

A Thesis submitted in Partial Fulfilment of the Regulations for the degree of  
Clin. Psy. D. in the University of Birmingham

**Volume I**

**Research Component**

**The Therapeutic Relationship in Psychodynamic Therapy**

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## **Thesis Overview**

This thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology (Clin.Psy.D.) at the University of Birmingham. It comprises two volumes, including a research and clinical component.

Volume I of the thesis contains the research component, which consists of a literature review following a systematic approach and a research paper. The literature review used a systematic approach to explore the evidence base of psychodynamic therapy for individuals diagnosed with a personality disorder. This review has been prepared according to the requirements of the Clinical Psychology Review<sup>1</sup>, but adaptations have been made to meet the University of Birmingham regulations. The research paper explores client and therapist experiences of therapeutic rupture and repair during long-term psychodynamic therapy. Using a qualitative approach, semi-structured interviews were completed with four client-therapist dyads to explore their experiences. This paper has been prepared according to the requirements of Psychodynamic Psychotherapy. These papers are followed by a public briefing document, which includes an executive summary of both papers. Appendices are also provided with additional detail of the research process.

Volume II of the thesis is the clinical component of the thesis containing five clinical practice reports completed during clinical placements, which reflect the core training of the Clin.Psy.D. degree. These reports include a therapeutic models report, a single case experimental design report, a service evaluation report, a case study and an abstract of a case study presentation.

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<sup>1</sup> See Appendix A for instructions to authors for Clinical Psychology Review and Psychoanalytic Psychotherapy.

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Paper to be edited for submission to the Clinical Psychology Review

**LITERATURE REVIEW FOLLOWING A SYSTEMATIC  
APPROACH:**

**WHAT IS THE EVIDENCE FOR USING PSYCHODYNAMIC  
THERAPY WITH INDIVIDUALS DIAGNOSED WITH  
PERSONALITY DISORDER?**

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Words: Personality Disorder; Psychodynamic Therapy; Mentalisation Based  
Therapy; Transference Focused Therapy

## **1.0. Abstract**

18 studies investigating the evidence base of psychodynamic therapy for Personality Disorder (PD) were reviewed. These included Randomised Controlled Trials (RCTs), cohort and naturalistic studies. Out of the RCTs, 12 studies demonstrated superior results for psychodynamic therapy for individuals with PD. This included four studies that compared psychodynamic therapy with another type of therapy. However, two RCTs found the cognitive-based therapies demonstrated superior results to dynamic therapies. In terms of non-RCTs, there were more mixed findings with two studies demonstrating positive results for psychodynamic-based therapy and one study demonstrating less favourable findings for the psychodynamic approach. The majority of included studies looking at dynamic-based therapies with Borderline Personality Disorder had positive outcomes, which mainly concentrated on Mentalisation Based Therapy and Transference Focused Therapy. There were also good outcomes when using psychodynamic therapy for individuals with PD on a short-term and long-term basis in a range of settings. However, the longevity of dynamic therapy seemed to depend on the severity of PD and individual's level of risk. Future research should address methodological issues of previous dynamic research, including the use of active comparator group and follow up periods, to understand the ingredients of therapy that seem to generate change for PD.

### **Highlights:**

- 18 studies exploring the evidence base of psychodynamic therapy for treating personality disorder (PD) were reviewed, which included randomised controlled trials (RCTs), cohort and naturalistic studies.
- Out of the RCTs, 12 studies demonstrated superior results for the effectiveness and efficacy of psychodynamic therapy for individuals with PD.
- However, two RCTs found the cognitive-based therapies demonstrated superior results to dynamic therapies. For non-RCTs, there were more mixed findings with two studies demonstrating positive results for psychodynamic-based therapy and one study demonstrating less favourable findings for the psychodynamic approach.

## **2.0. Background**

Typically, Personality Disorder (PD) is marked by long-standing, pervasive and dysfunctional inner experiences and behaviours (Livesley & Jang, 2000). Individuals diagnosed with PD tend to have unstable perceptions of self and others, maladaptive interpersonal relationships and difficulties with affect regulation (Perry, 1993). The common experience of severe mental distress amongst individuals with a PD means that they are heavy users of mental health resources (Perry, Banon & Ianni, 1999). The prevalence of individuals with a diagnosis of PD in psychiatric populations is high with estimates of between 31% and 45% within an outpatient setting (Samuels et al., 2002).

### ***2.1 Conceptualising personality disorder***

Conceptualising PD is complex due to the high prevalence of co-morbidity with other mental disorders (Swartz, Blazer & Winfield, 1990). Within the Diagnostic Statistical Manual of Mental Disorder (DSM-IV), there are fourteen different PD categories, which are grouped into clusters A, B and C. (APA, 1994). Cluster A is termed odd-eccentric PDs comprising paranoid, schizoid and schizotypal PD, cluster B is dramatic-emotional type PDs including borderline, histrionic, narcissistic, anti-social PD and cluster C is known as anxious-fearful PDs consisting of dependent, obsessive-compulsive and avoidant PD. Dimensional models of personality, such as the five-factor model of personality, are often considered complimentary to these DSM categories and have demonstrated better clinical validity than the DSM classification system (Skodol, Johnson, Cohen, Sneed & Crawford, 2007). Therefore PDs could be considered to be extreme examples of normative personality patterns within the general population (Morey et al., 2007).

Individuals with Borderline Personality Disorder (BPD) are more likely to present to mental health treatment services compared with other PDs (Tyrer, Mitchard & Methuen, 2003). This could be linked to the role of trauma in the etiology of BPD, which impacts on emotional regulation, interpersonal relationships and the capacity for insight (Bateman & Fonagy, 2004).

## ***2.2. Treating personality disorder***

Historically, personality pathologies have been difficult to treat due to complicated transference and counter-transference reactions with unanticipated issues (Millon, Grossman, Millon, Meagher & Ramnath, 2004). Studies exploring the efficacy of psychotherapy have led to increased optimism about the treatability of PD (Fonagy & Bateman, 2006a). Therefore psychotherapy is now the treatment of choice for individuals with PD and pharmaceutical interventions seem to have limited added value (Leichsenring & Leibling, 2003).

There is now a wide range of psychotherapies with different modalities and durations offered to individuals with various PDs. Literature on psychotherapy has tended to conclude that the outcomes from different therapies are equivalent with no form of psychotherapy being superior, known as the Dodo Bird verdict (Luborsky, Singer & Luborsky, 1975). Verheul and Herbrink (2007) completed a systematic review of different modalities of psychotherapy for PD and found that both cognitive and dynamic-based psychotherapies were effective in reducing symptoms and improving functioning.

In the last 10 years, there has been a wealth of national guidance published by the National Institute for Mental Health in England (NIMHE) on the development of services for people diagnosed with a PD, such as 'Personality disorder: No longer a diagnosis of exclusion' (NIMHE, 2003a) and 'Breaking the cycle: The personality capabilities framework' (NIMHE, 2003b). The guidance outlined the range of psychological treatments available for PD, including dynamic psychotherapy and cognitive-based therapies, but also highlighted the need for long term, well structured, focused therapies with a clear treatment alliance between the therapist and client. For those individuals with significant distress and complex problems, the guidance also recommended that such psychotherapies are delivered in the context of a specialist multi-disciplinary PD team to promote a consistent team approach.

Within the existing National Health Service (NHS) climate in the UK, there is a drive towards using evidence-based psychotherapies, especially with the introduction of Payment by Results (PbR) within mental health services (DoH, 2010). There is pressure for clinicians to train and utilise psychotherapies that are in line with National Institute of Clinical

Excellence (NICE) guidelines that recommend treatments with long-term positive outcomes for patients. Given the NIMHE guidance on changes to PD services, finding evidence-base psychotherapies for PD is a growing area of research.

### *2.2.1 Psychodynamic therapy and personality disorder*

Psychodynamic psychotherapy has been criticised for a lack of evidence base that would justify its use (Galatzer-Levy, Bachrach, Skolnikov & Waldon, 2000). Shelder (2010) noted that many researchers within the scientific community have dismissed psychodynamic therapy as ineffective, which may be due to the historical reluctance of psychodynamic practitioners to engage with controlled research (Anestis, Anestis & Lilienfeld, 2011). Many psychoanalytic researchers have also highlighted the lack of compatibility between Randomised Controlled Trials (RCTs) and psychodynamic therapy, such as using manualised treatments (Leichsenring, 2005, Fonagy, Roth & Higgitt, 2005). Unfortunately, this has resulted in some blanket assertions that psychodynamic therapy is scientifically unwarranted (Shedler, 2010). To avoid the disconnection between psychoanalytic work and mainstream psychology, Bornstein (2001; 2002) underlined the need to illuminate psychodynamic work by using a combination of nomothetic and idiographic techniques to test clear hypotheses.

In the last decade, empirical studies have responded to this deficit in psychodynamic research and many have focused on PD (Lewis, Dennerstein & Gibbs, 2007). Two specific psychodynamic-based therapies for BPD have been studied more recently using RCTs, namely Mentalisation Based Therapy (MBT) and Transference Focused Psychotherapy (TFP). TFP is a modified psychodynamic psychotherapy based on Kernberg's (1984) framework, which focuses on the integration of internalised experiences of dysfunctional early relationships and uses the transference relationship to observe any repeating patterns (Clarkin, Yeomans & Kernberg, 2006). MBT is also a psychodynamic treatment for individuals with BPD, which aims to strengthen the capacity to understand their own and others' mental states to address difficulties with affect, impulse regulation and interpersonal functioning (Bateman & Fonagy, 2004).

