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Hear Us! Seven Women Diagnosed With Borderline Personality Disorder Describe What They Need From Their Therapy Relationships

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The purpose of my dissertation project was to explore the interpersonal therapy experiences of seven female participants diagnosed with borderline personality disorder (BPD) using a phenomenological approach with participants' narratives as the primary data source. Data was gathered from individual interviews, administration of the core conflictual relationship theme-relationship anecdotes paradigm interview (CCRT-RAP; Luborsky, 1990), and relational space mapping (Josselson, 1996). The analysis involved a back-and-forth process whereby I moved between the developmental information, identified interpersonal patterns, described therapy experiences, and my own reflections. Immersion with the material was ongoing and allowed themes to be modified and elaborated. Results are described in a manner intended to illustrate the benefits of a phenomenological approach that relied heavily on participants' voices and allowed for continual reflection on the material and deepening of meaning. As a group, the seven participants desired therapists who demonstrated caring and kindness and who joined them in their experiences through a deep form of listening and validation. These conditions were necessary but not adequate for the development of a healing alliance. Participants also desired clinicians who maintained a collaborative approach, balancing strength with flexibility, and who were willing to address conflicts and tensions head-on. Therapist neutrality, withholding, and inactivity were experienced as aversive and participants expressed a desire for explicit evidence of clinician humanity. The value of the qualitative approach for accessing the complex and vacillating therapy relationship needs of this patient group is discussed.

Keywords: borderline personality disorder therapy relationships, qualitative research on borderline personality disorder, borderline personality disorder voices of patients, phenomenological study of borderline personality disorder, psychotherapy relationships

The intent of my dissertation (Goldstein, 2014) was to take a phenomenological approach to understanding how patients diagnosed with borderline personality disorder (BPD) experience their interpersonal relationships with mental health professionals. The particular focus of the project was the nature and quality of patients' interactions with clinicians (e.g., psychologists, psychiatrists, social workers, psychiatric nurses, group therapists) while receiving services in various settings (e.g., individual psychotherapy, psychiatric emergency rooms, inpatient units, outpatient clinics, consultation sessions). Within that topic I was especially interested in learning about the specific interpersonal contexts in which relational patterns were enacted and the types of interactions with mental health staff that were perceived by patients as helpful or hurtful. The idea for the project was born from a desire to understand the tensions that develop between individuals who carry a BPD diagnosis and the clinicians who treat them. This interest grew over the course of

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several years, first while working as a masters-level clinician in a psychiatric hospital and later as a doctoral candidate training in various clinical settings. In direct and less direct communications, I learned from supervisors and other clinicians that working with individuals who carry a BPD diagnosis was far more difficult than working with any other diagnostic group. Specifically, that you must be prepared to establish airtight boundaries and to keep countertransference reactions, which will be strong, in check. That, in fact, the safest strategy was probably to maintain emotional distance from the start as only the most skilled clinicians would be able to avoid being pulled into the patients' web. I often heard seasoned therapists state that they were unwilling or unable to treat a patient with this diagnosis. As a training clinician I assumed these refusals came from a place of wisdom. Implicit in these warnings was an assumption about the source of the inevitable tensions that developed in these relationships; the responsibility, it seemed, landed largely on the patients' shoulders.

When I was later positioned in the role of intake coordinator for an intensive outpatient program for the treatment of personality disorders, I learned that those on the receiving end of therapy were also deeply troubled by their interactions and relationships with clinicians. Clinician refusals to treat, abrupt abandonments, pejorative or blaming language, boundary violations, dismissiveness, and inappropriate expressions of anger were some of the experiences patients recalled about their previous treatment encounters. Indeed, it seemed the dissatisfactions and frustrations were mutually felt. I considered the bind these patients must find themselves in: if their reputation for sensitivity to rejection and emotional neediness precedes them, then their complaints of feeling rejected or invalidated may be met by clinicians with further dismissals, thus, escalating feelings of isolation. For clinicians, there is also a bind: how to be a therapeutic presence while maintaining the firm boundaries that are seemingly crucial for effective treatment.

An initial review of the literature supported my impression that the relationships between individuals diagnosed with BPD and the clinicians who treat them are fraught with struggle on both sides and far beyond what might typically be expected in therapy (Fallon, 2003; Müller & Poggenpoel, 1996; Nehls, 1999). This seemed especially problematic, given the potential for countertherapeutic effects with a patient population whose diagnosis is, in part, defined by intense and tortured reactions to interpersonal stressors. The research also supported the idea that these troubled therapy relationships take a toll on staff attitudes toward and experiences of this patient group (Angell, Cooke, & Kovac, 2005; Bourke & Grenyer, 2010; Cleary, Siegfried, & Walter, 2002; Treloar, 2009). Servais and Saunders (2007) suggest that clinicians who hold negative attitudes toward BPD patients may have difficulty experiencing empathic caring and/or expressing hope for their recovery, and may even encourage stigmatization, thereby discouraging further treatment seeking. Aviram, Brodsky, and Stanley (2006) note that mental health clinicians who perceive BPD patients to be more difficult, manipulative, and attention seeking than those with other diagnoses may be less tolerant and less engaged with them. A survey conducted by Cleary et al. (2002) in Sydney, Australia found that 95% of mental health staff would welcome additional training and education on how to better manage and treat patients with borderline personality traits. Not surprisingly, BPD has historically been associated with low treatment completion rates (Barnicot, Katsakou, Marougka, & Priebe, 2011). It seemed essential that the troubled relationship between individuals with borderline traits and symptoms and the clinicians who treat them be better understood.

The literature touching on the subject of therapy relationships in the treatment of individuals diagnosed with BPD lacked direct connection with patients' experiences of therapy and their therapists. Most studies of therapist relationships with this population relied primarily on clinician reports and only rarely included the voices of BPD-diagnosed patients (Nehls, 1999; Perseius, Ekdahl, Asberg, & Samuelsson, 2005). This seemed especially problematic, given the dyadic nature of the issue and the interpersonal sensitivity that largely defines BPD symptomology. Even in cases of the most severe borderline pathology, primitive defenses that make up destructive interpersonal patterns do not emerge in every relationship context or to the same degree (Clarkin, Yeomans, & Kernberg, 2006; Westen, 1990). Research efforts that only identify maladaptive interpersonal

styles demonstrated by patients with borderline traits and symptoms have limited utility for addressing a problem that is relationally based.

I was interested in exploring the subjective interpersonal treatment experiences of patients through their own narrative accounts and the actual external and internal conditions that activate pathology. For the study I wanted a means of exploration that would do more than name participants' experiences. I was seeking to understand the feelings that transpire in the relational space between therapist and client and the meaning given by patients to the seemingly small moments that make up these relationships. Thus, it was important that patients' voices served as the primary data source for the project. A narrative approach was chosen for its potential to glean material of enough depth and detail that the research question could reasonably be addressed. Though I hoped by using a qualitative approach that I would get a more complete picture of each participant's therapy experiences, the information I was able to access exceeded these expectations. The purpose of this article is to highlight some of the findings from this project and to illustrate how qualitative methods created opportunities for finding meaning and, in some cases, transformed the overall essence of what was learned.

The Research Project

The seven women interviewed for the study responded to a recruitment poster displayed in common areas of local mental health clinics, community centers, or university counseling centers. Table 1 provides a basic demographic profile of each participant. The criteria for participation in the study included having received a diagnosis of BPD from a clinician, having sought therapy or treatment for BPD or BPD-related problems within the last 5 years, having at least three treatment or therapy encounters, and a willingness to share with some depth one's experiences of their therapy relationships. In all but one case, treatment histories included significantly more than three treatment encounters. Relationships with clinicians ranged in duration from very brief (e.g., a 1-time meeting with an inpatient psychiatrist) to relatively long (e.g., a 5-year relationship with an individual psychotherapist).

