and Burnette (2013). They suggest that those psychotherapists with more experience react less negatively towards clients with BPD and are less susceptible to burnout as compared to the novice psychotherapist.

In addition to this, all of the participants have worked or are currently working with clients with BPD. As such, the perspectives that they are providing, are linked to their personal encounters and this cannot be excluded from the understanding.

It is important to keep in mind, that clients with BPD have the pattern of shifting and changing their interaction with themselves and people around them. Koekkoek et al. (2009) alluded to this in their study, by informing mental health professionals that clients whose interpersonal interactions and character or personality are challenging may be deemed as difficult. This affects the therapeutic relationship as well as the progression of the client, but importantly here, the therapist, may essentially carry the strain of the pattern that characterises the client with BPD. To this effect, Breen and Greenberg (2010) add that clients with BPD may be deemed as difficult, even to experienced physicians.

The participants of the current study provided insight into some of the challenges they faced as therapists working with clients with BPD. Participant 3 stated BPD patients'

> *reactions might be more heightened than another patient's to things that you do. So, whereas, you could interpret with one patient, you know quite freely, the borderline might get their back up easier. So, you have to be a bit more careful about what you say, especially not what you say but how you say it.*

It seems then, that working with clients with BPD, present with heightened emotional sensitivity.

Further, the use of splitting as a main defence as proposed by Akhtar and Byrne (1983) resonate here as well. The inability to integrate both good and bad parts, as well as the stark separation of good and bad parts leads to several difficulties within the client. The intensity, emotional acting out and impulsivity are among the five clinical manifestations of splitting proposed. The clients' clinical pictures are therefore consistent with the responses of the participants in the study. This is indicated by participant 5 highlighting the highly expressed emotions experienced, acting out and self-harm, as well as participant 3 reporting heightened reactions by the client.

Participant 6 said that, "*Borderlines is a very apt description. Like boundaries, it is not just that they have, they don't respect their own boundaries, they don't respect your boundaries. So that is the main thing I think that makes it difficult".* With regards to boundaries, it seems that clients with BPD will, based on their affective state at the time, break boundaries that are being set by the therapist. For example, participant 4 said that:

> *usually they* [clients with BPD] *sort of interrupt also with time and stuff like that; basically one that might change appointments or not pitch to appointments. They are just difficult to form a relationship with on the whole. Ja(yes)I mean by the time they get to you, you know sometimes they have seen quite a few people and I have seen*

some of them that have seen like eight therapists before, and then ja(yes).

The presenting challenge that participant 4 brings forward here, is not only the difficulty maintaining a working relationship with the client with BPD, but also, the reality that clients with BPD may change therapist based on their needs. However, for a therapist who has not yet developed the experience to understand that this is the pattern of behaving that is typical for clients with BPD, they may invariably start questioning themselves or their training, or both. To this effect, participant 6 alluded and said "*I think particularly if you are, if you start out as a Psychologist and you are very inexperienced and you don't know what you are dealing with, you find very often that Borderline which I saw for example".*

The experience of the participants, working with clients with BPD indicates that these clients are perceived as being difficult to work with. This is specifically related to the presenting symptoms as well as the typical behavioural, affecting and thought patterns that are typical of the BPD. In 2009, Fazio-Griffith and Curry (2009) indicated that clients with BPD experience many negative effects in their lives, with strained relationships, negative self-image and marked shifts in social activities being mentioned. Ruggiero (2012) said that clients with BPD are both fragile and aggressive and they are likely to act out impulsively. This implies that the interaction and relationship with the therapist may in itself be characterised by manipulation, impulsivity, fear of abandonment and even, self-destructive behaviour (Fazio-Griffith & Curry, 2009).

4.1.1 Perceptions of therapist influenced by practical training and therapeutic experience

Based on the responses from the participants, it seems that their understanding of clients with BPD is aligned to both the diagnostic tool that is utilised in determining if they are diagnosable with the disorder as well as with the predominant clinical understanding of the client with BPD that exists in the literature. The descriptions and understanding of BPD provided by the participants, was both theoretical as well as based on personal experience. There was no significant difference between

participants who have four years or less experience and those with more.

This, we understand as being linked not so much to the experience or competence developed by the practitioner, but rather, is linked to the symptoms of the disorder itself – which invariably places the client and therapist in a therapeutic space that lacks consistency of interaction, behaviour and affect. Fonagy and Bateman (2005) and McMurran et al. (2010) report that clients with BPD may experience difficulty complying to treatment – not by choice – but rather, due to the maladaptive interaction style that is typical for the disorder.

By virtue of the presenting symptoms of BPD, the strain this may place on the therapist must be considered as this will affect the therapeutic progression of the client. Additionally, the strain placed upon the therapist may essentially result in stress and frustration that could lead to burnout. Maslach and Jackson (1986) define burnout as incorporating elements of emotional exhaustion, depersonalisation and reduced personal accomplishment. Cotes (2004) states that burnout in the therapist may be associated with negative outcomes for the client. It becomes important to understand how therapists manage clients perceived as being difficult.

4.2 Management of clients with BPD

The term countertransference was first introduced by Freud (1959) and refers to the unconscious and defensive reactions to a client's transference. In line with this psychodynamic framework, Cambanis (2012) states that if the client projects an image of the therapist as hostile or unhelpful, there is a psychic pull within the therapist to respond to the client's projection. Participant 1 captures what all the participants interviewed experienced working with clients with BPD: *"you know after a point you just want to get some distance from them".*

Essentially, this confirms and reinforces that client's initial projection onto the therapist and the subsequent reactions, validates the position of victim in the client. With clients with BPD, this is expected and it can be stated that the interaction between therapist and client will at some point, give way to the styles of behaving, feeling and thinking that characterises the disorder. As stated above, this makes the

client with BPD more difficult to manage as they may change their pattern or style of behaving.

The participants of the study alluded to the fact that clients with BPD have a high dropout rate from therapy. Participant 4 stated that they (clients with BPD) "*usually they sort of interrupt also with time and stuff like that; basically, one that might change appointments or not pitch to appointments"*.
Participant 4 further stated that:

> *On the other hand, there is an aspect of it that you know, once I sort of accepted that, I suppose it also made it easier because they sort of sometimes; when they come in and they are covered in cuts and they have seen four therapists and all that, you lower your expectations. You do your work and you go through it like row by row and you, ja(yes) you do your best but you don't, you don't have to really take a lot too personally…*

The continuous shift in the therapeutic alliance and relationship may take a strain on the therapist, and, generally, it seems that scheduling "*more earlier sessions where you have the more capacity to deal with it, because you know, if you are tired or you haven't eaten properly or you are tired of the previous night, it is more difficult to work with the BPD client"* (participant 1).

This idea is shared by Cambanis (2012) in which great value is placed on the therapeutic alliance. Clients with BPD tend to have a higher drop-out rate from therapy, which in turn has an impact on the therapist. Managing this alliance so that it is healthy for both the therapist and the client needs to be at the fore.

However, participant 3 stated that:

> *They are difficult, they will challenge you more than any other patient. Do I have to invest more, do I have to give more? They can become easily suicidal and you don't want too many suicidal patients in your practice. Basically, it is about how much you want to manage a case. So, case management; borderlines often present you with case management. So, you have to manage the case. It is*

not like an anxious patient who is, you know, who is anxious about a certain area of their life…There is no case management involved. The furthest the case management will go is okay go to the G.P. and get a Benzodiazepine. But with a borderline patient you need to follow up with Psychiatrists and/or liaise with them. If they are suicidal you need to think about admission or not. How do you contain self-harming impulses?