In line with this work, the published NICE guidelines (NICE, 2009) for individuals with BPD recommend the use of MBT (Bateman & Fonagy, 2004) and Dialectical Behaviour Therapy (DBT; Linehan, 1993) based on cognitive behavioural principles for at least 18 months. This is especially relevant for individuals with more severe personality pathology and low functioning BPD. However, NICE guidelines (2009) acknowledge that research on the effectiveness of psychological therapies for PD is in its infancy.

### ***2.3 Literature reviews on psychodynamic therapies and personality disorder***

A number of literature reviews have summarised the favourable outcomes of psychodynamic psychotherapy for PD (Fonagy, Roth & Higgitt, 2005; Bateman & Tyrer, 2004; Leichsenring & Leibing, 2003). In particular, Leichsenring and Leibing's (2003) meta-analysis and Fonagy and colleagues' (2005) review demonstrated that both psychodynamic therapy and Cognitive Behavioural Therapy (CBT) were effective treatments for PD. However, Anestis, Anestis and Lilienfeld (2011) criticised Leichsenring and Leibing's review for including mainly naturalistic psychodynamic studies, while the CBT studies tended to be RCTs, which may skew the findings in favour of dynamic therapy.

Other psychodynamic meta-analyses by Leichsenring, Rabung and Leibing (2004) and Leichsenring and Rabung (2008) exploring the effectiveness of psychodynamic therapy have also been heavily criticised. Bhar and colleagues (2010) found that these meta-analyses included underpowered studies, which were highly heterogeneous with regards to the participants treated, interventions, comparison-control groups and outcomes. Anestis and colleagues (2011) also highlighted the lack of dynamic studies that compared psychodynamic therapy with another type of validated therapy and the majority of reviews focused on treatment as usual conditions. Shedler (2010) urged psychodynamic researchers to address this within future research.

### ***2.4 The current review***

This review attempted to provide an understanding of the current evidence base for the use of psychodynamic therapy with individuals diagnosed with a PD. Since the review by Fonagy and colleagues (2005), research in this area has continued to grow rapidly. Governmental pressures and PbR initiatives to use therapies with a sound evidence base may

have prompted this. Six years on from the Fonagy and colleagues (2005) review, it seemed useful to appraise the growing literature in this area and explore whether any more detailed conclusions can be drawn.

### **3.0. Existing review assessment**

Preliminary searches of existing systematic reviews and meta-analyses were conducted in Cochrane Library, PsycInfo, MEDLINE and EMBASE in order to search for existing reviews (completed on 11/02/11). Considering these reviews and the scoping search employed prior to initiating the review, there have been no systematic reviews published in this area since the review by Fonagy and colleagues in 2005 (see Appendix A). As McKay (2011) highlighted the difficulties with previous psychodynamic reviews overlapping in publication time periods, this review concentrated on articles from 2005 onwards.

### **4.0. Aims and objectives of the review**

#### ***4.1 Aims***

This systematic review aimed to explore the evidence base of psychodynamic therapy with individuals diagnosed with PD. Papers reviewed were published from 2005 onwards to ensure inclusion of the most up-to-date evidence and avoid overlap with previous reviews.

#### ***4.2 Objectives***

The objectives of this systematic review are as follows:

1. To determine the nature of the evidence base of psychodynamic therapy with individuals diagnosed with PD.
2. To explore the evidence base of different types of psychodynamic therapy for individuals diagnosed with PD.
3. To explore the differences between long term and short term psychodynamic therapy for individuals diagnosed with PD.

### **5.0 Sources of literature**

A search was conducted on electronic databases including PsychINFO (2005 to current completed on 11/02/11), including Journals@Ovid Full Text), MEDLINE (2005 to current completed on 11/02/11), EMBASE (2005 to current completed on 11/02/11), CINAHL

(2005 to current, completed on 26/03/11) and Web of Science (2005 to current, completed on 26/03/11). Meetings were also held with experts in order to gain additional resources and email contact was attempted with two authors. One author replied with additional resources that had already been identified in the systematic search. When relevant articles and literature reviews were identified, the reference lists were scanned to ascertain any other relevant literature to include within the systematic review.

## **6.0 Search strategy**

The databases were accessed electronically and limits were placed on these searches. Searches were restricted to articles written in the English language due to both financial and time constraints of translating studies. Editorials, comment papers and unpublished work were also omitted from the search. Although excluding unpublished work may lead to some publication bias, it was deemed practical due to the time constraints of obtaining original articles, as well as lack of peer review of unpublished work. The same searches were applied to all electronic databases, but there were slight variations in searches due to the relevant search tools for each database. Relevant searches and references were saved (see Appendix B for syntax). The Journal of Personality Disorders was also searched from 2005 onwards to retrieve any relevant articles.

## **7.0. Search terms**

The search terms entered into the search are documented in Appendix B. Although mapping to subject headings is a more efficient way to search, keywords were used in order to reduce the amount of studies that might be lost due to incorrect coding. This did greatly increase the number of hits and duplicates in the search, but it allowed for consistency across electronic resources, as some databases did not have the mapping option. To be clear about how the search terms were defined, Box 1 highlights the definitions of the main search terms.

### **Box 1. Definitions**

#### **Psychodynamic psychotherapy:**

Psychodynamic psychotherapy serves as an umbrella concept (Henry, Strupp, Schacht & Gaston, 1994). The commonality that brings the different strands of psychodynamic therapy is the consensus that unconscious conflicts create emotional distress. Psychodynamic therapy aims to investigate unconscious psychic life through the transference and counter-transference within the therapeutic relationship. Dynamic therapy seeks to work through symptoms and defences to develop an integrated self-knowledge and self-understanding (Bateman, Brown & Pedder, 2000).

Psychodynamic psychotherapy incorporates a diverse range of therapies and is expanding (Bateman & Fonagy, 2004; Yeomans, Clarkin & Kernberg, 2002). For the purposes of this review, psychodynamic therapy includes, short term and long term dynamic therapy, mentalisation-based therapy, transference focused-therapy and dynamic deconstructive therapy.

#### **Personality disorder:**

General diagnostic criteria for a personality disorder (DSM-IV; APA, 1994)

- A. An enduring pattern of inner experience and behaviour that deviates manifested in two (or more) of the following areas:
  - 1) Cognition (i.e. ways of perceiving and interpreting self, other people and events)
  - 2) Affectivity (i.e. the range, intensity, liability and appropriateness of emotional response)
  - 3) Interpersonal functioning
  - 4) Impulse control
- B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations
- C. The enduring pattern leads to clinically significant distress or impairment in social, occupational or other important areas of functioning
- D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood
- E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
- F. The enduring pattern is not due to the direct physiological effects of a substance (e.g. drug of abuse, a medication) or a general medical condition (e.g. a head trauma)

### **8.0. Study selection**

With reference to the aims of the review and initial scoping searches, inclusion and exclusion criteria were developed, which were divided into population, intervention, comparison and outcome. This is known as the PICO (population, intervention, comparison and outcome) model (Petticrew & Roberts, 2006), which is a helpful way to ensure the selected studies

meet the aims of the review. A copy of the inclusion and exclusion criteria utilised to assess all studies is shown in Appendix C. Those abstracts that did not reveal enough information to apply the criteria were assessed using the full text article. Those that were not available were ordered from the British Library via a local library.

Excluded articles and reasons for exclusion have been listed in Appendix D. Purely group interventions were excluded, as the large majority of psychodynamic therapy with individuals diagnosed with PD had some element of individual therapy (e.g. Bateman & Fonagy, 2004). Naturalistic, non-controlled studies are considered low quality (Evans, 2003) due to their lack of sequence of events and difficulty indicating causation (Petticrew & Roberts, 2006). However, based on an initial search, it was clear that the best available research in this area included some naturalistic studies therefore the search strategy did not exclude on the grounds of study design alone.