I conducted all of the in-person interviews which were completed in single meetings and varied in length from just over one hour to nearly two and a half hours. The interview consisted of three parts: an introductory interview, administration of the core conflictual relationship theme-relationship anecdotes paradigm (CCRT-RAP) method (Luborsky, 1990), and relational space mapping (Josselson, 1996). The introductory interview was loosely structured and meant to help me develop some familiarity with the participant as a person, her developmental history and her experiential history of being diagnosed and treated for BPD. Example prompts included, "What has this diagnosis meant to you?", "What are some of your thoughts and feelings when you reflect back on your treatment experiences?" and "How has being diagnosed with borderline personality disorder affected the way you view yourself?"

The relationship anecdotes paradigm (RAP) is an interview form of the CCRT (Luborsky, 1990) designed to yield a qualitative picture of individuals' recurrent central relationship patterns and themes through analysis of relationship events (REs) with others (e.g., family members, friends, coworkers, strangers) as de-

Table 1
Participants' Basic Demographics

Name	Age	Ethnicity/race	Marital status	Education	Occupation
Judith	43	Asian American	Divorced, remarried	Masters	Grad student
Arielle	33	Caucasian	Married	JD	Attorney
Beth	36	Asian American	Divorced, remarried	Bachelors	Realtor
Tanya	29	Caucasian	Single	MSW	Vet assistant
Jessie	28	Caucasian	Single	Masters	SAT tutor
Raina	32	Caucasian	Single	Some college	College student
Karen	45	Caucasian	Divorced 2×, single	Bachelors	Unemployed

Note. All names have been changed.

scribed by the interviewee. An adaptation of Josselson's (1996) relational space mapping method provided an additional opportunity to learn about how each participant experienced their relationships with individual clinicians. Participants were asked to map their past and current clinicians on paper according to the impact that person had on them. Once drawn, we reviewed the map together as I encouraged participants to describe exactly how each clinician impacted them and, if possible, to provide illustrative examples.

Data Analysis

Synthesis of the interview material. Analysis of the interview material began immediately upon leaving each participant and continued until completion of the analysis several months later. The initial phase of the analysis began with written reflections on my experience of sitting with each of the participants. I began with general observations of each participant's appearance, behavior, narrative style, and affect during the interview, and then focused on my emotional reactions and my perception of the quality of the rapport between us. To the extent that it was possible, I attempted to reflect on how my own emotional reactivity and interpersonal style may have impacted the quality of the interviewer-interviewee dynamic, the information generated, and the participants' overall experience. I attempted also to consider the power dynamics between myself and the participants and what it might be like to be the object of interest in a study about people with a particularly stigmatized mental disorder. A more complete discussion of the reflexive analysis can be found in a previous article (Goldstein, 2017).

Analysis of the transcribed material continued with repeated readings of the interviews. Initially, I read without an agenda and simply to gain familiarity with the material. Participants typically offered autobiographical information that helped me to place the participant within a developmental context. With repeated readings, I was able to begin to consider how autobiographical information was connected to the participants' relational experiences and patterns. During several readings of the transcribed interviews, I attended particularly to participants' developmental experiences of their families. Several readings were dedicated to seeking parts of the narrative that relayed something about the participants' experiences of being diagnosed with and treated for BPD and its' meaning to them. I began developing very tentative hypotheses about the participant's developmental experiences, relational patterns, orientation to her BPD diagnosis, and the meaning or source of any interpersonal difficulties with clinicians or frustrations with treatment.

In addition to analyzing the narrative content, I followed established approaches to narrative analysis that emphasize consideration of the narrative process. This involved looking for some of the qualities that signify meaningful points in narratives such as, frequency, emphasis, primacy (Schultz, 2002) and use of details and linguistic devices to structure stories (Riessman, 2000). Emphasis on a story or theme within the narrative was noted according to relative time spent in the telling, primacy of content, repetition, intensity of emotions expressed, volume changes, affect changes (e.g., laughing, crying, anxiety), amount of detail, and verbal emphasis (e.g., use of hyperbolic language). Defensive avoidance or shutting down around particular topics was also considered a possible signifier of meaning.

I was guided, in part, by the approach to analysis proposed by Lieblich, Zilber, and Tuval-Mashiach (2008). The authors suggest attending to how narrators describe their own and others' agency (i.e., power, influence), the impact of serendipity (i.e., that which is not within their control), the role of cultural structures on personal events, and the integration of these factors. In this vein, narratives are considered inherently subjective and, in fact, meaningful, precisely because they are constructed and interpreted within both immediate and historical social contexts (Lieblich et al., 2008; Riessman, 2000). Thus, attempts to identify the objective reality of participants' portrayals of events were not part of the analytic process. Rather, I paid special attention to how participants communicated their identities and roles within their stories. For instance, I considered how participants positioned themselves in relation to others (e.g., passive or active), how they described their own and others' degree of role flexibility, and to whom they attributed power (Riessman, 2000).

Scoring the CCRT-RAP interview. I began analysis of the CCRT-RAP interviews by reading through each several times then identi-

fying and numbering each of the 10 REs, and identifying parts of each RE that denoted either a wish, need, intention (W); response from the other person (RO); or, response of the self (RS). The 10 REs identified in each interview were scored four times—twice using the Edition 2 standard categories and twice using unique categories and subcategories created from participant narratives. With the tailor-made scoring system there are no predetermined categories; rather categories are generated from the narrative material of each interviewee (Luborsky, Barber, Schaffer, & Cacciola, 1990). I initiated use of the tailor-made scoring system in an exploratory manner and found that this method vastly improved the quality of the data. The most frequently identified W, RO, and RS categories were then combined to create a written statement that represented the individual's core relationship conflict(s).

Analysis of the relational space maps. Over the course of several readings of the transcribed relational space map interviews I attempted to identify the quality of each described relationship and to develop an understanding of why and how that relationship impacted the participant. With each successive reading, I looked for details or descriptions that illustrated how each relationship was experienced by the participant and both the immediate and lasting effects it may have had. As I did with the introductory interview material, I again considered how participants used detail, emotional emphasis, primacy, repetition, and other discursive elements to structure their narratives. As a final step, I considered the narrative methods used by each participant (as described above) to relay her sense of positioning and power within the larger social context. To make this information more manageable for later analysis, I made margin notes to describe the quality and impact of each relationship discussed by the participant along with my reactions as a listener.

Identification of themes. Several readings of the transcribed interviews were dedicated to identifying important themes. Themes were expressed thoughts, feelings or experiences that I perceived to contribute significantly to my ability to understand the participant and her experiences. Once all themes were identified, broader topic categories were created in order to organize the information. All themes were placed under one of the following topics: developmental and family history, experience of BPD diagnosis, experiences seeking treatment and in treatment, what is needed from clinicians, relationship experiences, response to the study, and a miscellaneous category for themes that did not fit elsewhere. Theme lists were created for each participant separately and then combined to create a master theme list for the group as a whole. From the master theme list, a chart was created to identify the participants who endorsed each theme and the overall frequency of theme endorsement within the group.

Approach to the Analysis

The data were analyzed in two phases. The first phase was focused on formulating psychobiographical hypotheses "within subjects." My general inquiry during this phase was guided by an interest in how the information gathered in the three parts of the interview was related. In particular, I searched for any meaningful connections between the participant's core interpersonal patterns and conflicts as determined from the CCRT-RAP interview results and their narratives of their in-treatment relationships. I also considered each participant's interpersonal treatment experiences within the context of their interpersonal histories and overall orientation to having a BPD diagnosis. Lastly, I attempted to integrate my interpersonal reactions to the participants into broader developmental and interpersonal themes culled from each narrative.