From the participants, there was a developing sense, that with clients with BPD, a lot more of the therapist's time and energy will have to be utilised, over and above the time and energy spent on another client. This is mirrored by the study done by Linehan et al. (2000). It was found that therapists become emotionally exhausted from therapy as a result of high expectations for therapeutic success. As such, therapists work harder, investing more time and energy which leads to emotional exhaustion as well.

Looking at psychotherapeutic treatments, it is found that participant 1 describes processes within the framework of Cognitive Therapy. From this premise, schemas that may have been functional earlier on in life will be maintained even when they are now dysfunctional. Borderline clients therefore operate within three main beliefs; 1) "I am inherently unacceptable." 2) "I am vulnerable and powerless." And 3) "The world is dangerous and malevolent" (Beck, Freeman, Davis & Associates, 2004).

Participant 1 stated the following:

Ja(yes), so I… But in terms of all my clients I will generally start the same because I want that uncontainable example of behaviour. So for me I will start the same. Obviously then in the therapy, as soon as I formulated my case which I can do within the first session if need be, and obviously at the end of the session I can maybe start putting some things in place if I feel necessary. Most of the time, I find that they feel powerless or that the world is against them, and because of that, they sort of test you to see if you too will give up. So I use a bit of the cognitive therapy as well to focus on moments like those.

Participant 1 therefore reported the client feeling powerless and that the world is indeed a place in which one needs to be vigilant.

Similarly, participant 4 found that the use of Dialectical Behavior Therapy (DBT) is greatly beneficial. He stated that:

> *You teach them mindfulness as a way of, and you can talk through the skill rather than have to sit and you know then something that you turned into a bad object and you are reflecting on this. I quite enjoy DBT as it incorporates the mindfulness, interpersonal skills and so forth. I found that those kind of practical things work well for some of the Borderlines.*

According to Linehan (1993) DBT is based on a biosocial theory of personality which suggests that BPD is a dysfunction of the emotion regulation system. DBT utilises directive, problem-orientated techniques, as well as draws on behaviour therapy, supportive techniques and techniques drawn from Zen Buddhism (Linehan, 1993). At the core, the focus is on helping clients gain control over their behaviour. This program further assists with skills such as mindfulness, interpersonal effectiveness, emotion regulation, distress tolerance and self-management.

Participant 5 stated the following:

> *Ja(yes), so I am very confrontational with it, because I know that it is defensive. So when someone then becomes really angry at me I find that this is a good thing, because then we can work with okay so what was the intrigued, why are you angry with me, why did I not… You know, what did you feel I didn't deal with? Then that sort of opens up a stage where you can explain why I don't find the fact that you are cutting yourself important, I don't. It is not something that I spend time with. It is not something that I really even entertain in sessions at all.*

Transference-Focused Psychotherapy (TFP) is based on ego psychology, object relations theory and contemporary attachment theory (Groot, Verheul and Trijsburg,

2008). TFP suggests that the core problem of clients with BPD is that of poorly defined and fragmented self and object relations, which results in identity diffusion. The goal of TFP is therefore to better integrate the fragmented inner representations of the client. It utilises techniques such as clarification, confrontation and interpretation in order to facilitate change in the behaviour as well as the personality structure. Participant 5 is found to take a more directive, confrontational stance with clients with BPD, similar to that of TFP. Being confrontational and directive is found to address the underlying emotions as opposed to the defences.

4.2.1 Therapists invested time and energy in clients with BPD

Ruggeiro (2012, p.359) informs mental health professionals that the ability to contain as well as the "capacity to share prolonged states of suffering of the self without defensive recourse to interpretations that are premature and inevitably obstructive" are an important component to a healthy therapeutic alliance with the client with BPD. To this effect, it seems that appropriate management of the client with BPD is important, due to the emotional strain that it may place upon the therapist. Furthermore, the therapist needs to pay careful attention, when frustrated, to their own propensity to act in through a premature or cutting interpretation towards the client with BPD. Participant 3 stated that:

> *there is a high dropout rate. There is… The management of the borderline patient is often the thing that gets to the clinician. It is the management thereof. How do I deal with missed sessions? Because, they miss more sessions than other patients.*

The resultant effect of this is that:

> *you are not always lus[feeling keen] to deal with the challenging, very demanding client. So, there it does take a bit more time management. You have to work a bit smarter and you have to be aware of your own capacity … do you have enough resources to deal with the very, very challenging ones? So, you can make the right calls and the right decisions.*

The challenges of working with a client with BPD go beyond the conventional client-

therapist relationship. Participant 7 stated that when working with clients with BPD, therapists should, *go the extra mile.* Essentially, therapists are required to "*do things that you normally wouldn't do for other patients…in the sense that you might accompany them to something important. You might write a letter to somebody, officially, that normally you would leave to your patient to do".*

Therefore, the higher investment with these clients leads to exhaustion of the therapist. Perseius et al. (2007) indicates that clients with BPD are known to be more difficult in therapy as they make more emotional demands on the therapist. As a result, the therapist works harder and may feel pulled into doing things they would not normally do, such as contact with third parties as mentioned by participant 7.

Participant 7 further elaborated that as per the symptoms that characterise BPD, the client feels as if:

> *they have got nobody in their corner. They have never had anybody really in their corner like their wingman. You must be their wingman. Of course, you stay within the bounds of professional ethics, blah, blah, blah. But, if you draw that too narrow with them I think you lose out on a lot of therapeutic benefit. I have seen often, just the fact that you are willing to pick up the phone and call the teacher when in other therapies you would reflect it back. You would say to the patient, "how come you want me to do it for you?", or you want them to do it for themselves; because you want to help them individuate. You know, all of that. With them it is about this thing, you either stay with them in their regression, and then from the regression you slowly start helping them individuate to a less regressed state.*

From this, the participant reflects his active supportive role to the client. At times, this may become difficult as the boundaries of the therapeutic relationship need to be kept in mind. There is therefore a juggle of active involvement with the client, as well as being aware of the boundaries needed to be adhered to in order to protect oneself and the client.

As per the symptoms that characterises BPD, clients may display suicidal tendencies. Regardless of whether this expression is ideation or not, the responsibility to protect the client's well-being rests upon the therapist. Herein, keeping in mind, that a client with BPD may shift and change his/her behavioural stance to maintain the role of victim, especially in instances where the therapeutic alliance places the client in a position of facing his/her own flaws.

To this effect, participants indicated that working in a hospital setting is a lot more manageable when working with the client with BPD:

> *I am lucky that most of the borderlines that I see are in a hospital setting. So, I don't see them generally in private practice. In a hospital setting you actually don't have to contain the suicide behaviour because they are already in the hospital* (Participant 3).

Bovensiepen (1994) makes reference to the institution as a container. Therefore, the hospital, for instance is seen as a container in which the client can be held. The staff as well as the physical structure of the building provides containment and structure for the clients, providing a feeling of being held. The focus is therefore on creating a structure in which the client feels contained, and not only a therapist-client relationship which does this. The function therefore, relieves the clinician of some responsibility of containing the client as the hospital and its staff (nurses and doctors for example) undertake this function to some additional degree.

4.2.2 Impact of training on management of clients with BPD

One of the factors that seem to influence a therapist's ability to manage difficult clients has to do with their training:

> **Interviewer**: *Okay. So, it sounds as though your experience and your training has helped you to be in this position where you feel more comfortable with them?*
>
> **Participant4**: *Ja,(yes,)I mean it doesn't really help in private practice though, you know, because, like I had a lot of experience*

with Schizophrenia and Bipolar. Ja(yes), it is not necessarily things in private practice you want to do therapy with you know, and running groups for Borderline is a lot nicer in a government hospital-type frame.