## **9.0 Quality Assessment**

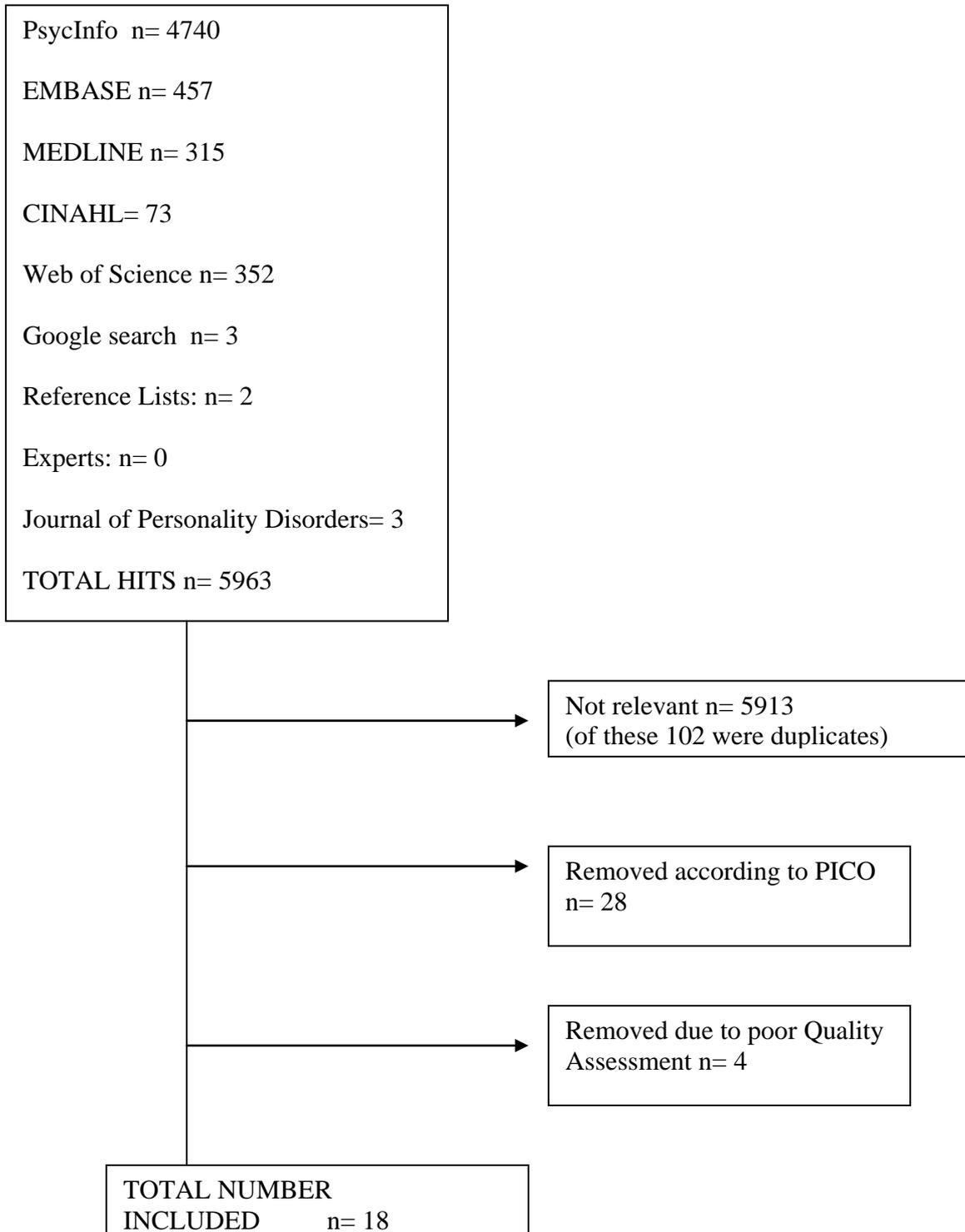
All studies were assessed on quality criteria adapted from the Critical Appraisal Skills Programme (CASP, 2000). CASP has developed well-utilised quality checklists to help researchers interpret the best available evidence from health research. Based on these checklists, the key variables assessed were: aims of the study; study design; sample selection; attrition rates; statistical analysis; clarity of outcome measure; identification and measurement of variables; and appraisal of limitations. Each item on the scoring sheets (see Appendix E) was assessed on a three-point scale (Yes (2), Partly (1), No (0)), with an option for 'unknown', which was excluded in the scoring, but given extra attention in a qualitative manner. By adding the scores of each item and the number of fundamental criteria fulfilled (shown in Appendix E with an asterisk), the total quality score was obtained. Due to the large volume of studies, only those assessed to be of good quality were included. Similar to other quality checklists used by Wong, Cheung and Hart (2008), good quality studies was defined as more than 70% of the quality assessment criteria and the majority of the fundamental criteria fulfilled. Although this might produce some bias, it suggested that the conclusions and recommendations of this review were based only on those studies assessed to be of good quality. When possible, authors were approached for copies of their empirical research and clarification if there were uncertainties about any information obtained in

studies. To ensure that the variables were being assessed correctly and consistently, a second independent reviewer also assessed each study, which demonstrated high inter-rater reliability. Characteristics of quality-assessed studies (n=22) are collated in Appendix F, including four studies assessed as poor quality (Gregory et al., 2008; Gregory, Remen, Soderberg & Ploutz-Snyder, 2009; Vermote et al., 2009; Leichsenring, Masuhr, Jaeger, Dally & Streek, 2010). These studies were removed due to a range of reasons, including a lack of statistical analysis, limited information on participant recruitment and outcome measures, small samples (e.g. n=15), lack of clarity on the type of psychodynamic therapy and length of treatment and an inadequate discussion of study's limitations (further information is documented in Appendix F).

## 10.0. Results

The study selection process resulted in 18 studies, which met the inclusion/exclusion criteria and were assessed to be of good quality. Figure 1 displays the process of study selection with detail regarding the number of studies excluded at each stage.

**Figure 1: Description of studies flowchart**



## **11.0 Data Extraction**

Data were extracted from the studies using a structured pro forma, which incorporated the quality assessment results of each study. The pro forma (see Appendix G) was established in order to extract relevant data from each study based on an example recommended by Petticrew and Roberts (2006). Indecipherable information from the studies was recorded as 'unknown'. With more flexible time constraints, the authors of the study would be contacted in order to establish this information.

## **12.0 Descriptive Data Synthesis**

The results of the included studies were not statistically combined for quantitative data synthesis due to the heterogeneity of studies. Therefore, in reaching conclusions, studies were examined in a qualitative manner. Collation of data from included studies can be viewed in Appendix H.

### ***12.1 Study populations***

Out of the 18 studies included within the review, three were conducted in Sweden, three in North America, three in the United Kingdom, two in the Netherlands, two in Norway, two in Canada, one in Denmark, one in Belgium and one across Austria and Germany. The sample sizes varied across the studies with some papers having up to 180 participants (McMain et al., 2009) and others having as few as 19 participants in the whole sample (Jorgensen & Kjolbye, 2007). In terms of demographic information, the mean age of participants across the included studies ranged from 28 years (Jorgensen & Kjolbye, 2007) to 40 years (Gude & Hoffart, 2008; Abbass et al., 2008). All of the included studies had more female participants than males, especially those focusing on BPD. This is unsurprising given that a large proportion of people diagnosed with BPD are female (APA, 2000).

### ***12.2 Types of therapies***

As illustrated in Table 1, seven studies used short-term psychodynamic-based psychotherapies. The remaining eleven studies focused on long-term psychodynamic psychotherapies. Long-term psychotherapy was defined as 40 sessions or more, as this was the criterion used in the majority of included studies and has been the definition used in previous literature reviews (e.g. Abbass, Hancock, Henderson & Kisely, 2009).

With regards to types of psychodynamic therapy, three of the included studies focused on TFP. Two studies explored the use of MBT with BPD, which were both carried out by Bateman and Fonagy (2008; 2009). One study used Dynamic Deconstructive Psychotherapy (DDP) designed for co-occurring BPD and substance misuse (Gregory et al., 2010). Two studies used intensive dynamic psychotherapy based on Davanloo's (1990) model (Abbas et al., 2008; Kallestad et al., 2010). The remaining articles included other psychodynamic-based therapies drawing from a range of psychoanalytic theories. Although the review

focused on individual therapies, some of the included studies used both group and individual dynamic interventions (Bateman & Fonagy, 2008; Jorgenson & Kjolbye, 2007; Gude & Hoffart, 2008; Chiesa et al., 2009; Bateman & Fonagy, 2009; Vermote et al., 2010). This is unsurprising given that MBT and inpatient settings typically combine both group and individual therapy (Bateman & Fonagy, 2004). However, the remaining studies focused on purely individual dynamic-based therapy.

**Table 1: Therapies used in included studies**

	<b>Transference Focused Therapy</b>	<b>Mentalisation Based Therapy</b>	<b>Other psychodynamic based therapy</b>	<b>Long term psychodynamic therapy (&gt;40 sessions)</b>	<b>Short term psychodynamic therapy (&lt;40 sessions)</b>
Vinnars et al. (2005)			X		X
Emmelkamp et al. (2006)			X		X
Giesen-Bloo et al. (2006)	X			X	
Levy et al. (2006)	X			X	
Clarkin et al. (2007)	X			X	
Jorgensen & Kjolbye (2007)	X			X	
Vinnars et al. (2007)			X		X
Bateman & Fonagy (2008)		X		X	
Gude & Hoffart (2008)			X		X
Abbass et al. (2008)			X		X
Bateman & Fonagy (2009)		X		X	
Chiesa et al. (2009)			X	X	
Vinnars et al. (2009)			X		X
McMain et al. (2009)			X	X	
Gregory et al. (2010)			X	X	
Vermote et al. (2010)			X	X	
Doering et al. (2010)			X	X	
Kallestad et al. (2010)			X		X

**12.3 Outcome measures used**

There was a wide range of different outcome measures used within the included studies. These measures can be grouped into symptomology measures, global assessment measures, specific PD measures, measures of psychodynamic concepts and service utilisation.

The two most commonly used tools were the Symptom Checklist- Revised (SCL-R; Derogatis, 1983) and Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988), which were both used in seven of the studies (Vinnars et al, 2005; Giesen-Bloo et al., 2006; Jorgensen & Kjolbye, 2007; Vinnars et al., 2007; Gude & Hoffart, 2008; Abbass et al., 2008; Bateman & Fonagy, 2009; Vinnars et al., 2009; McMain et al., 2009; Vermote et al., 2010; Kallestad et al., 2010). The SCL-R is commonly used to measure subjective experience of symptoms and the IIP measures the subjective experience of interpersonal distress. The most common measure of PD was the Structured Clinical Interview for DSM-IV (SCID-II; First, Gibbon, Spitzer & Williams, 1997) in eight studies.

The majority of psychodynamic measures were based on open-ended interviews with trained professionals to gain detailed information about the participant's early experiences, attachment figures and therapeutic relationship, such as the Adult Attachment Interview (AAI; George, Kaplan & Main, 1985), Karolinska Psychodynamic Profile (KAPP; Weinryb, Rossel, Gustavsson, Asberg & Barber, 1997) and Object Relations Inventory (ORI; Blatt, 1998; Harpaz-Rotem & Blatt, 2005).

