
THE THERAPEUTIC RELATIONSHIP IN BORDERLINE PERSONALITY DISORDER: A COGNITIVE PERSPECTIVE

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Abstract

This article deals with the role of the therapeutic relationship in psychotherapy of patients with Borderline Personality Disorder (BPD) (APA, 2013). Firstly, the paper refers to the therapeutic relationship in BPD in general as well as more specifically in the light of Cognitive Psychotherapy, through the major principles and new developments in clinical practice and survey. Cognitive treatment regards the therapeutic relationship as a necessary but insufficient component for the therapeutic change. However, in recent years, it has attached special importance to it, as indicated by clinical studies. Then it goes on to an overview of the major theoretical and clinical approaches for BPD, mainly through the work of Linehan, Kernberg, Gunderson and Young, which is followed by an elaborate analysis of the difficulties and instability of relationships in BPD as major characteristics, as well as of the peculiarities that the therapeutic relationship between the therapist and a BPD patient displays. Psychotherapy with BPD patients, the difficulties and suggestions for a positive therapeutic outcome are the major points of the third part of the paper, which is completed with the potential of the cognitive therapist and the contribution of cognitive therapy through a focus in the present, structured treatment, identification of thoughts, emotions and behaviors, cooperative work, concrete boundaries and honest and substantial communication.

Keywords: borderline personality disorder, therapeutic relationship, cognitive therapy

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I confirm that I have complied with APA ethical standards in the treatment of their sample, human or animal.

The (therapeutic) relationship in BPD

The desire for a stable, consistent, caring and strong relationship with someone else is almost universal. People who meet the diagnostic criteria for BPD often have a childhood and relationship experiences in adulthood characterized by problems of attachment. Therefore, almost every known kind of psychotherapy considers the safe, stable and close relationship with the therapist of central importance to treatment (Krawitz & Watson, 2003).

This stable, close relationship is not easy to be established and maintained. The fear of abandonment and the intolerance of aloneness have been recorded as major feelings of patients with BPD (Gunderson, 1996). It is a common phenomenon for these patients to ask by their therapists for more than the latter are able to give them. This puts in danger the therapeutic relationship because of the associated emotions of feeling hurt, anger, disappointment, rejection and abandonment. Without an adequately sustainable relationship, the treatment is deemed to fail. Training in skills and organizational formulas, though important, will prove insufficient if not integrated in a model that supports and asserts the importance of the therapist-patient relationship. This relationship, in turn, needs to be supported by the respective therapeutic structure that should offer supervision to the therapist.

The difficulty in building a therapeutic relationship may be more effectively studied by taking into consideration the fact that difficulties in interpersonal relationships constitute one of the key features of BPD, as repeatedly highlighted by psychiatric literature for over 70 years. Older studies (Grinker, Werble, & Drye, 1968) mention instability in interpersonal relationships and symptoms of depression as a response to the feeling of loneliness. More recently, modern factor analytic studies of BPD (Skodol *et al.*, 2002) have suggested three core sectors of psychopathology in BPD: 1) interpersonal disturbances, 2) affective or emotional dysregulation and 3) impulsivity or behavioral dyscontrol. When referring to “difficulties in interpersonal relationships in BPD”, we refer to unstable relationships, devaluation/ manipulation/ sadism, demandingness, abandonment/ loneliness/ annihilation/ engulfment concerns, dependency/ masochism, treatment regressions, countertransference problems and boundary violations in treatment (Choi-Kain, Zanarini, Frankenburg, Fitzmaurice & Reich, 2010).

The special characteristics of patients with BPD in building relationships are confirmed by the fact that almost half of those who have successfully completed their treatment live alone. People who have difficulty in establishing and maintaining close relationships should rather avoid them and aim for less close relationships. Such a decision can be correct, and therapists should not hesitate to approve it. The problems emerge when both parties of a relationship have needs that are not satisfied. It is better to have one's demands moderated, so that they are satisfied fragmentarily. For some patients, for example, the relationship with a

broader community of people is more meaningful and does not require demanding emotional relationships (Dawson & MacMillan, 1993).