In the second phase of the analysis, I looked "between subjects" for common themes and patterns of experience among the participants as a group. I looked for similarities among participants' described experiences of their treatment relationships and the impact of these relationships, and of their thoughts and feelings about having a BPD diagnosis. Signs of shared experience may be found not only in narrative content but also in how participants express their thoughts and feelings during the interviews, what aspects of experience are emphasized or de-emphasized, and my own reactions during the interview and in the analysis phase.

Though the following discussion will focus primarily on findings from the second phase in which common themes among participants were considered, my ability to find meaning in the group results relied largely on my awareness

of the participant-specific material. In other words, even when considering the group as a whole, participants' unique histories and interpersonal patterns contributed substantially to hypothesis formation.

The Findings: Participants' Relationship Needs in Therapy

Not surprisingly, the seven participants in this study echoed the views of other samples of psychotherapy clients who have been asked about their experience of the therapy relationship (Frank & Frank, 1991). In broad terms, they desired clinicians who listen well, attempt to understand and validate feelings, are active in the helping process, and exhibit caring and compassion. Though the participants endorsed several of the nonspecific factors that are widely acknowledged as contributing to positive therapeutic alliances and treatment outcomes (Norcross & Wampold, 2011), their unique descriptions of their experiences understood within the larger context of the phenomenological material gathered allowed for a more satisfying and complete picture of what was actually desired. At times, it seemed as if I was not honing in on a thing (e.g., an empathic therapist) but rather a feeling (e.g., "being with me").

Table 2 summarizes some of the factors participants explicitly stated that they appreciated in past or current therapists or desired from future therapists. Some highlights from the table are as follows: All but one participant (Arielle) expressed a desire for a therapist who really listens and is understanding, who is empathic but strong, and who is kind and caring. All but one participant (Jessie) explicitly stated a preference for a therapist who is active and interactive versus neutral and/or passive. All but two participants (Arielle and Beth) stated that she wished for a therapist who would validate her experiences. Four participants expressed a need for a therapist who is knowledgeable about BPD, in particular, and four participants expressed a wish for a therapist whom they felt was on their side. Though these basic needs are helpful, several are too vague (e.g., to know and understand me, to be strong and empathic, to really listen) to meaningfully inform practice. In the following sections I will attempt to elaborate on some of the themes and bring them to life using the participants' own words and, when useful, my own reflections on my experiences with each participant. I also hope to illustrate how a phenomenological approach supported my engagement with the material and was essential for preserving some of the complexity of the subject matter.

To Be Seen and Heard

Several participants were immensely passionate in their expressions of desire to be heard and validated. When considered within their individual historical contexts, it seemed that the emphatic nature of these statements was propelled by profound or repeated experiences of

Table 2
What I Need From Therapists by Participant

What I need from my therapist(s)	Judith	Arielle	Beth	Tanya	Jessie	Raina	Karen
To know and understand me	X		X	X	X	X	X
To be on my side	X				X	X	X
To be interactive/active	X	X	X	X		X	X
To be strong and empathic	X		X	X	X	X	X
To be kind/caring	X		X	X	X	X	X
To really listen	X		X	X	X	X	X
To be knowledgeable about BPD	X			X		X	X
To avoid dredging up the past		X				X	
To give me control		X					
To tell procedures up front				X		X	
To be genuine	X						X
To validate my experience	X			X	X	X	X

Note. Participants were marked as endorsing a particular theme if they made explicit statements of endorsement. The absence of a marking does not indicate disagreement with an idea or experience but may simply mean the participant did not self-generate a comment on the matter. BPD = borderline personality disorder.

feeling dismissed, unheard, and misunderstood by clinicians and by others. In some cases, statements of participants' desires to be heard felt much like pleas:

- "Hear us, hear us!" (Karen)
- "I don't mean listening like here {signals to her ears}. I mean listening with your mind and with your heart." (Karen)
- "We don't want to be invisible to our therapists and to the mental health field." (Karen)
- "She (a social worker) wouldn't listen to me . . . I started screaming and yelling at her. 'Cause, like, you're not listening to me, I'm trying to be nice to you and I finally like slammed her door." (Tanya)
- "He (her therapist) doesn't want to hear about the reasons for anything." (Judith)

Logically, most people who seek help through mental health services will have an expectation of being heard by their clinicians. And for many, psychotherapy offers a new and uniquely gratifying experience of feeling heard. Still, the participants in this study seemed particularly impassioned around the need to be heard. For them, being heard carried a special meaning. It felt as if everything depended on being heard or, conversely, as if not being heard (yet again and by someone who is supposed to listen and care), had the power to devastate. While the participants, and more broadly, individuals with borderline pathology are not necessarily different than the typical patient or client in this way, they may be somewhat unique in their interpretation and reaction to experiences of having this expectation met or frustrated.

It is well established that individuals diagnosed with BPD often present with a developmental history marked by chronic and/or dramatic experiences of invalidation (Linehan, 1993; Selby, Braithwaite, Joiner, & Fincham, 2008). Thus, feeling unheard may carry idiosyncratic meanings embedded in significant events or associations from one's developmental history. These meanings (e.g., that one is worthless, powerless, alone) may be strongly paired with secondary emotional responses of anger, rage, rejection, and sadness and may even trigger defensive behavioral reactions (Linehan, 1993). Indeed, some of the participants seemed to find being unheard not just irritating or disappointing, but intolerable. Tanya's response to feeling unheard by a social worker at an intensive outpatient program was to quit the program and never return. And, when Beth felt that hospital staff failed to listen and understand her request to be discharged, she responded by cutting her wrist with a broken credit card.

Raina's experiences of feeling silenced in sessions with various psychiatrists were reminiscent of her experiences of feeling silenced in her family. Her narrative and CCRT-RAP interview were filled with interpersonal events marked by dismissals and rejections that reinforced her otherness. She described feeling that others had very limited time for her or cut her off before she had the chance to express her thoughts and feelings in a satisfying way. With her family, she suspected they were abrupt because she is "not good enough to talk to." Raina perceived psychiatrists as similarly aloof and disinterested due to their superior position. Here she describes what it felt like to be voiceless during a meeting with a psychiatrist:

Raina:	Because they give you five minutes of their time to try and diagnose you or whatever and that's not cool.
Psychiatrist:	Was someone trying to say you cannot have a sleeping aid?
Raina:	I couldn't even get that out, you know. Because I had to sit there and wait for an hour, then by the time I see the person, then I tell him I really do not want to take medication. And then he gave me Wellbutrin, it's like, you're not hearing what I'm saying . . . And I do not really have the skills and the tools to speak in their language. It's frustrating because here's some person who has all this medical schooling.

In this scenario, the psychiatrist's failure to listen (as evidenced by giving her Wellbutrin) signaled familiar feelings of being unworthy.

She is not good enough for her family and she is not good enough for the psychiatrist.

Judith's experiences of feeling invalidated by her mother seemed to have had significant bearing on her experiences of feeling unheard or dismissed in therapy encounters. Like for Karen, Judith describes real listening as an activity that is not passive (or, done "with one's ears," as she says) but active and intrinsically tied to therapist caring:

> They give you the time, try to listen to what you're saying and they try to see it. Instead of just, okay, I heard it fine, move on, they actually do try to process it . . . And, maybe they cannot really accommodate whatever you're asking, at least you feel like you have someone by your side for a moment. You feel like they are with you emotionally for a while.