#### ***12.4 Objective One: To determine the nature of the evidence base of psychodynamic therapy with individuals diagnosed with PD.***

There were 14 RCTs, two cohort studies and two uncontrolled, naturalistic studies. Out of the RCTs, 12 studies demonstrated positive results for the effectiveness and efficacy of psychodynamic therapy for individuals diagnosed with PD. Two RCTs found that CBT and Schema-Focused Therapy (SFT) demonstrated superior outcomes compared to dynamic therapies (Emmelkamp et al., 2006; Giesen-Bloo et al., 2006).

##### ***12.4.1 Psychodynamic therapy compared with another type of therapy***

Eight studies compared psychodynamic therapy with another type of non-psychodynamic therapy rather than a treatment-as-usual group and seven of these were RCTs. Levy and colleagues (2006) completed an RCT comparing the differences in participants completing TFP with those completing DBT and Psychodynamic-Supportive Psychotherapy (PSP). PSP is a manualised approach aiming to develop a healthy collaborative relationship with the therapist and to replace self-destructive enactments with verbal expression of conflicts. They

found that TFP participants significantly improved in narrative coherence ( $F= 6.28$ ,  $p<0.05$ ,  $r=0.64$ ), secure attachment patterns ( $\chi^2= 4.17$ ,  $p<0.04$ ) and reflective functioning ( $F= 15.05$ ,  $p<0.05$ ,  $r= 0.89$ ) compared to DBT and PSP participants. Importantly, there were no changes in resolution of loss or trauma in any of the three treatment groups, which may be a rehabilitative change occurring later in therapy. Similarly in another RCT, Clarkin and colleagues (2007) compared TFP, DBT and PSP and found that all treatment groups showed improvements on depression, anxiety, global functioning and social adjustment. Only participants completing TFP showed significant improvements in impulsivity, irritability, verbal assault and direct assault.

Equally, McMain and colleagues (2009) compared DBT with General Psychiatric Management (GPM) for individuals with BPD using an RCT. GPM consisted of dynamic psychotherapy and case management as based on the APA practice guidelines for treatment of individuals with BPD. The results demonstrated that both groups improved on the majority of clinical outcomes after one year of treatment, including suicidal self-injury (odds ratio= 0.23,  $p=0.01$ ) and non-suicidal self-injury (odds ratio= 0.52,  $p=0.03$ ) and health care utilisation, such as number of emergency department visits (odds ratio=0.43,  $p<0.0001$ ) with no between group differences.

Counteracting these results, Giesen-Bloo and colleagues (2006) compared SFT with TFP over three years of therapy using an RCT. They demonstrated that more SFT participants recovered (relative risk= 2.18,  $p=0.04$ ) and showed more reliable clinical improvement (relative risk=2.33,  $p=0.009$ ) on the Borderline Personality Disorder Severity Index. They also showed improvements on psychopathologic dysfunction ( $p<0.001$ ) and increases in quality of life ( $p<0.001$ ) compared to TFP participants. This was attributed to the more confrontational techniques in TFP resulting in a higher attrition rate. In a similar vein, Gude and Hoffart (2008) conducted a cohort study comparing SFT with psychodynamic treatment and showed that the cognitive condition had greater improvements in interpersonal problems ( $F=11.41$ ,  $p<0.01$ ) rather than the psychodynamic group. Importantly, the authors noted that the therapists included within the study had allegiance towards SFT, which is likely to bias results in favour of the cognitive condition.

In relation to MBT, Bateman and Fonagy (2009) completed an RCT comparing MBT with Structured Clinical Management (SCM), which is based on a counselling model with supportive case management and problem-orientated psychotherapeutic interventions. They showed that MBT participants had a steeper decline in suicidal behaviour ( $\chi^2= 12.8$ ,  $p<0.001$ ), and hospitalisation ( $\chi^2= 0.7$ ,  $p<0.005$ ) than SCM. The decline in self reported symptoms, such as interpersonal distress, social adjustment problems, depression and symptom distress was greater for MBT than SCM.

Notably, MBT and DBT have different primary therapeutic aims to TFP and SFT (Giesen-Bloo et al., 2006). MBT and DBT aim to reduce self-destructive psychopathologic dysfunction of BPD and not overall personality change. Whereas SFT and TFP aim to integrate identity diffusion and make structural changes in the individual's personality by reducing both self destructive behaviours and pathogenic personality features (Verheugt-Pleiter & Deben-Mager, 2006). In other words, MBT often lends itself to lower functioning borderline individuals with prominent parasuicidal abnormalities and TFP may be more suitable for higher functioning borderline individuals. DBT is often viewed as standard treatment for BPD, but these findings suggest that other therapies are also available for this client group may be efficacious.

Two other RCTs compared psychodynamic therapy to another type of cognitive therapy. Kallestad and colleagues (2010) compared short-term dynamic therapy with cognitive therapy for PD. The dynamic therapy group significantly improved their levels of insight ( $t=3.5$ ,  $p=0.002$ ) and this was associated with improved levels of symptom severity and interpersonal function after terminating treatment compared with cognitive therapy. They suggested that insight seems to be the key mechanism for change in dynamic therapy, but less relevant in cognitive therapy for positive outcomes. However, Emmelkamp and colleagues (2006) compared CBT with brief dynamic therapy and a waiting list control group using an anxiety symptom questionnaire and a social phobia inventory. They found CBT was superior to dynamic therapy and control group in reducing anxiety symptoms ( $F=5.69$ ,  $p=0.02$ ), social phobia ( $F=2.98$ ,  $p=0.09$ ) and avoidance ( $F=5.25$ ,  $p=0.03$ ).

In summary, five studies showed superior results for TFP, MBT and other dynamic-based treatment for treating PD when compared to DBT, CBT and other psychotherapies. These studies showed improvements in narrative coherence, secure attachment patterns, reflective functioning, impulsivity, insight, symptom distress and service utilisation. However, three studies did highlight the benefit of cognitive-based therapies over dynamic psychotherapies in terms of symptom severity, interpersonal functioning and quality of life. Considering these findings, the mechanisms of psychological change in dynamic and cognitive-based therapies may be very different. As suggested by Shedler (2010), outcome measures may need to reflect this in order to detect potential change. This was addressed in some studies by including both cognitive-based and psychodynamic-based measures (e.g. Giesen-Bloo et al., 2006).

#### *12.4.2 Psychodynamic therapy compared with treatment as usual*

Two RCTs compared psychodynamic therapy with treatment as usual or control conditions. Bateman and Fonagy (2008) compared participants completing MBT with treatment as usual. They found that MBT was superior to the control group on diagnostic status ( $\chi^2= 16.5$ ,  $p<0.001$ ), suicide attempts ( $\chi^2= 8.7$ ,  $p=0.003$ ), service use ( $U=25.5$ ,  $p<0.0001$ ), medication use ( $U=58.5$ ,  $p<0.0001$ ), global functioning ( $\chi^2= 6.5$ ,  $p<0.05$ ) and vocational status ( $F=0.6$ ,  $p=0.005$ ). Further to this, Abbass and colleagues (2008) compared intensive short term dynamic therapy with a minimal contact control condition and found that the therapy group had significant improvements on both BSI (1.51-0.51,  $p<0.001$ ) and the IIP (1.56-0.67,  $p<0.001$ ). In both studies, control participants continued taking medication and community support, but did not start any specialist psychotherapy during the study's duration.

#### *12.4.3 Psychodynamic therapy compared with another type of dynamic therapy*

Doering and colleagues (2010) explored the use of TFP compared with treatment by experienced community psychotherapists based on psychodynamic, behavioural, systemic or client-centred therapies. The TFP group had fewer suicide attempts ( $d=0.8$ ,  $p=0.009$ ), improvements in borderline symptomatology ( $d=1.6$ ,  $p=0.001$ ), psychosocial functioning ( $d=1.0$ ,  $p=0.002$ ), personality organisation ( $d=1.0$ ,  $p=0.001$ ) and inpatient admissions ( $d=0.5$ ,  $p=0.001$ ) compared to the other group. It is noteworthy that the comparison group of

community psychotherapists were free to choose the treatment intensity according to their method while the TFP group had two 50-minute sessions a week.

#### *12.4.4 Naturalistic, uncontrolled studies*

Two naturalistic, uncontrolled studies were included, which are deemed lower quality studies than RCTs and cohort studies. Jorgensen and Kjobye (2007) carried out a naturalistic study with participants who had completed long-term psychoanalytically orientated psychotherapy. They found that there were positive changes in anxiety ( $F=6.55$ ,  $p=0.01$ ), depression ( $F=4.74$ ,  $p=0.03$ ) and general functioning ( $F=14.36$ ,  $p<0.001$ ) after completing therapy. Using psychodynamic-based measures, Vermote and colleagues (2010) explored a hospitalisation-based psychodynamic treatment with patients diagnosed with PD. Similarly, they demonstrated significant improvements in personality functioning, self and object relationships and felt safety as well as symptomology, which were maintained upon the 12-month follow up. Unlike the study by Levy and colleagues (2006), there was no linear increase in reflective functioning, but it fluctuated throughout treatment. The authors suggested that the complex association between reflective functioning and attachment might mean there is not a linear trend. Overall, these naturalistic studies demonstrated positive results for dynamic therapy for PD in uncontrolled conditions

#### *12.4.5 Psychodynamic therapy and personality types*

12 studies looked at specific PDs with nine included studies focused on BPD. The majority of these included studies used MBT and TFP, which are discussed in Section 12.5.1. Another included RCT explored the use of Dynamic Deconstructive Psychotherapy (DDP) with participants diagnosed with BPD and alcohol misuse and compared this with a community care condition (Gregory et al., 2010). They found large sustained treatment effects with DDP, including significant improvements in BPD symptoms ( $F=18.09$ ,  $p=0.002$ ), depression ( $F=13.43$ ,  $p=0.004$ ), parasuicide ( $S=23$ ,  $p=0.031$ ) and recreational drug use. However, DDP is a newly developed therapy by Gregory and Remen (2008), which requires further exploration.