Identity diffusion and other identity-related dysfunctions that are prevalent in patients with BPD seem to contribute to the difficulty in interpersonal relationships in BPD. The processes of normal conflicts during the identity analysis and the integration of the identity in adolescence have often failed to a great extent, thus not having allowed the creation of a subjective sense of identity coherence. Based on object relations theory, identity diffusion may be defined as «a psychological structure characterized by the fragmentation rather than integration of the representations of the self and of others that are internalized in the course of any individual's development» (Yeomans, Clarkin, & Kernberg, 2002, p. 8). Therefore, identity diffusion on the Ego-identity level results from the fragmented nature of a split or a split internal organization.

We conclude who we are based on how others respond to us and our identity is normally formed and stabilized by a continuous feedback from significant others. Therefore, close relationships play an important role in the development and maintenance of a coherent sense of identity. A stable and coherent identity is developed and maintained only when we repeatedly receive a feedback from significant others that confirms our self-image. Serious deficits in mentalization, or the capacity of processing and understanding the behavior of others, which have been associated with BPD (Bateman & Fonagy, 2004), make it hard for patients with BPD to perceive themselves from the perspective of others and contribute to the difficulty developing a stable and coherent relationship (Jørgensen, 2010).

In patients with BPD, the experience of the self as a single entity is disturbed by the impulsive behavior that results from a more general impulsivity that may be temporal or a consequence of an early trauma, an insufficiently developed mental ability, a biologically determined emotion control weakness, or other factors. Impulses are so direct that the individual does not experience himself as the agent of the action, thus putting interpersonal relationships at risk. Especially when the attachment schema is activated, the responses of the patient are often so absurd and unpredictable and dictated by so intense emotions and impulses that the patient feels unable to understand or explain his behavior: an experience that contributes to the lack of a coherent sense of self and to the characteristic of identity diffusion in patients with BPD (Jørgensen, 2010).

The important role of relationships in BPD is mentioned in contemporary therapeutic approaches such as Young's cognitive schema therapy (1990). This approach suggests three core manifestations of dysfunctional schemas on which the therapeutic intervention focuses: a) difficulties with interpersonal relationships, b) self-functionality (identity diffusion) and c) emotion regulation. The treatment is exploratory and focuses on awareness rather than action. BPD patients are

encouraged to boost their self-consciousness through an increased self-awareness of their behavior, thought and emotions and to acquire an awareness of the mechanisms of their conscious and unconscious psychical functionality (Louw & Straker, 2002).

Given the fact that schemas are interpersonal in nature, the therapist-patient relationship is central for the achievement of the therapeutic goal of changing and restructuring schemas. Gold (1993) suggested three important facets of the therapeutic relationship: a) the emotional climate (of the interaction), b) the interactional stance and c) the role of interactional data. By the term *emotional climate*, Gold means the “quality and quantity of affective engagement and involvement between patient and therapist which are thought to be helpful, necessary or ameliorative” (p. 526). This facet of the therapeutic interaction is defined in terms of such issues such as the therapist’s activity level, the roles and responsibilities assigned to both patient and therapist, the place of the specific therapy upon such continua as egalitarian versus authoritarian, directive versus non-directive and exploratory versus didactic (Gold, 1993). Thus, this interactional stance becomes an oscillation between engagement and flexibility. Gold (1993) distinguished two modes of processing the interactional data: an intrapsychic-transference and an interpersonal-characterological mode. From the intrapsychic-transference perspective, the therapeutic interaction is determined by internal needs, wishes, conflicts, representations of the self and of others, and defenses of the patient. This pattern suggests that the therapeutic interaction is determined by internal and archaic characteristics and that the behavior and characteristics of the therapist play a secondary role only. The interpersonal-characterological model, on the other hand, considers that the therapeutic interaction integrates *in vivo* the characteristics of the patient and the usual way in which he relates to other people.