Cambanis (2012) stated that challenges regarding clients with BPD are often magnified for trainee psychologists. This is based primarily, on the lack of experience in implementing treatment plans as well as their still developing understanding of underlying personality dynamics. However, as participant 4 informs us, that hospital training and experience may be the best context for experience to be gained. Experience gained at government facilities aside, the participants shared interesting observations about clients with BPD that they picked up through their interactions in hospital settings. These stereotypes are important to understand, as they may set the tone for the interaction between the therapist and clients with BPD.

Participant 2 said:

I learned interesting stereotypes of Borderline that I didn't know before.… we worked quite closely with one of these big psychiatric experts in the forensic setting. She always said, 'you spot a Borderline long before you have spoken to them. They come with their nails painted green and the hair is died blue and they have their high heels with their Lycra ski pants. You can spot them because they are flashy'.

Participant 6 added that at the hospital, during ward rounds, they would:

hear certain things such as attention-seeking behaviour, mutilation, saying, 'I feel empty inside'. 'If you feel empty inside', is one of my questions that I always ask, 'How do you feel inside?' They almost always say, 'I just feel empty and dark'. When they say that and you can see mutilation has been formed and you can see clothes being inappropriate, this boundary thing.

Snowden and Kane (2003) states that clients with BPD being labelled as "attention seeking" or "time wasters", may contribute to trainee psychologists developing

attitudes towards certain groups of clients. Specifically, Proctor (2010) indicates that those who are diagnosed with BPD are often stigmatised and marginalised and the result of this, is an impaired standard of care for the client.

Participant 1 said that, "*the biggest stereotype is the DSM".* This was quite an interesting statement and as the conversation continued, participant 1 clarified:

> *the diagnosis falls within that context. In itself, for me, it is where the first challenge lies, because, obviously, the DSM works on a medical model, and… then the difficulty or the disorder is seen within a medical model. It is seen as an illness which for me is the first difficulty of, it limits… If you see it in that context it limits the potential possibilities of what to do with it.*

Participant 1 implies that not only are trainee psychologists exposed to the stereotypes of BPD held by other psychologists and medical professionals, but that also, the diagnostic classification system utilised, seems to keep the client in the role of client, permanently. This in itself presents challenges as in many ways, the BPD diagnosis is a lifelong one and the implications for the therapist and client, is the establishment of a relationship that is long-term. And, as per the symptoms that define the disorder, the therapeutic relationship in itself will not be consistent, but will rather shift and change.

However, as explained by Participant 6, "*many of the stereotypes are correct"* and that they are "*based on those (criteria), but I think many of those criteria are actually correct*". Firstly, patients with BPD are regularly stereotyped by health professionals and often assumed to be manipulative and attention-seeking (Brooke & Horn, 2010; Fallon, 2003). This is common amongst the BPD population and as such, these stereotypes carry consequences. As suggested by participant 6, many of the stereotypes are based on the criteria for diagnosis, that is, the defining behaviour that characterises the client with BPD. As such, the stereotypes are not 'made up', but rather based on the experiences that other therapists and medical practitioners may have had with such clients. It has been noted in the literature that many of the negative ideas regarding an individual with BPD are linked to the characteristics of the disorder itself (Aviram et al., 2006; Trelor, 2009). This may include the intense anger, chronic suicidal ideations, self-injury and suicide attempts

(Aviram et al., 2006). In addition, due to the fluctuations in the level of functioning, treatment for BPD is seen to be a slow process and this in itself may have contributed to the stereotypes that exist (McAllister et al., 2002; Perseius et al., 2007; Commons Treloar & Lewis, 2008).

Stereotypes may, in many ways, influence therapists' reactions to their clients, especially, if they are trainee psychologists. This is based on the trainees' lack of experience and the reliance on the experiences of more seasoned practitioners. However, participants of this study alluded to the fact that the stereotypes of clients with BPD are linked directly to the symptoms they display. According to Commons Treloar and Lewis (2008) impulsivity, issues with abandonment, poor self-image, and feelings of emptiness are seen to contribute to self-harming behaviours as well as difficulties in treatment. These are symptoms that are typically associated with BPD. It is further noted that negative attitudes by the clinician toward the client as a result of the self-harming behaviour can have an adverse effect on therapy.

To this effect, all the participants of the study indicated that one of the most effective ways of managing difficult clients with BPD is prioritising managing therapeutic boundaries as clients with BPD "*are more intrusive"* (Participant 3). In light of boundaries emerging as a theme through all the interviews, as an effective strategy to manage clients with BPD, the section below highlights what the participants voiced.

4.2.3 Boundary management

Boundaries refer to the agreed upon roles and responsibilities of the patient's and clinician's role. Stepping out of this role, by either party, results in a boundary violation (Gunderson, 2009). Boundaries "provide a foundation for this relationship by fostering a sense of safety and the belief that the clinician will always act in the client's best interest" (Smith & Fitzpatrick, 1995, p. 500). Because clients with BPD are considered 'intrusive' implies that they may not respect the boundaries that define the therapeutic relationship and they may in many instances and ways, demand a lot more time, effort, energy and attention for the therapist. Participant 3 further stated that, "*when they become intrusive, my initial instinct is to say, 'stop it, you are invading my space'"*, and "*I have to protect my identity as a Psychologist"*. It is noted in the literature, that clients with BPD may challenge their therapist and expect

them to assist them in other areas that extend beyond providing psychological therapy. It seems that the establishment of clearly defined boundaries are important when working with clients with BPD.

Participant 6 provided an example of a client who breached boundaries and how she managed the client:

> *one morning, on a Saturday morning, 03:00 am, my son got up and he said, "Ma, (Mom) one of your patients are (is) here". She was sitting on a motorcycle in front of my house. So, I decided, I'm showing her out now, because obviously this is now invasion of my privacy, in my mind. Even though I work from home the boundaries are clear, I don't see you in-between… But, I decided in the end, she was very suicidal, so, in the end I decided… I walked onto the balcony and when I opened the door she saw me coming out and I looked down she was in the street on her bike. She looked at me and she said, "It is okay, I just want to sit here, you don't have to come and talk to me", which I didn't. I closed the door and I went back to sleep.*

Participant 2 also stated:

> *…they are demanding and they will be demanding because that is their pattern. So with them, it is extremely important to put up your boundaries… Now, they are extremely sensitive to rejection, so to set up firm boundaries without rejection could be quite tricky… So yes they can be demanding. They can be demanding on your time. I had a difficult Borderline who would just rock up at my office. She is there to see the doctor and then she would just knock and come inside my office because she is around. So, it would be very important to constantly make sure you maintain healthy boundaries. If you maintain those healthy boundaries and you do it in a gentle way, then you could manage it. I had one client who, initially, constantly sent me WhatsApp's and then I would reply within working hours.*

Based on the participants' responses to effectively managing clients with BPD, it seems that the most important contributing factors, is linked to training and experience in hospital and private settings. Stereotypes regarding the client with BPD are linked to actual symptoms are not a far departure from the reality of working with clients with BPD. Even though these stereotypes indicate that clients with BPD may be more challenging and difficult to work with, the real management of clients with BPD, is with boundary setting. The participants of the current study indicated that when effective boundaries are set with clients, the management of the case will become more contained.