Three studies focused on individuals with Cluster C PDs, including Avoidant, Obsessive-Compulsive and Dependent PDs (Gude & Hoffart, 2008; Emmelkamp et al., 2006; Kallestad

et al., 2010). Two studies found positive outcomes in using cognitive-based psychotherapies with Cluster C PDs compared to psychodynamic treatment, in terms of improvements in interpersonal problems, anxiety, avoidance and insight into difficulties (Gude & Goffart, 2008; Emmelkamp et al., 2006; Kallestad et al., 2010).

Two RCTs explored the personality characteristics of good responders to psychodynamic-based therapies (Vinnars et al., 2007; Vinnars et al., 2009). Vinnars and colleagues (2007) showed that individuals with a higher number of personality disorder criteria had slower rates of improvement with psychodynamic therapy, but participants with higher rates of vindictiveness had higher rates of improvement ( $F= 8.90$ ,  $p=0.003$ ). Interestingly, individuals with high ratings of dominance tended to improve more with open-ended, non-manualised psychodynamic therapy ( $r=0.26$ ,  $p<0.001$ ) compared to the manualised psychodynamic therapy (Vinnars et al., 2009).

To summarise objective one, the majority of RCTs demonstrated superior results for PD when comparing psychodynamic-based therapies with either another type of therapy or treatment-as-usual. The two naturalistic uncontrolled studies also had positive results for dynamic orientated psychotherapy. In relation to personality types, MBT and TFP focusing on individuals diagnosed with BPD demonstrated superior results compared to established therapies. Individuals with Cluster C PDs tended to benefit from cognitive psychotherapies as opposed to dynamic therapy.

## ***12.5 Objective Two: To explore the evidence base of different types of psychodynamic therapy for individuals diagnosed with PD.***

### *12.5.1 Mentalisation-based therapy and Transference-focused psychotherapy*

Within the included studies, the evidence base of specific types of psychodynamic therapy mainly focused on MBT and TFP for individuals with BPD. Four studies found positive outcomes with using long-term TFP with BPD, including improvements in psychiatric symptoms, psychological outcomes and service utilisation (Doering et al, 2010; Clarkin et al., 2007; Levy et al., 2006; Jorgensen & Kjolbye, 2007). In terms of treatment intensity, this was based on twice weekly sessions of TFP. One study found that SFT was superior to TFP for BPD with positive outcomes in severity of BPD symptoms and quality of life (Giesen-

Bloo et al., 2006). Two studies by Bateman and Fonagy (2008; 2009) demonstrated positive change with MBT for individuals with BPD with improvements in service utilisation and symptomatology. This is based on once or twice a week sessions of MBT. However, there were no studies included that compared MBT with other non-psychodynamic therapies.

An important finding in two included studies on individuals with BPD was the lack of change in incidents of self-harming behaviour despite changes in other areas (Bateman & Fonagy, 2009; Doering et al., 2009). Based on work by Verheul and colleagues (2003), Doering and colleagues (2009) suggested high severity self-harming behaviour is more likely to change than low severity self harm therefore the incidents of self-harm may remain unchanged, but the severity may reduce. However, two included studies demonstrated some reduction in self-harming behaviour with dynamic-based therapies, not specifically MBT or TFP (Chiesa et al., 2009; McMain et al., 2009).

#### *12.5.2 Inpatient and outpatient settings*

The majority of studies included samples from an outpatient setting, but four studies used participants from inpatient, partial hospitalised and therapeutic community settings (Bateman & Fonagy, 2008; Vermote et al., 2010; Gude & Hoffart, 2008; Chiesa et al., 2009).

Both Vermote and colleagues (2010) and Gude and Hoffart (2008) used inpatient populations with some mixed results. Gude and Hoffart (2008) completed short-term psychodynamic therapy and cognitive therapy and found that PD participants had greater improvements with cognitive therapy. However, Vermote and colleagues (2010) completed long-term psychodynamic therapy with inpatients with PD participants, which showed improved symptomology and personality functioning. Both studies differed greatly in treatment intensity from once a week for 12 weeks in Gude and Hoffart's (2008) study to four times a week for a year in Vermote and colleagues' (2010) study.

Chiesa and colleagues (2009) conducted a cohort study comparing two modalities of psychodynamic treatment for individuals with PD, including a residential psychodynamic intervention known as a therapeutic community or community psychodynamic model. The therapeutic community is a voluntary 12-month residential programme with structured

activities, individual and group psychodynamic psychotherapy and participants are encouraged to return home at weekends. In comparison to individuals in the residential programme, community psychotherapy participants had lower early dropout rates ( $\chi^2=13.45$ ,  $p<0.001$ ) and were 2.4 times less likely to self-mutilate, 2.9 times less likely to attempt suicide and 12.5 times less likely to be readmitted to hospital.

In the same vein, Bateman and Fonagy (2008) explored the use of partial hospitalisation with MBT compared to community support (treatment as usual). Partial hospitalisation involved a weekly therapeutic programme including both group and individual MBT within a hospital setting, but the participants return home during the week. They found that MBT within a partial hospitalisation setting had superior results with both statistical and clinical outcomes compared to the treatment as usual condition. Both studies suggested the benefits of structured dynamic interventions without a purely inpatient approach and instead a community component to PD therapy may be more effective (Verheul & Herbrink, 2007).

#### *12.5.3 Manualised and non-manualised psychodynamic therapies*

Three studies by Vinnars and colleagues (2005; 2007; 2009) compared manualised with non-manualised, open-ended psychodynamic therapy for PD. In all three studies, the authors found no differences in outcome between manualised and non-manualised psychodynamic therapy and stated that they were equally as effective. Vinnars and colleague (2009) did find there were greater improvements in neuroticism in the non-manualised group within the follow-up period ( $F=5.65$ ,  $p<0.05$ ).

Notably, MBT and TFP are both manualised psychodynamic therapies, which have demonstrated some positive results for individuals with BPD (Levy et al., 2006; Bateman & Fonagy, 2008; Bateman & Fonagy, 2009; Clarkin et al., 2007; Doering et al., 2010). Gude and Hoffart (2008) reported some negative results for use of non-manualised psychodynamic therapy compared to other manualised therapies. There may be a number of variables that may impact on the effectiveness of manualised or non-manualised psychodynamic therapy, including the individual's level of functioning, type of PD and the length of treatment. Further exploration is needed in the area to clarify these variables.

To summarise objective two, six studies exploring TFP and MBT for individuals with BPD showed some beneficial results in comparison to another treatment group or treatment-as-usual conditions. Two studies compared psychodynamic-based treatment in residential or partial hospitalisation with a community setting and both highlighted the benefits of structured dynamic interventions without a purely inpatient approach. There also seemed to be few differences in outcome when comparing manualised with non-manualised dynamic therapies.

### ***12.6 Objective Three: To explore the differences between long term and short term psychodynamic therapy for individuals diagnosed with PD***

As highlighted in Table 3, seven of the included studies used short-term psychodynamic therapy and eleven studies used long-term psychodynamic therapy. Five studies highlighted positive results with improved symptoms, interpersonal problems, insight and psychological mindfulness for short-term dynamic therapy (Vinnars et al., 2007; Vinnars, et al., 2005, Vinnars et al., 2009; Kallestad et al., 2010; Abbass et al., 2008). However, two studies comparing short-term psychodynamic therapy and cognitive therapy found the cognitive condition was more effective in improving symptoms and interpersonal problems (Gude & Hoffart, 2008; Emmelkamp et al., 2006). Incidentally, both these studies included individuals with Cluster C PDs.

Out of the eleven long-term psychodynamic therapies, ten studies demonstrated positive outcomes for psychodynamic therapy for PD (Bateman & Fonagy, 2008; Bateman & Fonagy, 2009; Chiesa et al., 2009; Jorgensen & Kjolbye, 2007; Doering et al, 2010; Clarkin et al., 2010; Levy et al., 2006; McMain et al., 2009; Gregory et al., 2010; Vermote et al., 2010) and only one study (Giesen-Bloo et al., 2006) demonstrated that long-term SFT was superior over long-term psychodynamic therapy for PD. These long-term therapies also tended to be have higher treatment intensity with two to three sessions a week. Notably, these positive outcomes for long-term psychodynamic therapy included BPD participants, which is in line with NICE guidelines recommending more long-term, intensive psychotherapies for this client group.

Another factor to consider when assessing the differences in long-term and short-term psychodynamic therapy is the participants' PD severity and the risk associated with the disorder. Three included studies excluded participants who were at high risk of suicidal and self-harming behaviours within the sample (Emmelkamp et al., 2006; Abbass et al., 2008; Vinnars et al., 2009). Interestingly, all of these studies focused on short-term psychodynamic therapy. Whereas a number of studies exploring long-term psychodynamic therapy, included participants who were actively self harming (McMain et al., 2009; Bateman & Fonagy, 2009) or who were at risk of harm to self (Clarkin et al., 2007; Bateman & Fonagy, 2008; Chiesa et al., 2009; Doering et al., 2010; Gregory et al., 2010; Vermote et al., 2010). The majority of these studies included participants with BPD, which is associated with highly risky behaviours, in particular self harm and even suicide attempts (Skodol et al., 2002).

In summary, eleven studies including long-term psychodynamic psychotherapy showed positive outcomes for individuals with PD and only one study highlighted that another type of long-term therapy was superior. Five studies demonstrated benefits to short-term dynamic therapy, but only one of these studies compared this to another type of therapy.