Initially, borderline patients’ relationships with their treaters are distrustful or split (e.g. idealized or devalued) (Agrawal, Gunderson, Holmes, Lyons-Ruth, 2004; Butler, Brown, Beck, Grisham, 2002; Gunderson & Lyons-Ruth 2008; Shedler & Westen, 2004). Idealization is helpful and can be promoted by validation on the part of the therapist of characteristics of the patient and the promise of relief from dysphoric moods. The proactive “I can help you” approach offered by psychopharmacologists or cognitive-behavioral therapists encourages hope and perhaps idealization. More sustained trust can be engendered by reliability, availability, and resilience in the face of challenges. Clinicians of all sorts need to establish their trustworthiness. This sets the stage for emotional dependency, a good basis for an effective treatment. The changes in psychotherapy, which in the final stage include increased self-respect and pursuit of individual goals (Linehan, 1993), involve intrapsychic changes that are consistent with the overall sequence of changes expectable from both generic and BPD-specific observations about the desired therapeutic outcome (Gunderson & Links, 2008)

The concept of therapeutic alliance

The concept of a therapeutic alliance helps frame the discussion of both the initial engagement of borderline patients in all forms of therapy and the subsequent long-term processes within therapies. The concept of alliance has special significance for BPD: at one time, the alliance was considered a prerequisite for dynamic psychotherapy, which, if true, would in theory render many such patients unsuitable for that modality. From all the known types of alliance, (see Table 1), we consider that the “*contractual*” alliance is the one that concerns mainly BPD, as it refers to defining roles and goals and establishing a concrete framework for the treatment. Regressions may, indeed, be reduced if special attention is paid to the mutually agreed expectations for the treatment.

Table 1. Types of therapeutic alliance.

Contractual (behavioral)	Relational (emotional/empathic)	Functional (cognitive/motivational)
This type refers to the agreement between the patient and the therapist about the goals of the treatment and their role in their achievement. This type of alliance may be agreed during the first session, but it usually takes two to three sessions.	Its importance was highlighted by the therapists of Rogers’ client-centered approach. It refers to the experience of the patient about the attention, empathy, authenticity and the acceptance he receives from the therapist. It is established during the first 6 months of the treatment.	A creation of psychoanalysis. In this type, the patient is a trustworthy partner who can recognize in the unintentional observation of the therapist the good intention of the latter. This type of alliance is established gradually and reinforced during the sessions.

Psychotherapy and Borderline Personality Disorder: The potential of the cognitive therapist

More generally, as far as the competencies a therapist should have are concerned, Gunderson and Links (2008) suggest that every mental health professional that has experience in treating BPD patients and combines good judgment skills with the readiness to communicate with the other can fulfill this role.

The authors mention the establishment of *contractual* alliance as the first priority of the therapist in treatment of a BPD patient. This starts from the training of the patient and his family about the diagnosis. Contractual alliance is constructed through a conversation with the patient about the roles he is going to assume and the therapy goals. Both dialectical behavior therapy (DBT) (Linehan, 1993) and psychotherapy with emphasis on transference (Kernberg, Yeomans, Clarkin, Levy, 2008) suggested an extensive process in which the patient’s motive for the treatment is assessed (and controlled) and in which the boundaries of the therapist’s role are set (e.g. availability only in emergency cases).

Gutheil (1985, 1989) noted that borderline patients are particularly likely to involve their treaters in liability suits. This is mainly related to these patients' ongoing suicide risks or tendency to display destructive behavior.