Real listening, thus, has an emotional component wherein two people are joined in an experience. When it happens, Judith feels connected, cared for, and understood. The gap between her and the other seems to close, a feeling of aloneness and separation may be relieved if only momentarily. Karen's described experience of feeling joined with a past therapist is incredibly similar to what Judith describes:

> She always said, I'm in it with you, Kare. For the 50 minutes that I'm here I am here with you, up against them, remember that. So, it, it was not like she just said, okay your mother made you upset, and analyzing. It was more about *sharing my experience*. Walking with me in my shoes, or walking aside, side to side with me.

Something is understood between Karen and her therapist beyond the content of the words. Though not quite spoken, an essential component of this type of understanding may be an implicit and deep form of validation. In what Karen calls "side-to-side" understanding, the therapist does not simply accept that the experience described is the experience had by the other. Rather, she may imagine experiencing the described conditions as if she were the other and implicitly agrees that the thoughts and feelings of the other under these conditions are reasonable and just. Indeed, having one's subjective mental state understood is likely to be experienced as deeply validating (Porr, 2010). And, while the therapist may encourage exploration of the assumptions that led to a feeling, the core message remains—you are okay, I not only get that this was *your* experience, I understand what it was like to be in your shoes and, in your shoes, I might feel the same. I understood these moments of joining as described by participants as neither a therapy skill nor a therapist trait per se but an experience between two people.

Judith provides an example of when use of a basic listening skill had a countertherapeutic effect that escalated her distress and feelings of isolation. It occurred when she entered a therapy session upset about an intense argument she had just had with her husband. Perhaps in an attempt to name her feeling or reflect back her experience the therapist tells Judith she is "enraged." But instead of feeling understood in this moment, the therapist's observation conjures a scenario that she experienced painfully throughout her childhood: she is complaining and making a fuss when, according to those around her, there is nothing to be upset about. Judith says, "It's like somebody stabbed me and I'm bleeding but everyone else is like why can't you be functioning like all the normal people? Without asking questions, you know, *why* are you bleeding?" Unknowingly, he has aligned himself with others in her life, past or present, who did not want to understand her feelings, who wanted to deny their validity, who wanted her to act as if everything is fine like the rest of us. She says, "And when the therapist said, you're enraged, all of the sudden I feel so alone . . . I'm abnormal."

Each participant in this study described experiencing herself from an early age as an outsider who was abnormally, even defectively, emotionally sensitive. For every participant, the natural yearning to feel understood had been met with various forms of inattention. Several participants seemed to be in a constant state of struggle to relieve chronic feelings of deprivation from inattention and, thus, used various methods to engender attentiveness by others. Tanya insightfully acknowledged that her suicide attempts and self-injury were desperate efforts to elicit attention. Jessie, fearful of being overshadowed by others in her dialectical behavior therapy (DBT) group (as she had been by a younger sibling in childhood), creates conflict that required special focus from the group leader. A web cam allows Raina, who did online sex work at the time of the interview, to be seen by others and, perhaps, connected her to earlier feelings of being valued through her sexuality. Karen draped herself in "all this dreck" and

"accouterment" (heavy makeup, jewelry, colorful clothing) ensuring others would attend to her visually. And, Arielle looked to a "doting" exboyfriend to fill in for her much less attentive husband. It occurs to me how easily misunderstood each of these examples might be without the benefit of a relational context to provide meaning.

Several participants spoke of battling feelings of invisibility throughout childhood. Being seen as special in the eyes of others was particularly important to Jessie and Karen. Each felt their unique value had escaped at least one parent (Jessie's father and Karen's mother). As adults they seemed to pull for responses from others that might challenge the tenacious messages of their insignificance from their earlier life. I came to understand more fully the importance of standing out for Karen when she asked at the close of our meeting, "Hey, is this the best interview?" Reflecting on my desire to reassure her that indeed it was the best interview brought me closer to understanding Karen as an individual and in relation to others, including her therapists. It also provided a subtle but enduring experiential lesson on how my own needs respond to the needs of another (i.e., her desire to be special spoke to my desire to be gratifying).

To Bear Witness

Fears of being inaccurately seen were also prominent among participants and some made special efforts to prevent therapists' misinterpretations. In some cases, this included calling upon therapists to serve as witnesses. After an argument with her husband, Judith feels adamant that her therapist bear witness to her interactions with her husband:

> Yeah, first of all I knock on his door, I said, we just had a big fight, is it possible to bring my husband in to the session today. He was very hesitant and he basically, he closed the door and talked with me for, I do not know how long, basically telling me why we shouldn't do that. And, so I explained to him that I really wanted him to hear both sides of the story and, also, I feel like I cannot talk to my husband right now. The only thing I want to do is to fight with him but I do not want to fight. But with you here I can talk with him indirectly. And, I thought I made it pretty, I said I'm not asking you to dispense any advice I just want to help you understand who I am. He was just not very accommodating at all and finally he says, if you insist, I'll do that.

Judith, like several or all of the participants, seems to have integrated messages that she is manipulative and untrustworthy; consequently, she has come to understand that her words are not enough—she must prove that her feelings are valid. Though Judith's therapist eventually agrees to allow her husband in the session, Judith experiences this as appeasement not validation. Her hope that witnessing the marital relationship will bring her therapist closer to understanding is not fulfilled. From Judith's perspective he did not see the value in serving as a witness and this leads Judith to question if she will return.

Karen tells me she always requests that a new therapist meet her mother, not for the purpose of family therapy but simply to gain vital information about Karen's experience: "I always bring her there so they see who we're dealing with. It's very important for me. It's so you see who she is." By allowing this, Karen's most recent therapist, Allison, was able to serve as witness to a young Karen's pain and confusion and to speak in defense of the helpless 3-year-old she once was:

> My mother would say to her, you know, Karen was a very bad little, 3-year-old. She {Allison} would say, {Karen's mother's name}, there's no bad 3-year-olds but there's 3-year-olds with bad parents. So, all that information. She got so much. It made a difference.

Karen goes on to describe just how Allison joined her:

> Allison made me feel not invisible. When I would come in very, very upset to her, she would want to know what happened, what did my mother say, what did my mother do, and how I was I feeling at that time. How did I relate that to all the other times she did that and how can—okay, here's how you feel now, how can we change that? How can we, always, how can we protect you from her. For those 50 min that she gave me of herself, she was *part* of the plan.

Allison asks the questions that Judith's therapist did not—in Judith's words, Allison was asking Karen why she was "bleeding." Karen felt that Allison joined her in her experience while Judith felt her therapist remained on the periphery. We recall that Judith's therapist's attempt to name Judith's feelings in the moment was not enough; in fact, it served only to distance him further from her. She says:

> When the therapist said, 'You're enraged,' I just felt so alone. I feel like even this person who is supposed to

> understand why I'm abnormal. He is not interested in helping me to row my boat to the other end.

The desire to have one's pain shared through witnessing may be tied to confusing, inconsistent and invalidating interactions with early caregivers. The developmental histories of each participant suggest disruptions in accurate mirroring from parental figures. Mirroring, in which one's internal experience is reflected back accurately in the reactions and response of the other, facilitates the development of a coherent self and trust in one's emotional life (St. Clair, 2004). Josselson (1996) describes this form of deep knowing as follows:

> When we are empathically responded to, we feel affirmed as that which we are. Buber stresses this concept as "imagining the real," which is a form of deeply knowing the other's existence and participating with the other where he or she is. This need to be known, to have our experience articulated and recognized by someone else, is a profound and basic one. (p. 104)

Josselson contends that our need for "eye-to-eye validation" remains throughout the life span. For those who have mostly experienced frustration of this need, there may be an element of desperation in having it met.