Given boundary-setting emerging as the dominant theme for managing clients with BPD, it can be stated that all the participants of the current study had a deepened understanding of the symptoms and characteristics of clients with BPD and the complexity that is inherent to working therapeutically with them. Essentially, this indicates that the educational backdrop that defines clinical psychology provides therapists with the appropriate foundation they require to begin developing their therapeutic expertise. All the participants in this study were comfortable in their descriptions and definitions of BPD as well as the effective manner and ways of managing them.

4.3 Coping strategies

It must be noted that generally, working with any client therapeutically, is challenging. The therapeutic relationship will include both reactions and impact from both client and therapist, for example, transference and counter-transference. Essentially, therapists find themselves working with more than one client and with multiple issues daily.

Participant 1 said that,

> *obviously, any client you see will impact you. The more escalated and the more rigid and the more challenging or the more… Even if your heart goes out to them, whatever, the harder the impact, you can't take the impact away, even though you can… You can, in the session, move on a meta-level and not be influenced by that impact,*

> *or just take the impact as information but not change your behaviour towards the client. But yes, after the session those impacts remain. So, you have to-, you are right, you have to deal with it. It is very, very important, because if you don't deal with it, it creates unfinished business in yourself. It creates frustration or being tired. That is the impact; and obviously it affects your next client.*

The resulting frustration and carry over from one client to the next may impact negatively on the therapeutic relationships as well as on the therapist him/her self".

Specifically, a client presenting with BPD is considered amongst the most difficult of client to work with as, "*they are demanding and they will be demanding because that is their pattern"* (Participant 2).

Participant 1 cautioned that the:

> *central core that makes it difficult to work with Borderline Personality,* is *the acting out.* The acting out, "*is so severe and can be so dangerous and can be so in your face that very often therapists stride back from that. But the problem is that creates an impasse in the therapy, because if you are too afraid to confront a person on their patterns because you are afraid that they are going to cut, or this or that or the other, that puts you in a helpless position as a therapist.*

Aviram et al. (2006) add that clinicians may respond to clients' demands in unintentionally damaging ways, for example, emotionally withdrawing from clients. This may cause difficulties for clients as well as lead to clinicians missing important information regarding the client's subjective experience. Studies have also found that clients with BPD describe mental health professionals as being unhelpful, negative, hostile, unsympathetic and socially rejecting (Castillo, 2000) and this may be linked specifically to the clinician not feeding into the demands of a difficult client.

In light of the presenting difficulties that may be faced working with clients with

BPD, it becomes important to understand the coping strategies employed by clinical psychologists. This understanding is essential as self-care and self-preservation becomes an integral component to therapist success as clients with BPD often "*challenge your identity as their therapist"* (Participant 3). Participant 3 further relayed that:

> *a lot of the difficulties with borderline patients-the clinician's experience, I think has got to do with when their therapeutic identity feels threatened. So, when do they not become a therapist anymore, when do they become the friend that needs to phone them all the time, that needs to follow up constantly regarding missed sessions. You know, when does that feel like it has been taken away from you?*

Implicit to this and discussed above, is that healthy boundaries are required in order to facilitate a conducive therapeutic alliance. However, the emotional strain that this places upon a clinician, cannot be ignored. Participants indicated that supervision and personal therapy are important as coping strategies. This links to the literature, specifically Cleary et al. (2002), who reported that insufficient training and supervision regarding self-harm can lead to poor knowledge and understanding of BPD. To this effect, participant 7 stated that, "*if you are inexperienced* then you will *experience it* [BPD symptoms] *as a test".* Additional training as well as supervision however are both useful in different ways. Training was found to involve didactic and experiential instruction of some kind, whereas supervision is seen as relational and is based upon and focused exclusively on the clinician's clinical work.

Participant 1 stated that going for *supervision twice a week* has proven to be quite effective in coping with the stress that is presented by clients. It was further stated that:

> *if I had a tough client that I know let's say; let's say I see a very difficult one at 09:00 or 10:00 and I have, I often have an eleven, I have another client, and I can feel I am impacted, I will phone one of my colleagues and I will just vent, take it out and they will give me empathy. So, you have to… It is very important to constantly vent, especially in psychology, constantly vent and have as many*

avenues as possible. Either with colleagues or in personal therapy, supervision, just venting helps… to share that load.

Participant 2 further stated that,

I would say supervision is so extremely important, peer supervision as well. Not always… even just peer supervision. We are a bunch of friends who are all Clinical Psychologists and we get together and we have dinner. We haven't talked about our patients, but we talk about the difficulties of being a Psychologists and how things are challenging.

The participants reflected their understanding of the importance of group support obtained from other clinical psychologists. This allows a healthy platform through which the therapist can express his/her experiences and frustrations. Essentially, this functions as a debriefing session and allows the therapist to resume functioning without carrying the emotional overload or strain caused by difficult clients. A study by Patterson et al. (2007) reflected that there was reduced negativity towards clients who self-harmed after the staff had undergone a training programme on self-harm. This is a similar experience that the participants in the study reflected on, indicating that their supervision allowed them the opportunity to make sense of their feelings. This indicates that supervision can aid in creating more positive attitudes towards clients with BPD who self-harm.

Participant 1 also indicated that:

you have to vent to such an extent where either in an hour time I can see another client, or if I can keep it in the fridge for the whole day and at the end of the day then I can as a whole take it out so that I am ready again for tomorrow…

However, indicating that this:

only works for a month or two… because then it gets to burnout. Obviously, different Psychologists have different capacities of how long they can go, or how much times the can deal with… Obviously I think the longer you are in therapy… You get therapy fit. .But I am at a stage now where I am taking next week off. I

need a break; because if you have unfinished business and you are impacted by clients, the first thing that goes is your empathy. You just don't have empathy, you are just like, 'I don't care anymore. The next thing you want to do is you; because obviously therapy is a, you can't just go around the mountain, you can't take the short road, you have to go over the mountain and taking the long route. When you are very tired I feel I don't want to take them around like this. [Talking to the client] "That is what you do, stop being stupid!". So, obviously you want to avoid getting to those type of stages. You have to be smart about managing yourself. It is harder than what it sounds. It is actually quite difficult.

In addition to supervision, vacation time to recuperate was prioritised, along with other leisure activities. Participant 1 stated:

I do go to the driving range. I have set it in now to go to the driving range after work straight. I just go straight there. Whether I either need to bliksem the ball to get out all of my frustration, you know, and all my anger or whatever is needed to be.

Participant 2 stated that she does dancing that combines various activities, *"They combine ballet, martial arts and yoga. I loved that … and Horses, I do horse riding"*. This is also expressed by participant 5 who stated that "*I (therapist) spend time with the children running around in the garden and see my friends and go listen to music"*. Gardening and doing handy man chores are further highlighted by participant 4, "I do *a lot of handy man stuff too, as well as gardening. I experiment with growing tomatoes…"*.

Leisure activities, hobbies and personal interests are therefore found to also be a pertinent part of self care. Doing these activities allows the therapist to feel more relaxed and to better manage the stress they may experience.

Furthermore, personal therapy was also a strategy that allows for healthy functioning for practicing therapists. An excerpt from the interview with participant 4 is provided

below, which provides insight to the importance assigned to personal therapy by the participants.