## **13.0 Discussion**

### ***13.1 Summary and interpretation of findings***

#### *13.1.1. To determine the nature of the evidence base of psychodynamic therapy with individuals diagnosed with personality disorder*

The majority of included studies found positive outcomes for individuals with PD after completing psychodynamic therapy, in terms of service utilisation, symptomology, quality of life and interpersonal relationships. Compared to previous psychodynamic reviews, it demonstrated more support for the use of dynamic therapies with PD. Both Fonagy and colleagues (2005) and Leichsenring and Leibing (2003) noted the equal effectiveness between dynamic and cognitive therapies for PD. In this review, the majority of studies comparing dynamic and cognitive therapies for PD demonstrated positive results for psychodynamic approaches (e.g. Clarkin et al., 2007; Levy et al., 2006; McMMain et al., 2009; Kallestad et al., 2010).

The review demonstrated that psychodynamic-based therapies had more positive results with BPD than Cluster C PD. Two of the three included studies that explored psychodynamic-based therapies with Cluster C PD found that cognitive therapies were more effective (e.g. Emmelkarp et al., 2006; Gude & Hoffart, 2008). The superior results of dynamic therapies with BPD could be attributed to the relational aspects of psychodynamic therapy, which may be more appropriate for individuals diagnosed with BPD who have enduring interpersonal difficulties and emotional instability in interpersonal relationships (Bateman, Brown & Pedder, 2000). Through psychodynamic therapy, it is possible to explore unconscious processes creating this emotional instability by using the transference relationship.

Previous reviews by Bateman and Fonagy (2004) and Leichsenring and Leibing, (2003) have suggested clear guidance on the type of therapies that work for specific PDs. As Blatt (2004) suggested, it may be helpful to conceptualise individuals with PD as an overemphasis of either anaclitic or introjective personality styles. The anaclitic cluster is characterised by high relatedness and neglected self-definition whereas the introjective cluster tends to have a dominant self-definition and neglected relatedness. Interestingly, dependent, histrionic, passive-aggressive and borderline PDs tends to fit in the anaclitic cluster, while schizoid, schizotypic, paranoid, narcissistic, antisocial, avoidant, self defeating and obsessive

compulsive PD tends to correspond with the introjective cluster (Blatt, Besser & Ford, 2007). According to Blatt and colleagues (2007), introjective clients tend to respond well to less structured, insight-orientated therapy and anaclitic individuals respond better to more structured, supportive treatments. In other words, introjective individuals are primarily focused on insight, while anaclitic individuals are focused on support in interpersonal relationships. It may be more appropriate to match the individual and the type of therapy depending on their dominance towards self-definition or relatedness to others.

With reference to the quality assessments, the average quality score across the included studies was 80% (see Appendix G). Positively, the majority of these studies used well-validated measures, a clearly defined therapy and population, selected cases representative of the population, accounted for attrition rates, used appropriate statistical analysis and discussed limitations. However, intention to treat analysis, treatment integrity checks and follow-up periods were not always included. In some studies, there were also biases with researcher allegiances to certain types of treatment and blinding assessors to participants' outcome was not always used.

### *13.1.2. To explore the evidence base of different types of psychodynamic therapy for individuals diagnosed with personality disorder*

The majority of the TFP articles and both MBT papers demonstrated positive results for the use of these therapies with BPD. Unsurprisingly, there were some researcher allegiances with the therapy in some of these papers, in particular regarding MBT (Bateman & Fonagy, 2008; 2009). In addition, the majority of these studies did not include follow-up periods (e.g. Levy et al., 2006). The results for these types of psychodynamic therapies are promising, but further investigation is required to explore the longevity of findings.

Another interesting finding is the positive results for both manualised and non-manualised psychodynamic therapy based on three included studies. Using manualised approaches within psychodynamic therapy for PD is a contentious issue. Encapsulating these concerns, Henry (1998) suggested that reducing psychodynamic therapy to manuals for specific disorders might do serious damage to the breadth of clinical experience and training. Leichsenring (2005) also highlighted fears about manuals undermining the therapeutic

process by distracting away from the transference within the therapeutic relationship. Despite such fears, using manuals did not seem to impact on therapeutic outcome. However, it remains unclear when manualised approaches may be more appropriate to use over non-manualised therapy. There may be a number of participant variables impacting on the suitability of manualised treatments, such as individual's level of functioning, type of PD and length of treatment, but this needs further clarification.

A small collection of included studies explored dynamic therapies for PD in inpatient, partial hospitalised and therapeutic community settings. Although only two studies compared a psychodynamic hospital-based or partial hospital-based model with a community model, both highlighted the benefits of a structured dynamic intervention without a purely inpatient approach (Bateman & Fonagy, 2008; Chiesa et al., 2009). This is obviously dependent on the individual's level of risk and resources within the community. These findings paralleled Verheul and Herbink's (2007) review, which found the optimal mode of psychotherapy for PD was a step down approach. This involved a short-term inpatient phase if necessary followed by a long-term outpatient follow up treatment as opposed to purely inpatient care.

### *13.1.3. To explore the differences between long term and short term psychodynamic therapy for individuals diagnosed with personality disorder*

The majority of included studies used long-term psychodynamic therapy for PD and only one study showed that long-term cognitive therapy was superior to long-term psychodynamic-based therapy (Giesen-Bloo et al., 2006). Some studies showed that short-term psychodynamic-based therapy was effective for PD, but seemed to be with individuals with less severe symptomology and risky behaviours. (e.g. Vinnars et al., 2007; Kallestad et al., 2010; Abbass et al., 2008). In line with NICE guidelines for BPD (2009), studies using participants with BPD tended to have higher PD severity and required longer, more intensive therapy to address these enduring difficulties.

The findings are similar to a review by Perry and colleagues (1999) that explored a range of psychotherapies with PD. They demonstrated that studies including participants with Cluster C PDs tended to recover using short-term therapies while studies with BPD participants tended to have more severe psychopathology and required long duration therapy.

Leichsenring and colleagues (2004) and Leichsenring and Rabung (2008) completed meta-analyses on long-term and short-term psychodynamic therapy for a range of mental disorders. They noted that a considerable amount of people with PD did not benefit sufficiently from short-term psychotherapy and instead long-term dynamic therapy is a more effective treatment for such complex mental disorders. However, there was significant variation in how short-term and long-term therapy was defined in previous meta-analyses and reviews. As Leichsenring and colleagues (2004) noted, it still remains unclear under what circumstances short-term dynamic therapy is preferable over long-term dynamic therapy and further clarification is needed on this.

### ***13.2 Latest developments in psychodynamic research***

Historically, there has been a gap between psychodynamic therapists and academic psychologists, which has resulted in limited empirical research on the effectiveness of psychodynamic psychotherapy in comparison to other cognitive therapies (Shedler, 2011; Bornstein, 2001; 2002). With the development of new dynamic-based therapies, there appears to be strong evidence base for PD emerging that does not rely solely on naturalistic, uncontrolled studies. As demonstrated by this review, MBT and TFP have been tested in RCTs with superior results (Clarkin et al., 2007; Levy et al., 2006; Bateman & Fonagy, 2008; 2009). Previous criticisms of psychodynamic research have been the absence of optimal comparative treatment conditions with the tendency to use waiting list controls or treatment as usual (Shedler, 2010). It is evident from the studies reviewed here that researchers are now making comparisons to cognitive-based therapies, such as DBT and SFT.

One of the challenges with comparing the effectiveness of different psychotherapies is ensuring the chosen measures assess the phenomena that the therapies are trying to address. The goals of psychodynamic therapy include, but extend beyond, the alleviation of acute symptoms (Shedler, 2010) and include measurements of inner capacities. Shedler (2010) noted that the Dodo Bird verdict on psychotherapy might reflect a failure of researchers to adequately assess the range of phenomena that can change in therapy. However, this review included studies using a wide range of measures assessing symptomology, service utilisation, quality of life and cognitive and psychodynamic specific constructs.

There have been a number of changes in how psychodynamic therapies for PD are being researched, which has demonstrated an increase in scientific rigour. With this shift in psychodynamic research, it may help to merge the gap between psychodynamic therapy and the academic community and possibly shed some light on the Dodo Bird verdict (Shedler, 2010).

### ***13.3 Problems with psychodynamic research on personality disorder***

Despite the advances in psychodynamic research on PD, there remain a number of problems with current research that need to be addressed to further improve its scientific credibility.

As Shedler (2010) highlighted, there continues to be a lack of clarity on the characteristics of patient samples and how treatment methods are employed and monitored. To improve this and minimise bias, Bhar and colleagues (2010) made a number of suggestions. By using the Cochrane Collaboration tool (Higgins & Altman, 2008), they highlighted a number of ways to overcome bias in RCTs, including; clear randomisation procedures; blinding assessors or participants; clear allocation concealment; clear treatment integrity; use of intention to treat analysis; and balanced treatment uptake between groups. Although these standards were employed by some of the RCTs reviewed here, this was not done consistently. In particular, intention to treat analysis was only clearly displayed in 4 RCTs and the absence of this analysis can artificially inflate or deflate the difference between treatment groups (Newell, 1992). This needs to be addressed in future research to avoid similar methodological flaws.

Notably, a number of studies did not include a follow-up period (e.g. Giesen-Bloo et al., 2006; Levy et al., 2006; Clarkin et al., 2007; Doering et al., 2010). Anestis and colleagues (2011) have argued that this is a major criticism of psychodynamic studies with some findings of short-term dynamic therapy being inferior to other approaches after a one year follow up (e.g. Svartberg & Stiles, 1991). Long-term follow-up of therapies should be used consistently to understand the longevity of findings. However, follow-up periods may be in progress for the papers included in this review, as they were only recently published.