Every participant shared early experiences of having their emotional pain dismissed, ignored, punished, laughed at and/or minimized. Emotional pain consequently became linked with secondary feelings of frustration, anger, guilt and shame along with related insecurity and confusion about what is real. Not surprisingly, others (including clinicians) are often assumed to be incredulous, dismissive, or skeptical leaving the burden of proof always on the participants' shoulders. Feeling that one has successfully demonstrated credibility to a clinician may relieve this burden and the haunting feeling that one will be viewed, once again, as manipulative, irrational, dramatic or impaired.

To Be Cared For

All but one of the participants (Arielle) explicitly stated a need to feel cared for by their clinicians. Genuine caring was often engendered by a therapist's way of communicating or listening. As articulated by Judith above, feeling heard and understood or validated was directly tied to a more global sense of being cared for. Of a favored therapist Raina saw for a year and a half, she says simply, "She really seemed to care about my life and me as a person and wanted to help me in my life and wanted to understand and help me understand." Another therapist, a social worker at a homeless shelter, was also experienced as caring. The caring was unspoken but Raina sensed it, as described here:

> No, I could tell. Because here I was like angry and constantly feeling like all this negativity but when I would talk to her she would kind of like listen to me and she encouraged me and reinforced that, she identified with the fact that my life has been hard and she understood that.

All of the participants cited indirect means of communicating caring as evidence of a therapist or clinician's emotional investment. Participants often recalled specific acts or events that supported their experience of feeling cared for. In these cases, caring was not an abstraction that was difficult to articulate but something that was either present or not present and shown or supported with evidence. Evidence came in the form of investment of time or energy, attention to detail, and small gestures of kindness. These acts or events were highly valued and duly noted by participants, easily recalled long after they occurred. I had the sense that some participants needed such evidence to feel cared for in the relationship and even experienced relief when it was presented. These acts of caring by therapists were often experienced as especially meaningful when contrasted with the behavior of maligned clinicians from the past.

Several participants communicated experiences of psychiatrists as quick, detached, uninvolved, and even sadistic, but psychiatrists who proved different made strong, favorable impressions. Beth felt especially cared for and special to a psychiatry resident because of his ability to stay up-to-date with her case:

> I was a little surprised that even though I only saw him once a month, he was always on top of my file. I mean he really reviewed my file before I would go see him . . . he seemed to know all of my references when I talked about my husband or whatever.

Jessie also experienced a psychiatrist's active involvement in her case as symbolic of caring:

> She like wanted to talk about everything and really listen to me and was more like a therapist and was not just interested in, like when she saw me it would be for 30 min, not just like, or 45 min, not just like 10 min to write me a prescription and she like talked to my therapist and they would stay in touch about what was going on and when I started the day

> program at {Hospital Name} and so she had contact with them as well. So she was always very involved and definitely showed that she cared and came to be sort of like a second therapist. And was very supportive and helpful . . .

Jessie's previous experiences with psychiatrists had been quite different. She says:

> . . . I felt like psychiatrists in general were like worthless and um didn't care about you and were only there to write you a prescription. And, so she was the first psychiatrist I ever saw who I thought gave a crap about me.

Tanya describes her appreciation for her current psychiatrist similarly: "Yeah, she's very nice. Um, she listens to me. She'll ask me how I'm doing . . . she explains to me what she's giving me, she's not just throwing meds at me. And I appreciate that."

Like most clients, Jessie was "looking for someone [a therapist] to be kind and reassuring," who had "compassion and understanding" and provided comfort. She says, " . . . like there has to be all this other compassion part first for me to trust them and be attached and because otherwise it just feels like mean and they don't get me and they don't really care." What Jessie articulates is not unusual—she desires to feel her therapist is caring and she is unlikely to trust until this has been established. But the phrase "otherwise it just feels mean" sheds light on what her experience may be like in the perceived absence of these warm therapist qualities. The implication is that the clinician who does not explicitly communicate caring and compassion might be perceived as cruel and punishing.

Clearly expressed concern and vested interest in client well-being was also perceived as a sign of caring. Though, on the surface, Jessie felt somewhat annoyed when her clinicians took a hardline against her cutting, ultimately, the communicated message of care and concern had substantial therapeutic value. This was missing for Raina in her work with a previous therapist:

> And then I started getting into escorting and I was bothered because she didn't really seem like this was a bad lifestyle for me and I felt like it's a very questionable, dangerous lifestyle and she just didn't really seem concerned. So that's when I kind of stopped going there.

This therapist's silence, possibly intended to communicate nonjudgment, was experienced as a lack of concern. Perhaps Raina may have felt differently had the therapist honestly communicated her concerns for Raina's safety as well as her desire to avoid causing Raina to feel judged.

To Balance Structure and Flexibility

Experts in the area of personality dysfunction have noted that individuals with borderline structures may present seemingly contradictory needs that leave clinicians feeling confused about the degree of flexibility to allow in the relationship and therapy frame. Individuals with borderline defenses may have a tendency to send mixed signals about their need to be in control and to be controlled (Clarkin et al., 2006; Linehan, 1993) a phenomenon that may be associated with unstable sense of self and rapidly shifting self-states (Gersh et al., 2017). Notably, DBT holds as a central tenant a philosophy of dialectics in which therapist and client are always working toward balancing opposing tensions, a process Linehan (1993) likens to a teeter-totter.

Indeed, the therapy experiences of participants in this study were often complex and dynamic and required much more than a surface depiction in order to develop a reasonable level of understanding. For instance, every participant described, in her own way, times when she felt controlled and powerless in relation to clinicians (wishing for more control), as well as times when she felt overly powerful and unsafe in therapy (wishing to be cared for).

Though, as a group, their relationship needs vacillated, the participants were articulate in describing the therapist characteristics and therapy conditions that best suited them. Overall, the participants expressed preference for therapy that was not too soft and not too hard, so to speak. They seemed to desire the allowance of moderate movement and collaborative reworking of the therapy structure and relationship but, ultimately, they did not want to call all the shots or to feel they were stronger than their therapists. Interestingly, Jessie and Tanya, the two participants with the most DBT experience and the only two actively engaged in DBT at the time of the interview, were most expressive about the importance of balancing structure and flexibility in the therapy relationship. When Jessie's DBT treatment team decided to create consequences for her cutting behavior (i.e., she

must report to the emergency room), Jessie was atypically able to moderate her habitual reactions of anger and rejection:

> No, I felt like they were being mean in the moment but they were definitely being harsh and hard and my therapist said that she was frustrated with my cutting behavior but also like it was also from a place of concern and um . . . they could be frustrated with my behavior or with me but not like, not like me anymore.

A context of "compassion and understanding" along with continued access to therapist warmth and comforting was crucial for Jessie to withstand the limit-setting:

> . . . like I feel rejected really, really easily and really hurt really easily and so if there's like, there has to be like a lot of the compassion and then some well-placed like, this is not okay, this is the boundaries or whatever.

Jessie's report suggests that the intervention was only effective because it was applied within a particular relationship context. This context provided Jessie with an alternative explanation for her treatment team's "mean" behavior. Despite her tendency to experience rejection when faced with limits, Jessie was able to integrate direct messages from her team that the consequences were being established out of care and concern and did not bear on their liking for her as a person. My sense was that this was communicated in a direct and unambiguous manner so that there would be no mistake.

Tanya articulates the balance a bit differently. When faced with seemingly weak and indifferent clinicians, she reports disengaging or consciously creating a false persona to appease them. She tells me she "controls" and "manipulates" these "easy" clinicians who seem either too naïve, disinterested, or unskilled to see through her act. Like those Judith describes as the "worst of the worst" (those who are neither skilled nor kind), these clinicians lack both compassion and expertise in Tanya's view and inspire neither her respect nor her participation. Her relationship with her current, well-liked therapist is quite different:

> And she's a really nice person. We get along really well. I think the most important thing is that I respect her . . . Like she comes up with like if I ask her about something she comes up with it very quickly and tries to, not resolve everything, but tries to get me to resolve it. She's not an enabler, she makes me work . . . I cannot get away with anything with her.