> **Participant 4***: What we did is we had some, there were some issues in my relationship with my father and… You know I think the problem is everything you… When you do this work everything plays into your work you know. You get married and you have kids,- you get into a relationship. Everything mixes up. You know your work plays into your personal life; your personal life plays into your work. You take care of any one of those aspects. It is systemic you know. You know you fix your marriage you are able to work better with clients. You know you learn a new way of working better with clients…that put less stress on your marriage.*
>
> **Interviewer**: *Okay, so did you find that helpful for you in coping?*
>
> **Participant 4**: *Ja(yes)I think it is. But as I say, my father is an extreme character. So, you know, everything going on there, I don't think a lot of that is also stuff you sort of… You do it and you speak it into the universe and you know that it is just that you could make a little statement. But it doesn't… That is all that happened. You just, ja(yes) you don't build that great relationship with my father. That is the way it is.*

Based on the above, it can be said that clinical supervision, regular vacations as well as personal therapy are important components for therapists to maintain a healthy sense of self. This becomes imperative when working therapeutically with clients especially difficult clients who may trigger certain vulnerabilities within the therapist.

Within the current study, it seemed that experience in itself is the best teacher, in providing a therapist with the most effective coping strategies. For example, participant 6 indicated that how experience has enabled for the development of an effective strategy in coping with clients with BPD:

I will give you an example, with my accountant that is very Borderline. She has the most beautiful BMW that you don't find normally on the street. My first reaction would be I will compliment her on the car, which I don't do anymore. In the past I would have. She would have said, "well, let me take you for a spin". I would have gotten into the car and I would have gone and then you fucked basically… Then we walked up the stairs, because my house was on two storeys. We walked up the stairs and we go into the room… I always burn a candle before my clients come. So when she sits down she would comment on that again. Can you see again the pull to enter my world?

Again, therapists need to be alert to the continuous pull from a client with BPD to enter into the therapist's personal world. Additionally, it becomes evident how important it is to remain as objective as is possible, especially when working with clients with BPD. From this, we find that the therapist's experience working with clients will provide the basis towards developing an effective strategy that can be utilised to maintain a healthy sense of self.

4.3.1 Therapeutic experience working with clients

According to Skovholt and Rønnestad (2003), there are six phases to the counsellor/therapist's development. These six phases, see the practitioner moving from being a 'lay helper' towards the 'senior professional'. In particular, it is phase 4, the 'novice' phase, where the student enters the field after approximately five years of study. In addition to the natural anxiety and stress that comes with entering this phase, Skovholt and Rønnestad (2003) indicate that a sense of independence as well as seeking affirmation of their training through interactions with clients is sought. The expected struggles and challenges that are bound to be experienced, may result in a feeling of disillusionment with the profession. It is important to note, that even though therapeutic challenges are expected during clinical work, the onus it seems, rests on the confidence that a practitioner has in his or her ability. This brings to the fore, the focus of the current study. 'Difficult' clients, particularly those presenting with BPD, are considered as such, even in the literature, given the nature of the

symptoms typical of the disorder. It follows, that novice professionals, who have four years or less experience may essentially face challenges working with BPD for two reasons.

Firstly, they may lash out towards their professional training that may not be rigorous enough in educating them about the expected challenges. The result may be a lack of trust in their training, which Skovholt and Rønnestad (2003) label as disillusionment. Secondly, novice professionals, may not yet, have built their own confidence in their own ability to work with or manage difficult clients and may not yet, have integrated their own personalities and therapeutic preferences or style. As a result, the practitioner may doubt his or her training and ability in working with and managing difficult clients.

Clients with BPD present with very specific needs. One of these needs, is the ability to establish clear boundaries. The experienced professional, according to Skovholt and Rønnestad (2003) has had a number of years working in the field and has developed a therapeutic self. That is, the ability to work with a range of clients, regardless of their presenting symptoms. These practitioners are more trusting of their professional judgment and are able to establish very comfortable working relationships with their clients. Paramount to this development of the practitioner, is the presence of a 'sense of knowing' and being open to learning from new experiences.

The participants of the current study can be divided into two main categories, as defined by Skovholt and Rønnestad (2003). That is, novice and experienced/senior professional (as seen in the table below).

Participant	**Number of years working with clients**
1	5 years
2	3 years
3	4 years
4	12 years
5	8 years
6	15 years
7	24 years

Table 1: Therapeutic experience working with clients

Participants 1, 2 and 3 have five years or less experience working with clients. This places them in the novice phase of counsellor/therapist development. While, participant's 4, 5, 6 and 7 have six years or more experience, placing them in the experienced/senior phase of counsellor/therapist development.

In understanding clinical psychologists' experience working with difficult clients, it is assumed that the participants who have been categorised as novice, will experience significantly more challenges than those participants who are in the experienced/senior phase. In the current study, there did not seem to be any significant difference between participants in the two categories, regarding the conceptual understanding of the difficulty in working with clients with BPD. Instead, there seemed to be similarities in participants' understandings that working with clients with BPD presents a unique set of challenges that are linked directly to their pattern of behaving. Essentially, this speaks to the disorder itself and the challenges that are presented by the arrangement of symptoms.

As per the findings, it seems that any therapist working with clients with BPD will experience the similar client-related stressors. However, it is noted, that experience itself may be valuable in providing a clinician with a deeper, nuanced understanding of the therapeutic process, which will ultimately allow for the development of strategies of coping that are sustainable.

CHAPTER FIVE: CONCLUSION

This study aimed to explore the experiences of clinical psychologists working with clients with BPD. The exploration of these experiences was considered important, given the symptoms and characteristic behaviours that define BPD. Through this exploration, several aims were set. Firstly, to understand the conceptualisation of patients diagnosed with BPD by the participants of the study. Secondly, the management of BPD was also considered, given that these clients, by virtue of the disorder's characteristics, may present more challenges in providing effective treatment. This led into the third aim of the study, which was to explore the coping strategies that participants as therapists put in place to enable them to work more effectively with patients diagnosed with BPD.

This chapter provides concluding comments of the overall findings of the current study. The limitations and strengths of the study will also be discussed as well as suggestions for further research will be made.

To begin, it seems that the participants of the study understood BPD as being a "difficult" disorder to work with. All participants, even participant 5, who indicated "enjoying" working with BPD, provided understandings that suggested how difficult it was to work with these clients – based on the symptoms of the disorder. Evidence indicates that the relationship between the physician and the client is important and to a large extent, the interaction with the client may influence the extent to which a client is considered as difficult (Miksanek, 2008; Haas et al., 2005). In light of this and the participants' understanding of the characteristics that define BPD, it follows the creation of a perception that essentially places such a client within a "difficult" framework.

By virtue of the defining characteristics of the disorder, the participants developed preconceived notions of how these clients are likely to behave. It must be noted, that even though the participants indicated that BDP clients are difficult to work with, they based their understanding from personal experiences and either gained this knowledge through private practice, work in hospitals, internships and / or interactions with colleagues. In addition, the impression created of the client does

have an influence on the way in which the client is conceived by the therapist. Therefore, the perception held by the participants, of clients with BPD being difficult, was based on both experience and the understanding of the disorder itself. Rightfully so, it was assumed that the participants, in light of their training *should* have an adequate, theoretical knowledge of BPD as well as therapeutic experience working with them. All the participants of this study, both displayed an excellent understanding of the disorder, as well as shared anecdotes and case studies from therapeutic experiences. However, it was found that the association to being perceived as difficult was not limited to the diagnostic criteria alone. Factors including the therapeutic relationship, rudeness of the client and undesirable behaviour are found to be contributing factors to the likelihood of being viewed as difficult.