There are no agreed common outcomes for PDs and measures like global functioning, quality of life, symptomology, problematic behaviours and service utilisation are all useful in assessing change, but are not specific to personality and can be influenced by factors independent of personality. Future research on psychodynamic therapy with PD needs to consider using measures exploring change in personality status and core features of PD (Bateman & Tyrer, 2004).

Some of the included studies compared a specific dynamic-based intervention, such as TFP or MBT with a psychodynamic supportive psychotherapy (e.g. Clarkin et al., 2007; Levy et al., 2006). Comparing two interventions that fall within the broad umbrella of dynamic psychotherapy may confuse the specific components responsible for change. As Connolly Gibbons, Crits-Christoph and Hearon (2008) point out, studies that explore efficacious treatments for PD should go beyond specific treatment packages within the same therapeutic camp and instead identify the ingredients needed for change within the treatments. Focusing on process variables of psychodynamic therapy may provide information on the ingredients of therapeutic change for PD, such as frequency and accuracy of transference interpretation, fluctuations in the therapeutic alliance and therapist skilfulness (Leichsenring, 2005). It may be the qualities and style of the individual therapist, client and the patterns of interaction between them that generate therapeutic change rather than the brand of therapy.

#### ***13.4 Strengths and weaknesses of review***

Positively, the current review included studies from a range of different countries and cultures. This systematic review also avoided a publication overlap with other previous reviews, including a similar review completed by Fonagy and colleagues (2005). This has been a criticism of previous reviews of dynamic therapy in the past (McKay, 2011).

A major weakness of the review is the variability in quality of studies included. The review did include four uncontrolled and naturalistic studies. Although these studies were not RCTs, they were still deemed high quality studies. Many of the included studies also utilised self-reported measures when measuring outcome. With the exception of studies that also included service utilisation measures or third party raters (Bateman & Fonagy, 2008; Bateman & Fonagy, 2009; Chiesa et al., 2009; Doering et al., 2010; Kallestad et al., 2010), self-report

measures and semi-structured interviews on symptomology, mental concepts, interpersonal functioning and quality of life were used.

As found in previous reviews (Fonagy et al., 2005; Leichsenring & Leibing, 2003), the review is compounded by the heterogeneity of clinical population, as many of the included participants had co-morbid diagnoses. By the very nature of PD, there are high levels of co-morbidity with other disorders of both personality and mental state (Tyrer et al., 1997).

### ***13.5 Methodological considerations***

The search strategies utilised in this review were comprehensive, but there were some constraints in terms of the methodology of the review. There were time constraints when conducting this review making it difficult to hand-search through all relevant journals, which may have been beneficial in increasing the studies included. Articles that were not written in English were excluded from the review due to both time and financial constraints.

Due to the heterogeneity of statistical analyses, it was not possible to calculate effect size and provide an overall quantitative analysis of the included results (Petticrew & Roberts, 2006). The variety of clinical populations and methods applied within the included studies continued to suggest that meta-analysis is premature. Perhaps the criticisms of previous reviews highlight some of the difficulties with premature meta-analysis (Bhar et al., 2010).

Publication bias is a problem with most systematic reviews in which published findings tend to be significant (Petticrew & Roberts, 2006). As a result, this provides an unclear picture skewed towards significant results. Furthermore, excluding studies that lack methodological robustness may introduce some bias, as important findings could be lost. Using a quality assessment increases clarity on how studies are selected and decreases the exposure to other forms of bias (Petticrew & Roberts, 2006). It was also possible to scrutinise the papers in more detail and derive a score of the overall quality of the study including both strengths and weaknesses.

## **14.0 Conclusions and recommendations**

### ***14.1 Implications of findings***

There are several clinical, service and training implications of the results of the studies reviewed. Clinically, the findings of the review provide further evidence for the use of psychodynamic therapy for individuals diagnosed with PD. Although DBT is the treatment of choice within the NICE guidelines for BPD (NICE, 2009) and across many services within the NHS, there is also evidence to suggest the clinical effectiveness of other dynamic-based therapies, such as MBT and TFP.

Considering the agenda for Payment by Results (PbR) being introduced in the NHS, there is increasing emphasis on using timely, evidence based therapies. The review highlighted the short-term and long-term benefits of dynamic-based therapies for a range of PDs in comparison to other validated cognitive-based therapies, especially for BPD. The evidence is more mixed for Cluster C PDs with a number of studies finding less favourable findings for psychodynamic therapy. As stated in the NICE guidelines (NICE, 2009), research into the effectiveness of psychotherapies for PD is still in its infancy, but a more positive picture seems to be emerging for dynamic therapies.

Another issue that emerged from the research was the matching of PD clients to therapies. Based on the evidence reviewed, it may be that certain individuals with PD benefit from different types of therapies depending on their interpersonal style and preferences. Therapies tend to lie on a continuum from supportive to interpretive/ directive interventions, which seems to exist within and between therapeutic orientations (Leichsenring, 2005). Previous research has demonstrated that individuals with PD improve if they are matched appropriately to the intervention (Blatt et al., 2007).

In terms of training on psychodynamic therapies, there is an increasing emphasis on branded therapies for PD, such as DBT, MBT, TFP and SFT. Training and materials for these therapies seems to become a profitable business for the authors of these therapies. This review demonstrated some positive findings for dynamic therapies, it seems misleading for one brand name to monopolise the treatment of PD. Future research is needed to understand

the process variables within these therapies that are the mechanisms for therapeutic change (Shedler, 2010).

### ***14.2 Future research***

Firstly, it is important for any future research to address some of the methodological problems within the existing psychodynamic research in order to continue to enhance the credibility of dynamic research in line with other psychotherapies. As more dynamic-based therapies for PD are becoming manualised, it may be important to consider when manual-based psychodynamic therapies for PD are more effective than non-manualised psychodynamic therapies. It would be interesting to examine whether certain variables determine the effectiveness of manualised approaches for PD, such as PD severity or interpersonal style. Future research could also examine process variables in dynamic therapies for PD and explore the ingredients of therapy that seem to generate change in individuals with PD.

Although not examined in this review, it would be beneficial to review the literature on group psychodynamic therapy for PD and how this compares to other group psychotherapies. Seven studies in the review combined both individual and group psychodynamic therapy, so a further literature review could examine the effectiveness of psychodynamic group interventions compared to individual dynamic therapy. Although Verheul and Herbrink (2007) conducted a review exploring the efficacy of various modalities of psychotherapy for PD, it also seems fruitful to review the evidence base of group psychodynamic therapy compared to other approaches. However, from an economic perspective, group therapy as a stand-alone treatment in the community setting can be highly expensive with high drop out rates making it less appealing within the NHS (Verheul & Herbrink, 2007).

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**WHAT ARE THE EXPERIENCES OF THERAPEUTIC  
RUPTURE AND REPAIR FOR THERAPISTS AND CLIENTS  
WITHIN LONG-TERM PSYCHODYNAMIC THERAPY?**

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## 1.0 Abstract

Outcome research has shown that a rupture-repair process in the therapeutic relationship can have a beneficial impact upon symptomology, interpersonal problems and social functioning. There is a lack of qualitative research on therapeutic ruptures and how they are repaired. This study explored parallel accounts of therapeutic ruptures produced by clients and therapists during long-term psychodynamic therapy. Interviews were conducted with four client-therapist dyads. The data were analysed using Interpretative Phenomenological Analysis (IPA). Five overarching themes and six sub-themes are presented. These included: clients' experience of the danger of emotional experience (*Emotions as dangerous*); accounts of the discovery during therapy being a difficult and gradual experience (*Therapeutic discovery; gradual and hard work; to and fro*); the experience of the hurdles and problems within the therapeutic relationship (*The struggle; not knowing; control and power*); followed by a connection within the relationship (*The positive connection; emotional sensitivity; shining a light*); and the experience of the end of the therapeutic relationship (*Leaving and being left*). The results are discussed in relation to the literature on the emotional experience of psychodynamic therapy. The findings demonstrated the importance of attunement and reciprocity within the therapeutic relationship to help maintain a *positive connection* in the dyads.

## 2.0 Introduction

### 2.1 *Therapeutic relationship and therapeutic rupture*

A positive therapeutic alliance has consistently been shown to be a robust predictor of positive outcome rated by client, therapist and third-party perspectives (Alexander & Luborsky, 1986; Horvath & Greenberg, 1989; Horvath & Symonds, 1991). Bordin (1979) conceptualised the therapeutic alliance as a common change factor that consisted of three interdependent components: the relational bond between client and therapist; the tasks of psychotherapy; and the goals of psychotherapy. He went on to describe how the tear and repair of a rupture in the alliance strengthens the relationship and is therapeutically beneficial. In his view, a tear or rupture in the alliance is inevitable in therapy and if it does not occur then therapy is not possible.

Safran (1993) has broadly defined a therapeutic alliance rupture as, “*a negative shift in the quality of the therapeutic alliance or an ongoing problem in establishing one*” (p.34). The severity and duration of the rupture can vary from subtle misunderstandings to major barriers in establishing an alliance, often resulting in treatment failures and high attrition rates. It is generally viewed as a bidirectional, interactional process between the client and therapist (Safran, Crocker, McMain & Murray, 1990; Safran, 1993). Although the concept of therapeutic alliance originates from psychodynamic theory (Sterba, 1934; Menninger, 1958; Zetzel, 1959; Greenson, 1967), an embedded therapeutic alliance is now a core component of all genres of psychotherapy. Safran (1993) urged different theoretical orientations to elucidate types of rupture and resolution processes within their own therapeutic traditions.