Dawson and MacMillan (1993) made a significant contribution to the treatment for patients with BPD with their book *Relationship Management and the Borderline Patient*. Unlike most books that emphasize ways to interpret or confront borderline patients' relational problems with treaters, Dawson and MacMillan, through a cognitive perspective, move into operational ways to side-step these problems and have borderline patients be responsibly involved in their own treatment – or otherwise not be in treatment at all. *Central* to their thesis is the traditional proactive approaches of psychiatrists and institutions (e.g. prescribing, directing, controlling) expected by- indeed, welcomed by- most patients are approaches that provide the materials with which borderline patients destroy their therapies and make themselves worse. Hence the wise clinician will step back and wait for borderline patients first to identify what they want, even though the clinician's inaction may be protested. One useful principle of relationship management is that the primary clinician shifts (i.e. "demedicalizes") the focus of discourse from diagnosis, pills and suicide risks to social competence, for example, employment, budgeting, and self-care. *A second principle* involves practicing what Dawson and MacMillan call "no-therapy therapy". Thus, in response to the borderline patient's wish for psychotherapy, a regular time for sessions may readily be offered, but with the caveat that the therapist is not sure how she or he can be helpful. This "contract" is well suited to primary clinicians within a health care system in which the patient is assigned a clinician than in a system in which the patient selects the clinician. In the private-practice sector, Dawson and MacMillan's approach -unless buttressed by explanations for the patient and the patient's significant others – will evoke devaluation and a search for a therapist who evokes more hope of the patient being helped.

"Splitting" is a term, deriving from the school of psychoanalysis, that within the larger mental health community is used to describe a defensive process, which became identifiable by the borderline patient's tendency to perceive others in dichotomous, "all-good" or "all-bad" terms and then to treat others very differently (idealized or devalued, respectively), depending on which side of the internal split they occupied. Because of this tendency to split, prior generations of clinicians have been warned to beware of splitting lest they develop antagonistic views toward the member(s) of a treatment team who are on the opposite side of the patient's split or lest they otherwise get involved in counter-transference enactments (Gabbard, 1989, 1994).

As a solution to this problem was suggested the principle of *split treatment*, in which treatment plans for borderline patients should routinely involve at least two treaters, two modalities, or any two components. When coordinated, two components in a treatment can provide a container for the splits and projections that keep the borderline patient in treatment. Linehan (1993) nicely

operationalized the response that clinicians or therapists should make when confronted about the alleged failures, cruelties, and so forth of the other “bad therapist”. The “good” therapist should *neither agree with the patient nor defend the other*, but simply encourage the borderline patient to express complaints directly to the object of the complaints. Split treatments are advantageous to borderline patients if provided by knowledgeable and mutually respectful clinicians. If not, split treatments can be harmful and increase liability risks.

Engagement in treatment

Most BPD patients have sought and rejected help for many years, therefore at the given moment their motive for therapy cannot be taken for granted. Thus, the patient’s engagement in a useful and constructive dialogue is of central importance to the treatment. Even if patients seem to be involved in the treatment, their motive changes quickly, sometimes even within a day, what makes it difficult for them to get involved in a meaningful dialogue. One minute they ask for help and the next they reject it, what has led therapists to “discontinue” these patients too early. It is not right to deny treatment to a patient just because he seems to have a weak desire for change. Ambivalence about a change is central in a borderline personality type structure. The offer of treatment can threaten the psychological balance and increase anxiety, and that is exactly why it is likely to be rejected at some point. The process of engagement includes constructive negotiation, possible ruptures and disagreements in treatment where they occur and the gradual establishment of a trusting therapeutic relationship. Non-monitoring the treatment is a threat not only to its existence but may also destabilize and disrupt the whole program e.g. a therapy group (Dawson και MacMillan, 1993).