Another central aspect which was prominent, in the current study, was that of having to carefully manage therapeutic boundaries and therapist availability in the era of instant technology which creates an expectation of constant availability. The tendency of clients with BPD to test and push boundaries, both personal and within the therapeutic relationship, was evident. Clients therefore come across as intrusive, demanding more time, energy and attention of the therapist. Managing these manoeuvres is vital as the therapist needs to be aware that this forms part of the clinical picture of the diagnosis. As a result, this places strain on the therapeutic relationship, leaving the therapist with feelings of frustration or irritability to some degree. It is thus important, according to the participants, for the therapist to set appropriate boundaries from the outset and to be consistent in implementing them.

In addition, participants with more therapeutic experience, expressed through the number of years they have been working in the psychological field, added to the 'perceived competence' in working with clients with BPD. The current study draws on the term 'perceived competence' here to indicate that those participants with six or more years of experience displayed more confidence in their ability to work with clients with BPD. However, it must be noted that in the current study, all participants, regardless of years of experience, indicated that clients with BPD require more therapeutic attention (Skovholt & Rønnestad, 2003).

The second theme was the management of clients with BPD. The participants of the study were conscious of the therapeutic role they play in assisting the individual. Given the acknowledged continuous shift in the therapeutic alliance, the participants of the study indicated that they in many ways as psychotherapists anticipate certain reactions from a client. This is not to say, that the participants would assume that a client with BPD will react in a certain manner, but rather, they were aware of the pattern of behaving and interacting that characterises the disorder. It was acknowledged that the client with BPD requires a lot more attention, energy and time. This may invariably result in stress and strain on the therapist, as indicated by the participants. However, it also seems that the more experience as a psychotherapist has working with clients with BPD, the more adept one becomes. This is further indicated by Skovholt and Rønnestad (2003).

For the participants of the current study, it was also deemed important for the therapist to be aware of the mutual impact of the client and therapist on each other, for example, the transference and countertransference occurring within the therapeutic relationship. When the client projects onto the therapist that they are uncaring or hostile, and the therapist responds to this psychic pull in a manner which confirms this projection this can lead to an impasse (Cambanis, 2012). This pattern then clouds the relationship, as the therapist and client respond to projections as opposed to the individuals in the room or working through the transferences and projected material. If this is gone undetected, it could have adverse effects on the therapeutic relationship, as well as the therapeutic process (Evans, 2007).

Overall, the management of this specific clinical population was found to generally be more time and energy consuming for the therapist. It was found that clients with BPD involve more case management and following up as a result of the behaviours related to the disorder (Treloar, 2009). This was further reflected by the participants in the study. They had indicated that the management of the client is one of the most difficult aspects. Aspects such as increased investment of clinician time, increased vigilance of boundaries, high demands of the client, involvement with third parties and a greater expectation of the clinician, are amongst some of the factors mentioned which highlight this dynamic. Participants also indicated that the criteria of the

disorder were also a good indicator of the difficulties experienced or likely to be experienced by the clinician.

In addition, An et al. (2009) identifies other factors such as the issue of boundaries, which makes the therapist more vigilant with these clients. Further, a high dropout rate among this population leaves the therapist possibly anticipating an abrupt end to therapy. Clients often present to a therapist, with a history of previous therapists. This was found to lead to therapists already feeling discouraged as it paints a picture of a client who jumps from one therapist to the next. Additionally, missed sessions and the issue of boundaries are further aspects which leave the therapist feeling burnt out and challenged (Teo et al., 2013). Within this study as well, the themes of feeling burnt out and challenged were prominent. The participants had indicated that all of these factors mentioned relating to difficulties in managing the client with BPD, contribute to adverse affects on the clinician. These include feelings of being burnt-out, or challenged within the therapeutic relationship in some way. Participants referred to unfinished business being a problem which results from the clinician not adequately dealing with the impacts of the client. Further, elements related to the diagnosis of BPD such as the impulsivity and acting out behaviours pose a great challenge which leaves the participants feeling emotionally exhausted as the clinician has to frequently contain these.

Even though there were no notable differences in the attitudes towards clients with BPD from participants with less than six years' experience compared to participants with six or more years of experience, it seems from the data, that therapists require practical engagement with clients with BPD in order for them to effectively develop a management style or techniques. It is important to note, that university training and academic and therapeutic interaction with other therapist was indicated as some of the learning contexts through which participants gained insight as therapists into working with clients with BPD.

According to Bowers and Allan (2006) stereotypes pertaining to the difficulty of clients with BPD are found to be prominent. Through various interactions such as university training and working environments, stereotypes float freely which are generally negative in nature. These are generally based on the criteria for BPD and may in fact be true. With that said, the danger lies in the assumption that every client will fit

within this stereotype. This can lead to the therapist prematurely painting a general picture of the client, which influences the therapist's interaction with the client, even before initial contact. As a result, Liebman and Burnette (2013) suggest that the client may receive an impaired standard of care. The majority of participants in this study indicated that clients with BPD do receive inferior care as compared to other clients. Further, this was due to high levels of defensiveness, clinicians being tired or burnt-out and the stigma attached to the client with BPD. Within a hospital context, this extends as the patients are generally well-known. They are therefore viewed in a negative light as they return often, creating feelings of frustration within the team. In addition, these clients may get lost in the system as a result of being avoided. However, one participant did mention that he personally does not provide a poorer quality of care as the frame from which he views the client is different. Viewing the relapses as part of the process creates an expectation, to some degree, therefore working with this as part of the therapeutic process.

Self-care and self-preservation are important aspects when working with clients with BPD. The therapist needs to be cognisant of their own abilities, and to recognise when their internal resources have started to become depleted. Failure to be aware of this may lead to adverse effects for the client, such as the therapist becoming emotionally withdrawn or lacking empathy (Ungar et al., 2000). With the third theme, coping strategies, participants provided two streams of strategies that were employed. The first that will be discussed is that of group supervision and clinical self-care.

Participants indicated the importance of developing a network of like-minded and trained individuals, who meet regularly to discuss cases, and to in many ways 'let off some steam' such as peer supervision. The ability to relate to other therapists who may be experiencing the same or similar behaviours with their clients or, who have dealt with such behaviours with past clients, provide the basic framework to learn, develop a sense of confidence in the therapy being provided as well as allowing for interactive and mutual learning to occur within a formal or informal supervision context. Additionally, the ability to relate to others with similar experiences is cathartic as it creates a context for therapists to show each other a level of empathy (James & Cowman, 2007).

Individual therapy was also highlighted as each therapist, regardless of the nature of

qualification, has some experiences that may surface during therapy with a client. As the participants indicated, these experiences may never truly be resolved, but active engagement and understanding thereof may prevent carry-over and transference in session. In addition, the sensitivity of the information and unique experiences of the profession make it difficult to express to individuals not within the same or similar profession. These were also found in literature by James and Cowman (2007) which highlights the benefits of mentoring, supervision and self-care.

Engagement in formal or informal supervision therefore leads to debriefing which lightens the emotional burden or intensity on the therapist. As a result, these frustrations, concerns, worries or other emotions related to the case are somewhat contained and is less likely to spill over into the therapeutic space with the next client. Further, having a space to explore the therapist's own conflicts and blind spots is greatly beneficial. Knowing what processes are the therapists' and what are the clients', allows for a clearer therapeutic process as one is able to distinguish what is and what isn't solely the therapist. These findings were paralleled by James and Cowman (2007) as well as Wilson (2005).