Tanya reports respecting the clinic director, whom she meets with on occasion, as well. "And I can't manipulate her," Tanya says, "so that's like one of the most important things." As explored previously, the ability of these therapists to see through Tanya's attempts at manipulation fosters security in the relationships. In contrast to seemingly dull, indifferent clinicians, these clinicians are perceptive and invested. The caring context creates an environment that allows Tanya to meet the challenges they present. A group therapist Tanya feels does not listen and who failed to exhibit adequate caring (she did not visit Tanya at the hospital) does not earn the same leeway with Tanya. As it happens, Tanya is silent and unmotivated in this therapist's group.

Judith, hoping for the type of flexibility Tanya describes in her therapists, was angered and disappointed when her new therapist, an analyst, was unable to see the value of Judith's request to have her husband join their session. Though Judith desired a strong therapist, his rigidity felt like a dismissal of her needs and was, ultimately, a shame-inducing reminder of her "abnormality." The therapist did eventually allow Judith's husband to join, perhaps in an attempt to impede the fracture that was forming between them. The fact that this accommodation was not reparative suggests the damage had already moved from the realm of disagreements about therapy tasks to the relationship (Safran, Muran, & Eubanks-Carter, 2011). The event caused Judith to contemplate a return to DBT, mostly out of exasperation. Though she found the skills-focus empty, at least DBT therapists were validating.

As reviewed previously, caring, demonstrated through action, was identified as an essential component of therapy by all but one (Arielle) participant. Yet, caring was also felt to be an insufficient condition for the development of an effective and meaningful therapy relationship. Several participants reported experiences with well-liked clinicians who were perceived as caring but, nonetheless, ineffective. Beth recalled a therapist she saw for a year and a half whom she described as supportive and a good listener but inactive. She refers to her as "an ear" and considered the experience mostly a waste of time and money. Judith shared a poignant example of feeling affection for a therapist whom she ultimately chose to stop seeing.

The pivotal moment occurred when the therapist became teary as Judith described her childhood abuse. For Judith, the tears were proof that the therapist was empathic and caring but, she says, "It felt strange. I felt like I should protect her. So, I felt like I shouldn't be saying this to her, to pollute her somehow." With the benefit of also hearing Judith describe her developmental relationships I wondered if this therapist, unwittingly, surfaced a familiar discomfort wherein the listener (most notably, Judith's mother) comes to feel contaminated by Judith's pain and Judith, in turn, feels guilt and shame. Judith decided this therapist could not "carry" her.

In summary, supportive listening from a caring presence was not enough to create a healing relationship. The finding seems to echo Linehan's formative experience as a young therapist in which she found that simple application of humanistic principles was ineffective with her BPD diagnosed patients (Linehan, 2020). Participants described the ideal clinician as compassionate and caring without being indulgent or permissive. They desired clinicians who demonstrated confidence, strength and skill, engendering participant respect and feelings of security. "Show sympathy but not excessive sympathy," advises Beth. Inexperience, naiveté, lack of skill, insecurity, and lack of intellect—even in the context of caring—left participants wanting.

To Be Real: Transparency, Action, and Humanity

In my clinical work I have often heard individuals diagnosed with BPD express feelings of being separate from the human race. This feeling of being inhuman or unlike other humans is something the participants in this study also described, each in her own way. Thus, when the therapist joins with a client and meaningfully affirms her experience the interaction between them might be described as a moment of shared humanity. This bridging of worlds between therapist and client may be especially profound for those who have endured life on the outskirts. Feelings of alienation, I learned, were not only felt in response to something that was said or done by others, they also occurred in response to what was missing.

Six participants expressed explicit discomfort with therapist perceived neutrality or inactivity in session. The seventh, Jessie, did not express any thoughts about the issue, perhaps because, according to her descriptions, none of the therapists she encountered were experienced as having a neutral style or demeanor. For this discussion, "neutrality" will be used to describe therapists perceived by participants to be inexpressive, interpersonally withholding, and/or overly formal. "Inactivity" will be used to describe a therapeutic style that participants characterized by minimal participation/collaboration in session, limited use of interventions, and withholding of feedback or advice.

The participants, as a group, seemed to experience therapist neutrality and inactivity as a barrier that discouraged the development of closeness and safety in the relationship. Specifically, neutrality and inactivity precluded wished-for reassurance and acceptance from therapists. This form of withholding seemed to call therapists' humanity into question. Though participants varied in how they expressed their desire to know their therapists' humanity, this did seem essential for many. Karen says, of her favorite therapist, she was "a real person." In her view, "it's more about showing your soul and then showing who you are as a human being. You're a human being before you're a therapist." For Judith, humanity was evidenced by integrity, genuineness, and a compassionate heart; therapists who demonstrated these qualities were perceived to be "good people." Judith felt her new therapist, an analyst, resorted to "canned statements," a strike against his humanity and his ability to understand her. Here Judith describes how others she has met along the way also lacked human qualities:

> A good way to summarize is it just didn't click. I just feel like they do not really know me and uh, whatever they're saying um . . . you know they could be citing textbooks to me. I just feel like, if I really am interested I could read the textbook.

Tanya experienced therapists as human when they allowed the relationship to transcend the therapy hour (i.e., greeted her in public, checked on her during a hospitalization), an indication that their caring was real and not just a service provided. Jessie's enactments with therapists served to uncover their imperfections and emotionality, in a sense, confirming their humanity.

Proof of therapist humanity may be especially essential for these participants due to a sense that if, and only if, a therapist is human will there be any hope for true understanding and compassion.

It makes sense that, upon encountering a new clinician, an individual with a history of experiencing others as abstruse may wonder, how will I know if this person is human? The need to know one's humanity and to relieve the insecurity of not knowing may lead to a certain interpersonal hypervigilance. Interpersonal sensitivity, a cornerstone of BPD, often includes a tendency to be highly attuned to interpersonal cues used to infer others' thoughts, feelings, and intentions (Porr, 2010). Though individuals with BPD can be very perceptive, their interpersonal inferences may also be largely informed (i.e., distorted) by entrenched dysfunctional patterns of relating (Clarkin et al., 2006). In general terms, the object relations patterns of participants in this study would predict presumptions that others will be rejecting, withholding, or disinterested.

These presumptions and related thoughts and feelings were not, however, universally activated. Rather, they were activated (or not) in response to the particulars of each interpersonal context, including all the thoughts, feelings, and attitudes brought to the therapy dyad by both participants. While a client with BPD may tend to react to interpersonal stress with more primitive defenses (e.g., projective identification), even these defensive reactions are generated within a relational context. Thus, analysis of this context must be included in all attempts to understand the client's thoughts, feelings, and behavioral reactions. According to Atwood (2012), the necessary "radical engagement" of therapists in the psychotherapy process means:

> that the therapist, as an individual, is implicated in everything that takes place within the psychotherapeutic dyad. It means that there is no such thing as detached observation. It means that the transformations that occur, if any do, include both participants. (p. 22)

These transformations include all that transpires moment to moment, including small and large conflicts and fractures. Individuals with particular rejection sensitivity may be more prone to anxiety in the clinical context and to related behavioral or emotional reactions that inhibit the natural development of rapport. Yet, even in these cases, the site of action is not isolated in the individual but is located in relational events. Thus, interpersonal anxiety may be activated or relieved according to what occurs in the relational space. The participants in this study shared some ways that the anxiety of a new therapy relationship was effectively relieved (e.g., explicit statements of validation, therapist self-disclosures, provision of feedback or advice). As discussed above, several participants looked for other clues (e.g., tone of voice, facial expressions, small gestures), as well, to help decipher clinician intentions and to relieve the distress of interpersonal uncertainty. Neutrality, characterized by an absence of interpersonal cues, may frustrate these efforts, thereby increasing anxiety.