The perspective of Cognitive Therapy

With regard to the perspective of *Cognitive Therapy* (CT) for BPD, findings suggest CT is effective in treating BPD. According to cognitive theory, BPD patients are characterized by dysfunctional beliefs that are relatively enduring and inflexible and that lead to cognitive distortions such as dichotomous thinking. When these beliefs are activated, they lead to extreme emotional and behavioral reactions, which provide additional information for the beliefs. It is hypothesized that a change in dysfunctional beliefs is the primary mechanism of change associated with CT. However, additional mechanisms of change are likely also at work in CT, including enhancement of skills, reduction in hopelessness, and improvement in attitude toward treatment. Findings from the CT trial support the role of cognitive change during therapy and its continuation after termination (Wenzel, Chapman, Newman, Beck, Brown, Gregory, 2006)

Characteristic Borderline Beliefs

1. If people get close to me, they will discover the “real” me and reject me.
2. Unpleasant feelings will escalate and get out of control.
3. Any signs of tension in a relationship indicate the relationship has gone bad. Therefore, I should cut it off.
4. I am needy and weak.
5. I need somebody around available at all times to help me to carry out what I need to do or in case something bad happens.
6. I am helpless when I’m left on my own.
7. I can’t cope as other people can.
8. People will get at me if I don’t get them first.
9. People will pay attention to me only if I behave eccentrically.
10. I cannot trust other people.
11. I have to be on guard at all times.
12. People will take advantage of me if I give them the chance.
13. People often may say something and mean something else.
14. Someone with whom I have a close relationship may be unreliable and unfaithful (Butler, Brown, Beck&Grisham, 2002).

Cognitive approach, which dealt with BPD later than the psychoanalytic one, offers an important variation in treatment and contributes to a possible integration of different therapeutic schools. Cognitive therapists recognize that borderline patients’ transference offers a way to identify cognitive schemas that can control their relationships (e.g. “My therapist wants to control me”) or can be the triggers for their reactions within relationships (e.g. a therapist’s lateness triggers abandonment fears). Young (1994) and Beck *et al.* (2004) even suggest that cognitive therapists may need to do work (cognitive therapy) on themselves because of their counter-transferences. All the pioneering cognitive therapists give attention to the therapist’s need to invest energy in establishing a trusting and collaborative working relationship.

Westen (1991) has helped to bridge the conceptual and clinical gaps between the cognitive-behavioral and psychoanalytic approaches. Joining Beck and Freeman (1990), he refers to “splitting” as “dichotomous thinking”. Westen identifies it as a misattributional style involving global or polarized judgments about self or others. In this scheme, projection is considered a misattribution of our motives to others. Westen then describes how cognitive-behavioral techniques can be used within psychoanalytic therapy to diminish the borderline patient’s overelaboration of affects and impulsive behaviors. Essentially, Westen advocates a cognitive technique of labeling (i.e. highlighting or setting apart) affect states (e.g. anger), words (e.g. “terrific” or “perfect”) or cognitions (e.g. “he doesn’t trust me”) that may later be considered signs or warnings that help the patient to slow down and reappraise situations before acting.

In summary, treatment of BPD should take into consideration the problems of the present as a reflection of the lack of skills. Goal of the treatment is to improve these skills and apply them to situations that cause more distress to patients. Emotion regulation reduces the likelihood of patients acting emotionally in order to feel instant relief (e.g. overdose) and contributes to the development of more functional alternative solutions. Progress is gradual (often two steps forward and one backwards) (Dawson & MacMillan, 1993).

Conclusion: Communication and cooperation

The treatment experience of BPD patients has indicated that therapists need to communicate in a way that makes patients feel comfortable. The maintenance of a high level of awareness and motive in the session is another desideratum (Kramer, Caspar & Drapeau, 2013). Prolonged silences are not useful for patients who are suspicious about what you think of them and who feel insecure. A portentous style focusing on interpretations is unhelpful for people who need to be reassured that you are in touch with their feelings. Instead, therapy for patients with BPD is in some way like a conversation, it should be like talking to patients in a *natural and unpretentious way*. To be genuine and to facilitate collaboration, Linehan (1993) has suggested being “irrelevant” in therapy. Humor, for example, helps establish a sense of connection and also builds a neutral space around intense emotions. In addition, psychotherapy is full of metaphors. It is better to build on your patient’s metaphors rather than to introduce your own. Doing so can be creative and enjoyable for therapist and patient. Finally, the words you use should be as simple as possible. If you cannot explain a concept simply to a patient, you probably do not understand it yourself (Dawson & MacMillan, 1993).