The second stream of strategies that the participants spoke of was aligned to personal interests and hobbies which provided relaxation. Here, participants indicated that sport, from kickboxing to yoga is pursued and that it assists them in de-stressing. Essentially, all participants indicated having strategies, both professional and personal that assists them in coping with the strain and the stress gained through working with difficult clients. In addition, boundary-setting between one's professional and personal needs was considered imperative to the effective therapeutic relationship established with the client with BPD. This is further reflected by Lown (2007) who emphasises appropriate self-care to prevent burnout.

The development or implementation of various strategies to avoid compassion fatigue differs across therapists. It is found that this is a unique experience and as such, each therapist would benefit from different strategies. These aspects are gathered with exposure to these clients, so not necessarily years of experience in general, but rather direct exposure to clients with BPD. It appears as though therapists may try various outlets, and utilise ones that resonate most strongly with them.

Exploring the development of the therapist also ties to some degree with the therapist's confidence in his or her ability. As a result of the preconceptions of the BPD being difficult, those within the early stages of development may face difficulties. Firstly, beginner therapists may feel inadequately trained at a tertiary level as the courses may have not been as in-depth or they have had minimal exposure to BPD and the specific treatment strategies thereof. Skovholt and Rønnestad (2003) have outlined stages of development of the therapist, suggesting that those therapists in the earlier stages of development experience more difficulties.

Secondly, those earlier on in the developmental process are unlikely to have developed a strong therapeutic self in therapy. As such, aspects such as boundary setting and confrontation are found to be much more difficult as the therapist is unsure. With experience and exposure to various clients and those with BPD, the therapeutic self is formed and strengthened and the therapist is able to trust their professional judgement. However, it was found that this does not play a significant role as those with fewer years of experience were found to have similar experiences as those with more years of experience. From this study, it was found that participants had a similar understanding that working with clients with BPD presents with challenges related to the pattern of behaving. Further, it was found that those who had worked with clients with BPD specifically, for a longer period, showed a more detailed understanding of the therapeutic processes. Therefore, although the stress-related experiences may be similar, experience plays a role in providing a deeper understanding of the client.

5.1 Strengths of the study

Several strengths of this study were identified. Firstly, the study honed in on clinical psychologists' experiences working with clients with BPD and sought not only to understand, but to also explore the case management and coping strategies that are utilised. This therefore explored the subjective experiences of the clinical psychologists, leading to their understanding and ideas of the patient with BPD. Additionally, this study highlighted the experiences of clinical psychologists within Gauteng, in South Africa. Clinical psychologists within this demographic are underrepresented and poorly documented. As such, this study explores this specific

population to gain a deeper understanding of the relationship between the clinician and the client with BPD.

As a result of the focus of this particular study, the findings can be used to motivate further, in-depth studies into the coping strategies utilised and their effectiveness to the therapeutic relationship. Coping strategies in this field are found to be a practical tool which is greatly valued in order to build the therapeutic relationship as well as to better manage this patient population. Exploring the variety of strategies and their effectiveness may therefore be valuable as each therapist brings their own tips, techniques and methods, moulded by experience, which is unique.

Further, this study demonstrated that even though the perception of clients with BPD may generally be associated with being difficult, this is based primarily on experiences, rather than stereotypes. In many instances, the participants indicated that the stereotypes are actually factual information. These stereotypes though, are found to be prominent within the field, and are passed around freely.

Participants frequently spoke about boundary-setting with clients with BPD. This can be followed through with further research, which may influence the training modality at universities to include more engagement and training around boundaries. Being more aware of these common themes can therefore allow for students to be more adequately prepared. This further speaks to the need for more in-depth training and knowledge regarding this specific population. Doing so may build confidence, which alters the frame of reference of BPD for the students, not viewing them as “difficult” from the onset without having any experience with them.

5.2 Limitations of the study

In addition to the above mentioned, the following limitations of the study were identified. Firstly, the study did not highlight in detail the possible difference(s) in experience between novice and more experienced participants. This would have required further in-depth interviewing and analysis. A distinction of this may have provided a deeper understanding of the impact of experience on the

conceptualisation, management and coping strategies utilised by the participants. Secondly, this study did not account for gender differences in participants' experiences. More specifically, the experiences of male and female participants were not distinguished. There may have been possible correspondence between a specific gender and their interaction with the patient. In extension, various factors attached to this, for example perceived power by the client associated with a specific gender and cultural beliefs and/or norms pertaining to gender could have been explored. This is pertinent within the South African context given the variety of cultures present.

Further, the study did not include other factors into the analysis, which may have been influencing the participant's experiences. Examples of this include, but are not limited to the participant's family life, living arrangements or financial situation. These factors may influence the experience of stress and strain or might even exemplify these when working with clients. These factors however, were not probed for and it was therefore assumed that the participant had experienced these patients without significant influence by these factors.

In addition, many participants had reported further training as important for the management and understanding of the client with BPD. It would have been useful to explore this further, to gain an understanding of what training the participant has received and what training they would perceive as useful. For example, theoretical or practical training, as such understanding the aetiology of BPD, or a focus on case management.

5.3 Recommendations for working with difficult clients and suggestions for future research

Based on the findings of the study, the following recommendations for working with difficult clients are suggested. Firstly, clinic psychologists need to be provided with an appropriate platform through which they can express, discuss and find mutually beneficial solutions to working with clients with BPD. It is suggested that "therapeutic support groups", which locate their focus on exploring both academic developments within the BPD field as well as explore personal therapeutic experiences be pursued.

This will provide the therapist with: (1) a feeling of community of belonging, which could assist in the reduction of stress; (2) a space to share experiences and to gain insights; (3) to debrief and receive peer support and (4) continuously learn about BPD. This can be carried further and tested with research into the effectiveness of psycho-social support networks for clinical psychologists working with clients with BPD.

In addition, exploring the specific characteristics associated with non-stigmatising attitudes in clinicians towards BPD could result in a deeper understanding of who works best with this population. Specifically, the training of clinical psychologists during their internships should be tailored to identify those training psychologists who may have a leaning towards working with clients with BPD.

It is interesting that the participants of the study reflected some stereotypes of clients with BPD. Further investigations into the stereotypes that clinical psychologists have working with difficult clients in general may yield deeper insight to clients that are considered difficult to work with. This understanding, if carried out in the South African context will make therapeutic work more meaningful as the appropriate intervention strategies can be put in place to support the therapists.

South Africa is a country characterised by diversity of cultures, religions and ethnicities. As such, the expression of BPD symptoms may be different in differing contexts. Further research should be conducted into the impact of culture, religion and ethnicity on the therapeutic relationship, specifically working with clients with BPD. These cultural aspects may influence the expression of stress and burnout and it is therefore important to understand. Tied to this is the therapists understanding of that specific culture. That knowledge base or displaying a genuine curiosity invites the therapist into the client's world. This introduced worldview could aid the clinician in making meaning if the client's presentation that resonates more soundly with the client, thereby resultantly impacting on the therapeutic relationship as well.

Gender is a factor that must be investigated further, as it may influence the way in which therapists interpret the expression of symptoms being presented. For example, do therapists treat male and female clients with BPD in the same way, if they are expressing the same symptoms? It is likely that gender power dynamics may influence the therapeutic relationship and this understanding is vital and needs to be a future research priority.

Generally, mental illnesses have been stigmatised throughout the ages and despite the advances that have been made, at academic, institutional and social levels, there is still much need for advocacy for the rights of individuals with mental illnesses. However, with the focus of advocacy on the client, we often neglect the practitioners' needs even though they provide invaluable services to individuals, families and communities at large.