Karen understood her and others' discomfort with neutrality to be a consequence of confusing relations with early caregivers. Transparency is seen as the antidote for this discomfort and the interpersonal conflicts that so often result. She explained it to me this way:

Karen: Then I have a sense, I do not have to reach, you know, I can read people's body. And their *whole* gestalt. Their whole persona. Because we're (*people with BPD*) so perceptive because we had to be for a crazy, schizophrenic mother in this world. So, when, when the borderline patient doesn't have to *read* everything, it makes everything/

Me: You want to be told what I'm thinking.

Karen: Exactly. I cannot read your mind and it's too taxing for the person to be reading all your cues.

Me: Sometimes it's right sometimes it's not.

Karen: Yeah! And then, what happens is, like, me! You miss, 99% of the time you will misread the cues and this is what happened with my former therapist. I misread what she said. So, look, I lost the best therapist I had in 20 years. And now what! So, that's

> what you said. 'I see what you mean.' That's saying to me, okay, she heard me. Whether or not she agrees, I do not know. But she heard me. It means a lot.

Interpersonal sensitivity in combination with expectations of eliciting others' rejection, anger, and disdain does indeed set the stage for misunderstandings (Porr, 2010). Participants seemed to attribute neutrality and inactivity to therapist characteristics rather than to therapy approach. Those who failed to express or demonstrate warmth, compassion, or validation were not given the benefit of the doubt by participants. Assumptions of indifference, hostility, or lack of skill were common.

Several participants described experiences of clinicians as superior, cold, aloof or sadistically powerful. Karen recalls seeing several psychiatrists of a particular type: "A really uptight psychiatrist. The corporate type. Rigid type. The type that view us as being difficult patients." They were the type, she tells me, who would respond to learning of her trauma history with obtuse "um hms." Infuriated, Karen would try, with her words, to make a dent:

> I say, do you not hear that I was tied down, that my brother was beating me for hours and would unplug the phone when my mother went to work? That I was being abused and savagely beaten? And they'd say, "Um hm." I'd say, "Don't go, um hm!"

Karen is, in effect, asking, "Is there anybody home?" Is there a human being inside that suit? Their impenetrable armor was intolerable to her and disqualified them as potential therapists. Raina responded differently to feeling unheard by clinicians. When one clinician diagnosed her as having bipolar disorder, she attempted to protest before giving in:

> I said because borderline gets misdiagnosed as bipolar and she argued with me about that. And I said look, whatever, I do not come to therapy to argue with people. That's part of my problem. I'm not here to say, you have the degree, I do not have the degree, you're cooler than me. I'm already in that power situation.

The scenario depicts her sense of powerlessness in the relationship. Beth also recalls feeling belittled by a psychiatrist. She remembers that his "tone of voice" was "super condescending and really dismissive." His unhelpfulness felt like a choice to Beth. She says, it was "like he didn't want to tell me how to get better. He was just like, you have a problem and it sucks."

In contrast, the psychiatrist who offers Beth practical advice for resolving problems facilitated her feelings of connection. When I ask her what about his advice was helpful for her, she offers the following:

> Um, it helped me feel like I was more in touch with the therapy that was going on. Um, because when I do not get a lot of feedback I feel like the person just isn't really there to help me very much.

Other participants seemed to experience inactivity as a form of withholding as well. Raina recalls that one therapist's less interactive style seemed to inhibit the therapy relationship:

> Yeah, I just felt like she was not really involved. Whereas my other therapist, we would kind of have like interaction and she'd know what I was talking about, it was more like a relationship. I felt like the other woman was just more of a quiet person.

Jessie was similarly disappointed by the detached indifference she encountered from a hospital psychiatrist. She recalls that the psychiatrist, in response to Jessie taking an overdose, inanely suggested that she be "less impulsive." This uninspired advice, followed by inadequate aftercare, communicated disinterest and unavailability; Jessie felt that the psychiatrist had left her "high and dry."

To Address Tension and Conflict Head-On

In a meta-analytic study of therapy alliance ruptures, Safran et al. (2011) found that the process of working through alliance ruptures has therapeutic value, contributing favorably to therapy outcomes. The reports of the participants' in this study seemed to support this finding. Several of the women were able to offer detailed accounts of specific conflicts that transpired between themselves and their therapists and whether these were ultimately experienced as therapeutic. In several cases, the interview process afforded the flexibility to consider rupture events in great detail not only with regard to what happened but how it felt and the meaning attached at the time and in retrospect.

Participants had notably different experiences in the face of alliance ruptures with the different clinicians they encountered over their treatment histories. Positive and negative conflict outcomes were not, however, distinguished

by the presence or absence of participants' more problematic interpersonal patterns or sensitivities in the interaction but rather by how they were worked through in the relationship. In other words, prominent relational patterns were highly active in relationship ruptures that were, nonetheless, resolved with positive results. For example, Jessie's wish to be reassured in the face of perceived abandonment threats played out in several clinical relationship experiences that were ultimately satisfying and therapeutic for her.

Raina's pattern of feeling inferior to others and her desire to experience explicit acceptance were also present in several described therapy relationships but with varying outcomes. For instance, Raina recalls that her social worker at the homeless shelter seemed to have a more favorable opinion of Raina than she had of herself. Thus, it was not that Raina's expectation of rejection or her fears of being judged were absent in this relationship. Rather, it is likely because of these things that Raina found the relationship therapeutic. On the contrary, Raina and her pregnant therapist never broached the difficult topic of the pregnancy. Raina's defensive judgmental feelings were unexpressed and the distance between them grew, ultimately resulting in a premature termination.

Several (Karen, Jessie, Raina, and Tanya) described complicated relationships, some of which endured in the wake of ruptures while others crumbled. Though the entrenched insecurities fueling these patterns may have been ever-present, the degree to which defensive patterns were elicited may be attributed to the reactions and counterreactions that occurred between clinician and client. Indeed, flare-ups of problematic relational patterns are very likely to occur even in the most caring and validating relationship contexts (Porr, 2010). Preestablished trust and safety in these relationships, however, may be what allows the dyad to work through these moments in a manner that enhances growth.

Table 3 lists some of the relationship fractures described by participants along with the feelings experienced, actions taken and the outcomes. Relationship rupture events were gathered from all three sources of material (the interviews, the CCRT-RAP interviews, and the relational space map interviews). As a group, participants reported more negative outcomes resulting from conflicts or ruptures but these outcomes did follow a definitive pattern in which tensions were never meaningfully addressed. In a meta-analytic study of qualitative research on client therapy experiences, Levitt, Pomerville, and Surace (2016) found that when clients were reluctant to address tensions with their therapists, distrust grew to a point where the alliance could not be salvaged. Linehan (1993) notes that individuals diagnosed with BPD may be especially inclined to take the path of least resistance, that is, fleeing, in the face of conflict. Thus, therapist willingness to guide engagement when tensions develop may become a crucial turning point toward or away from therapeutic connection.

However, in every case in which the participant perceived her therapist as making an active and discernible effort to address the rupture, the outcome was favorable. And in each of these cases, the relationship, from the participant's perspective was not just maintained but meaningfully enhanced. This finding is consistent with Safran and Muran's (2000) suggestion that the therapeutic connection may be deepened when therapists recognize and stay with difficult feelings that arise in the relationship. The table illustrates this variation in outcomes and supports the hypothesis that the mere existence of defensive relationship patterns did not dictate relationship conflict outcomes for this group. Very clearly the outcome was a function of what transpired between participant and therapist in the face of tension.