One of the first things every therapist learns is how to build the so called *therapeutic alliance*, which establishes the conditions for the therapist-patient cooperation. The therapeutic alliance is built, as shown by research data, at the beginning of the treatment (during the first three sessions) and is a good predictor of the positive outcome (Luborsky, 1988). Difficulties in the alliance building have been seen in different ways by the various therapies for BPD. However, whether problems are defined as “therapy-interfering behaviors” (Linehan, 1993), transference (Clarkin *et al.*, 2007), or failures of mentalization (Bateman & Fonagy, 2006), they need to be addressed, or therapy will never get started.

The most important elements in alliance building are empathy, optimism, a practical focus on current issues and the provision of alternative solutions and choices (Orlinsky, Ronnestad & Willutski, 2004, Wright & Jones, 2012). An active and natural approach should bring most patients into an alliance quickly. However, some patients with BPD have a very fragile sense of trust, so that maintaining the alliance is difficult (Frank, 1992). A few can be too suspicious or too volatile to

enter psychotherapy at all. Fortunately, that kind of problem is exceptional. Most patients with BPD are willing at least to try therapy (even if they do not always stay in it). The key to building a therapeutic alliance is whether the patient feels understood. Current studies also, used randomized controlled trials, point to the significant role of dialectical behaviour therapy (DBT) (Bedics, Atkins, Harned, & Linehan, 2015; Jimenez, 2013) and schema-focused therapy to the quality and development of therapeutic alliance in BPD patients (Spidhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). For example, facets of the therapeutic alliance in DBT were associated with fewer suicide attempts (Bedics et al., 2015) and the therapeutic alliance and specific techniques of schema-focused therapy seem to interact with and influence one another and may serve to facilitate change processes underlying clinical improvement in patients with BPD (Spidhoven et al., 2007).

The usual term to describe the process of understanding feelings is *empathy*, but we need to think about what we mean by this much-used word. It does not necessarily imply a mindless “I feel your pain” or a knee-jerk “You were right to be so angry”. We are, again, in debt to Marsha Linehan for introducing the term validation. Linehan states (Linehan, 1993, pp. 222–223): “The essence of validation is this: The therapist communicates to the patient that his/her responses make sense and are understandable within current life context or situation”. In other words, validating does not mean agreeing with feelings or behaviors but understanding them in an interpersonal context. Doing so, the therapist avoids dismissing the patient’s reactions and leaves the door open for reframing and reappraisal.

In this context, humanistic-informed relational work may be a key ingredient in working with BPD clients group, when skilfully interwoven with more directive strategies as a dialectical behaviour therapy (Steffen, 2013). Current studies also, used randomized controlled trials, point to the effectiveness of motive-oriented therapeutic relationship (MOTR) in changing the biased thinking (Keller et al., 2018) and over-generalization (Kramer, Caspar & Drapeau, 2013) on BPD patients as well as to short-term treatments for BPD. These studies underline the importance of individualizing interventions, by using case formulations that rely on idiographic methods and integrative concepts (Kramer et al., 2015).

In summary, patients with BPD symptoms seem to have special difficulties creating and maintaining relationships, what renders especially hard the establishment of a therapist-patient relationship during the treatment process. Given that both the psychoanalytic approach and the cognitive therapy have dealt with BPD, the cognitive approach, deploying previous experience, can additionally offer valuable components to the effectiveness of the relationship component in the CBD treatment of BPD. *Focus on the present, structured treatment, identification of thoughts, emotions and behaviors, as well as the effort to regulate them, cooperative work, concrete boundaries and honest and meaningful communication* are some of the components cognitive therapy may add to a more efficient psychotherapy of BPD patients.

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