In South Africa, it is known, that more clinical psychologists are required to meet the mental health needs of population. However, due to the limited training resources available, psychology has not produced enough practitioners to cope with the rising psychological problems in the society. Therefore there are more demands placed on the clinical psychologist to service a greater population. This is hypothesised to create additional pressure and stress. The discipline of psychology therefore needs to explore the impact of the limited training resources and government or reduced fee services on the stress and burden on clinical psychologists.

As far as a sound theoretical and academic knowledge base is imperative, the therapist should not neglect the self. Self-care is vital in that overlooking the therapist's own needs, may be the accelerant towards stress and burnout. Leisure activities, as mentioned by the participants in this study, are therefore fundamental to keep alert and focused on both the client and one's self.

In conclusion, this study explored clinical psychologists' experience working with clients with BPD. The study found that participants indicated a thorough, working theoretical knowledge base of BPD as well as indicated an understanding of the difficulties that are presented by the arrangement of the symptoms typical of the disorder. The perception of clients with BPD as being difficult was based on a combination of experience working with clients as well as what they have heard

through their training and interactions with colleagues.

The study also found that participants manage BPD through understanding of the nature of the disorder, rather than a reflection on the person. However, the shifting nature of the therapeutic relationship causes stress and strain. The participants also indicated that formal and informal supervision as well as further training focused specifically on dynamics of BPD was useful in the management of these clients. In addition to this, leisure and sporting activities on a more personal level were also found to assist them to cope with clients with BPD. The management thereof was found to be specific to the individual clinician.

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Appendix A – Ethical clearance certificate

UNISA university of south africa
Department of Psychology

Ethical Clearance for M/D students: Research on human participants

The Ethics Committee of the Department of Psychology at Unisa has evaluated this research proposal for a Higher Degree in Psychology in light of appropriate ethical requirements, with special reference to the requirements of the Code of Conduct for Psychologists of the HPCSA and the Unisa Policy on Research Ethics.

Student Name: Veren Gyapersad **Student no.** 48414271

Supervisor: Christine Laidlaw **Affiliation:** Dept. of Psychology, Unisa

Title of project:

Exploring how clinical psychologists conceptualise, manage and personally cope with "difficult" clients presenting with personality disorders

The proposal was evaluated for adherence to appropriate ethical standards as required by the Psychology Department of Unisa. The application was approved by the Ethics Committee of the Department of Psychology on the understanding that –

- All necessary permission regarding the protection of privacy of the participants and confidentiality of the information as stipulated in the ethics form will be met to the satisfaction of the supervisor. If further counseling is required in some cases, the participants will be referred to appropriate counseling services.

Signed:

Prof. M Papaikonomou

Date: 2014/11/24

[For the Ethics Committee]
[Department of Psychology, Unisa]

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Psychology Department Ethics Review Committee. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*
3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

Appendix B – Information letter to participant

Dear Potential Participant,

My name is Veren Gyapersad and I am currently completing a research study in part fulfilment of my Masters degree in Clinical Psychology at the University of South Africa. The research which I am conducting aims to explore how clinical psychologists conceptualise and manage "difficult" clients presenting with Borderline Personality Disorder, as well as how the psychotherapist personally manages having dealt with these clients.

All participants in this study will be anonymous and no personal or identifiable information will be divulged to a third party. In order to collect information, an interview will take place at your convenience of approximately one hour. During the interview, you have the option to refuse to answer any questions which you do not feel comfortable answering. You may also withdraw from the study if you wish to do so which will have no negative consequences to you.

The interview will also be recorded. The recording will be used to accurately transcribe the interview without losing information. After it is transcribed, the recordings will be stored safely for five years and then deleted. The transcriptions will be labelled with pseudonyms so as to protect your identity and no identifiable information will be present. If you wish to have access to the study, this will be available on UNISA's institutional repository online.

Please note that you are not forced to participate in this study in any way. If you have any questions, concerns or queries, please do not hesitate to direct them to me in person or via e-mail. In order to proceed with the interviews, it is required to first obtain your informed consent.

Kind Regards,

Veren Gyapersad (Researcher)
E-mail: vgyapersad@gmail.com

Christine Laidlaw (Supervisor)
E-mail: laidlc@unisa.ac.za

Appendix C – Informed consent

Dear Participant,

I volunteer to participate in a research project conducted by Veren Gyapersad from the University of South Africa. I understand that the study is designed to gather information about clinical psychologists dealing with "difficult" clients presenting with Borderline Personality Disorder.

1. My participation in this project is voluntary. I may withdraw and discontinue participation at any time without penalty.
2. I understand that if I feel uncomfortable in any way during the interview session, I have the right to decline to answer any question or to end the interview.
3. Participation involves being interviewed. The interview will last approximately 60 minutes. Notes will be written during the interview. The interview will also be audio-recorded. From these recordings, the information will be transcribed verbatim. The recordings are done so as to ensure accurate information is transcribed. Any identifiable information which may breach confidentiality or anonymity will be changed when transcribing.
4. I understand that the researcher will not identify me by name in any reports using information obtained from this interview, and that my confidentiality as a participant in this study will remain secure.
5. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction.
6. Your signature below indicates that you understand and consent to the above conditions.

Kind Regards,

_____ Signature of Participant:_____

Veren Gyapersad (Researcher) Name of Participant:_____

E-mail: vgyapersad@gmail.com Date:_____

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Appendix D – Semi-structured questionnaire

1. How long have you been practising as a clinical psychologist? (Hinchey & Jackson, 2011).

2. What would you regard as a "difficult" client, more specifically in terms of those with Borderline Personality Disorder? (Adler, 2006; Koekkoek et al., 2006; Quinn, 2008).

3. From personal experience, when you hear that a client has a diagnosis of Borderline Personality Disorder, what effect, if any, does this have on you? (Aviram et al., 2006).

3.1. What are your impressions of the client?

4. What have been your general experiences with these clients? (An et al., 2009; Little et al., 2010).

4.1. Are these clients actively avoided / sought?

4.2. Are there any stereotypes, either personally constructed or general regarding these clients? If so, what are they?

4.3. Are clients resistant to therapy?

5. Has suicidal behaviour and self-mutilating behaviour been a common theme with these clients? (Aviram et al., 2006; Krawitz, 2004).

5.1. If not, are there any common dominant themes which these clients present with?

5.2. If it is, to what degree are they present? (mild forms – very severe?)

5.3. How have you dealt with this?

6. Do you think these clients receive the same quality of service as other clients? (Wilson, 2005).

6.1. Do you think your therapy sessions are different with these clients?

6.2. If they are, in what way?

6.3. Do you specifically approach these clients in a different way in therapy?

7. What consequences do you think being perceived as "difficult" has, if any, within the therapeutic context? (Aviram et al., 2006).

8. How do you manage these kinds of clients? (Elder et al., 2006).

9. What are the impacts of these kinds of clients on you? (Aviram et al., 2006).

9.1. Or what effect do these clients have on you, if any?

10. Having dealt with difficult clients, how do you personally cope? (Davidtz, 2007).

Appendix E – Confidentiality agreement

I, Kajal Haripersad, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentations received from Veren Gyapersad related to his research study on the researcher study. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents.

2. To not make copies of any audiotapes or computerised titles of the transcribed interviews texts, unless specifically requested to do so by the researcher.

3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession.

4. To return all audiotapes and study-related materials to Veren Gyapersad in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.

I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name: Kajal Haripersad

Transcriber's signature: 

Date: 20/03/2015

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Appendix F: Diagnostic criteria – Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.