Discussion

The particular sensitivity of individuals with borderline characteristics to interpersonal conflicts, along with a tendency to become dysregulated in the face of perceived or real rejection or hostility increases risk for countertherapeutic experiences with even the best-intended clinicians. Individuals with BPD have been found to be both more quarrelsome and more submissive compared to nonclinical controls (Russell, Moskowitz, Zuroff, Sookman, & Paris, 2007), to both desire and resist establishing intimate relationships, and to view others as either rejecting or understanding (Drapeau & Perry, 2004). It follows that individuals diagnosed with BPD may not respond in a predictable manner to the types of interventions or interpersonal ap-

Table 3
Relationship Ruptures, Interventions, and Outcomes

Participant	Rupture	Feelings	Interventions	Effect	Repair	Outcome
Judith	Judith feels analyst resists her request to include husband in session; states she is "enraged"	Misunderstood, angry; alone and unhelped	None reported	Judith considers terminating relationship	No	Negative
Arielle	Arielle is angered by psychiatrist's insistence that she has an eating disorder	Misunderstood, angry, defensive	None reported	Relationship is terminated	No	Negative
Beth	Therapist states she does not understand Beth's problems or how to help her	Unhelped and angry	None reported	Relationship is terminated	No	Negative
Tanya	Tanya feels snubbed by therapist at a restaurant	Rejected and angry	None reported	Relationship is terminated	No	Negative
	Tanya is hurt by group therapist's failure to visit or call during hospitalization	Rejected and angry	None reported	Tanya maintains negative feelings for therapist; is considering quitting group	No	Negative
Jessie	Jessie hacks therapist's social media	Ashamed	Unconditional regard for Jessie expressed; boundaries reinforced	Relationship is enhanced	Yes	Positive
	Jessie asks group therapist about her (therapist's) weight	Ashamed	Processed with assistance of third party (clinic director).	Negative feelings for therapist are transformed; bond created	Yes	Positive
	Group therapist reprimands her in front of group	Ashamed, angry	Therapist shares her feelings, offers apology	Bond is strengthened	Yes	Positive
Raina	Therapist's pregnancy triggers defensive reaction	Judgmental of therapist; distance between them grows after birth of baby	None reported	Relationship is terminated	No	Negative
	Raina feels judged by therapist regarding drug use and loss of daughter	Judged, ashamed, rejected; loss of safety in therapy	None reported	Relationship is terminated	No	Negative

Table 3 (*continued*)

Participant	Rupture	Feelings	Interventions	Effect	Repair	Outcome
Karen	Therapist runs late for session	Uncared for, devalued, and angry	Therapist reinforces that she values Karen	Karen feels cared for	Yes	Positive
	Karen and therapist disagree about Karen having adjunctive therapy	Hurt, betrayed; regretful for leaving voice message rather than bringing feelings to session	None reported	Relationship is terminated	No	Negative

proaches that other clients experience as therapeutic (Clarkin et al., 2006; Perlmutter, 1982). These seeming inconsistencies can leave therapists feeling confused, frustrated, or insecure (Clarkin et al., 2006; Gersh et al., 2017) further adding to tense interactions. When intense needs enter into the therapy relationship (sometimes via projective identifications) clinicians may understandably respond with enactments of their own in attempts to cleanse themselves of uncomfortable, confusing, or toxic feelings (Waska, 1999).

While the empirically supported treatments for BPD all seem to focus deliberate attention on the therapeutic relationship (Weinberg, Ronningstam, Goldblatt, Schechter, & Maltsberger, 2011), there has been little research on client experiences of this relationship. Yet, improving therapy experiences for individuals with BPD logically must include improved understanding of the complicated relationship between this patient population and the professionals who treat them (Cleary, Siegfried, & Walter, 2002; Treloar, 2009; Gersh et al., 2017). The purpose of the research project described was to explore what happens in the relational space between BPD-diagnosed patients and clinicians by eliciting narrative descriptions of these events and their effects directly from patient informants.

The therapy experiences of the seven participants interviewed for this study were not one-dimensional or amenable to gross simplifications. Knowing something about each participant's developmental history and associated relational impacts proved essential during the analysis as I was able to put the therapy experiences shared into a context that gave a much fuller picture of what had transpired. As described in an earlier article (Goldstein, 2017), my reflexive analysis of my experience of interviewing each participant added yet another layer of context. In every case, my reflections on what I experienced with each participant allowed dots to be connected that might otherwise have remained isolated data points of far less value. Immersing myself in the material allowed for a feeling of connection with each participant that further strengthened my ability to make meaningful connections during the analysis.

In summary, the participants desired therapists who were explicit in their caring and capable of a deep form of listening; however, enacting a caring presence was not sufficient to create feelings of connection and safety. Participants also needed to experience therapists as competent and genuine and many sought signs of humanity in their therapists. The ability to balance structure and flexibility was also essential as was the ability to adjust positions in response to participants' changing needs. This finding is consistent with suggestions that individuals who meet BPD criteria may at times appear highly competent, resourceful, and independent while at others times appear helpless, incapable, and dependent (Linehan, 1993). Reconciling these two positions can be difficult for therapists who may understandably find that they are offering too much or too little assistance to meet their clients' needs at any particular point in time (Linehan & Schmidt, 1995). The results also support others who have suggested that therapist failure to consider the diffuse and shifting sense of self and changeable reflexive capacities of clients with this diagnosis will have more difficulty sustaining successful therapy relationships (Gersh et al., 2017; Goodman, Edwards, & Chung, 2015).

The participants in this study by no means had an easy time finding therapy relationships that hit all the right notes. Still, as a group, they defied myths that individuals with borderline pathology are destined to bounce from therapist to therapist, endlessly dissatisfied. In fact, three of the seven participants (Karen, Jessie, and Tanya) reported feeling exceedingly pleased with the long-term therapy relationships they had at the time of the interview. I learned that while the reasons for discontinuation of a therapy relationship were not simple, they did have a rhyme and reason. Invariably, mutual avoidance or mismanagement of tensions led to relationship termination and therapist willingness to tackle such tensions directly resulted in therapeutic benefit. Adding to the complexity of studying psychotherapy processes in individuals being treated for BPD is the possibility that client relationship needs oscillate potentially limiting what can be understood through quantitative methods. A close look, such as the one taken in the described project, suggests complicated dynamics that might easily be misunderstood by surface level analyses. Thus, it is essential that our study of treatment experiences and outcomes for this population include substantial contributions from qualitative researchers.

So much of what I learned from this project informs the way I practice today. I learned that even the most subtle interactions can trigger painful feelings, that tensions are always cocreated, and that good intentions do not dictate what the other will experience. Judith, in particular, is with me at the end of every session when I escort a client out of my office. Her story of how this standard procedure triggered feelings of isolation stays with me:

> . . . I didn't really want to leave but I walked out. The moment I walked out, he closed his door. At that point I felt like, he thinks I'm a freak. Yeah, he thinks he doesn't want anything to do with me so as soon as time is up, my duty is up . . . It took me a long time to understand how I always internalize everything. At that time, I thought I was a freak and normal people do not want to deal with me.

In this case, the office door might represent the division Judith experienced and continued to experience between herself ("a freak") and others (those who punish and alienate her for her feelings). The lesson for me is not to tiptoe around sensitive clients but to allow for the possibility that the smallest gesture regardless of intention can stimulate meaningful reactions. Thus, willingness to understand and accept the client's relational reality as valid has become a grounding principle for me. And, despite the critical supervisor in my head telling me it is an unnecessary accommodation motivated as much by my own insecurities, I move slowly and gently when closing my office door, always leaving it cracked open slightly.

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