### 2.2. *Therapeutic rupture in psychodynamic therapy*

The process of rupture and repair is a well-established therapeutic cycle within psychodynamic literature, which stems back to transference and counter-transference enactments (Safran & Muran, 2006). Traditionally, transference is the repetition of past conflicts with significant others displaced onto the therapist and counter-transference is the therapist’s emotional, visceral and mental response to the client’s material (Gelso & Carter, 1994). Jung (1951) spoke about the use of transference and counter-transference reactions as a therapeutic instrument to help understand and overcome unhelpful repeating patterns in the client’s relationships.

The concept of transference is now one of the cornerstones of psychodynamic theory that has undergone many revisions (Allen & Allen, 1991; Stolorow, Brandchaft & Atwood, 1995). The process of psychodynamic therapy can be thought about as a series of transference cycles in which each cycle contains necessary rupture and repairs between the therapeutic dyad (Ellman, 2007; Freedman & Lavender, 1997). Ellman (2007) suggested that the rupture process could either endanger or facilitate the transition to the next transference cycle depending on how it is repaired. The survival of rupture and repair events can gradually develop analytic trust and love between the dyad. Therapeutic ruptures also signify opportunities to practice new, more productive interpersonal behaviours with the assistance of the therapist (Horvath, 2000).

### *2.2.1 Intersubjective experience in psychodynamic therapy*

There is now a shift in psychodynamic thinking towards phenomenological contextualism in therapy and the experience of relational systems (Orange, Atwood & Stolorow, 1997). According to Stolorow and colleagues (1995), transference is part of the psychological striving to organise experiences and create meanings, which includes contributions from both the therapist and client in shaping the therapeutic relationship. In other words, transference and counter-transference together form an intersubjective system of reciprocal mutual influence on the therapeutic process. Taking this view, both the client and the therapist contribute to the repair of ruptures in the therapeutic relationship (Beebe & Lachmann, 2003). Analysing the experience of therapeutic ruptures in the transference bond aims to mend and reinstate the developmental processes of psychological differentiation and integration from the client's early years (Stolorow et al., 1995).

### *2.3 Problems with therapeutic rupture and repair research*

There are some difficulties with previous research published in the area of therapeutic rupture. Some studies have not clearly stated the type of theoretical orientation used or have combined a number of therapies when studying therapeutic rupture. Bordin (1979) suggested that the intervention model and relational aspects of therapy are interdependent therefore different theoretical orientations may generate different rupture and repair processes. Interestingly, two quantitative studies (Stiles et al., 2004; Muran et al., 2009) have suggested

that different psychotherapies report varying levels of rupture and repair. It would be beneficial to focus on one specific theoretical model when understanding the impact of rupture and repair.

Historically, the experience of the client during psychodynamic research has been strikingly absent (Midgley, Target & Smith, 2006). Previous research has used therapists in training as client participants, which has lacked clinical realism. Henkelman and Paulson (2006) studied clients' therapeutic experiences and found that there were negative thoughts toward therapists, which were often left unspoken during therapy. To understand the bidirectional process in therapy, both client and therapist perspectives are needed (Rhodes et al., 1994). Therefore interviewing clients and therapists after therapy has ended may help to increase understanding of both negative and positive experiences of therapy.

#### ***2.4 Outcome studies on therapeutic rupture and repair***

Numerous outcome studies have assessed the impact of therapeutic rupture and repairs on symptomology and interpersonal problems. Kivlighan and Shaughnessy (2000) explored the changes in the therapeutic alliance and clients' interpersonal difficulties during time-limited psychotherapy. They found that a pattern of 'quadratic alliance development' (U-shaped curve) was associated with improved interpersonal capabilities, which seemed to mirror a rupture and repair process. Stiles and colleagues (2004) extended upon these findings by exploring differences in outcome and alliance development in Cognitive Behavioural Therapy (CBT) and Psychodynamic-Interpersonal (PI) treatments. They found V-shaped profiles, which suggested that repairing ruptures with immediacy is associated with better outcomes. They also showed that the rupture-repair process was more common in PI than CBT. Similarly, Muran and colleagues (2009) utilised different therapies to explore the rupture-repair process. Results indicated that lower rupture intensity and higher rupture resolution were associated with better outcome and session quality. Again, the CBT condition reported fewer ruptures than other conditions, which may suggest CBT therapists emphasised collaboration rather than exploring tensions in the therapeutic relationship.

In line with psychodynamic literature, the outcome studies underline the benefit of a low intensity alliance rupture followed by a successful, immediate resolution within an

established positive therapeutic relationship. With an increasing emphasis on outcome measures in the National Health Service (NHS), it seems important to account for the existence of ruptures impacting upon the outcome throughout therapy.

### ***2.5 Qualitative studies on therapeutic rupture and repair***

Given the plethora of outcome studies in this area, qualitative work on therapeutic rupture and repair may help to inform theory about alliance development and maintenance (Stiles, Agnew-Davies, Hardy, Barkham and Shapiro, 1998). However, there are only a handful of qualitative studies in this area.

Rhodes, Hill, Thompson and Elliott (1994) explored clients' retrospective experiences of alliance rupture in therapy. Resolved ruptures were linked to a good therapeutic relationship, the client's willingness to discuss the rupture, therapist's facilitation to discuss the repair and the therapist being flexible and accepting. Unresolved ruptures were linked to poor therapeutic relationship and the therapist's unwillingness to accept the rupture or discuss the repair. Notably, the clients used in this study were either therapists, or therapists in training. In terms of therapists' perspectives, Hill, Nutt-Williams, Heaton, Thompson and Rhodes (1996) described therapists' retrospective accounts of unresolved ruptures in long-term psychotherapy. They found that unresolved ruptures related to the client's history of interpersonal problems, a lack of agreement about therapeutic goals and tasks, interference in the therapy by others, problems in transference, therapist mistakes and therapists' personal issues.

### ***2.6 The present study***

Gaps in the field of therapeutic rupture and repair have suggested some avenues for future research. Exploring retrospective qualitative accounts of rupture and repair might shed some light on how individuals made sense of changes in the alliance and how it impacted on the progress of therapy. As alliance ruptures can be considered an intersubjective experience, it was necessary to explore parallel accounts of both therapist and client to understand this bidirectional process. Given the psychodynamic focus on transference processes in the therapeutic relationship, it seemed beneficial to expand on previous research by exploring the experience of alliance rupture and repair within this genre of therapy.

The following study aimed to approach this topic from a phenomenological standpoint and explored the following questions:

- What are clients' experiences of therapeutic rupture and repair in their relationship with their therapist during long term psychodynamic therapy?
- What are therapists' experiences of therapeutic rupture and repair in their relationship with their therapist during long term psychodynamic therapy?
- How do the experiences of alliance rupture and repair compare within therapist-client dyad?

### **3.0 Method**

#### ***3.1 Design***

The aim of this study was to undertake a detailed examination of therapeutic rupture and repair experienced by client-therapist dyads during long-term psychodynamic therapy. As the experience of the individual was the focus of the work, Interpretative Phenomenological Analysis (IPA) was used. IPA is a qualitative approach to understanding how people make sense of their experience (Smith, Flowers & Larkin, 2009).

#### ***3.2 Service context***

All participants were discharged clients or therapists at a Psychotherapy Service. This service is a tertiary, outpatient service providing psychodynamic psychotherapy to people who experience complex, severe and enduring mental health difficulties.

#### ***3.3 Reliability and validity***

In qualitative research, reliability refers to the trustworthiness of the data and validity refers to the trustworthiness of the interpretations (Stiles, 1993). To ensure reliability, Stiles (1993) suggested an acknowledgement of the researcher's ontological and epistemological position, disclosure of orientation and a clear grounding of interpretations. To demonstrate validity, the researcher is encouraged to: be sensitive to the research context; show commitment and rigour; and demonstrate transparency and coherence (Yardley, 2000).

##### ***3.3.1 Ontological and epistemological position***

Epistemologically, the IPA researcher aims to provide a rich description of the claims and concerns of the person-in-context and their relatedness to a particular phenomenon and combines this with a more speculative interpretative account within a psychological framework (Larkin, Watts & Clifton, 2006).

Notably, this study used IPA to make sense of the experiences of psychodynamic therapy. IPA and psychodynamic interpretations are two different epistemological perspectives (Smith, 2004). The authority for the reading is different for each perspective; the psychodynamic position explores outside the text, while IPA remains inside and grounded in the text. For this research, there was a struggle with these potentially conflicting positions,

but there was also an opportunity to combine both positions within the analysis and discussion. The consideration of psychodynamic concepts was employed as a way of informing rather than driving the interpretation within the discussion.

### *3.3.2 The researcher as a person-in-context*

I am a 28-year-old White British female Trainee Clinical Psychologist. Participants were made aware of my Trainee status and that the research was part of my Clinical Doctorate thesis. I have experienced psychodynamic therapy as a client for personal development, but not had a significant therapeutic rupture and repair process. As a Trainee Clinical Psychologist, I have experienced both repaired and unrepaired ruptures with clients. Repaired ruptures have felt like a key experience in therapy, but I have wondered about the experiences of clients. I felt it is important to gain an understanding of the views of clients and therapists after long-term psychodynamic therapy and how these views are similar and/or different.

When I embarked on this research, I expected issues relating to the experience of transference to emerge, given the psychodynamic perspective. When interviewing the therapist participants, I was aware that a dynamic-based formulation might be discussed. Although I did not have any fixed opinions, I avoided potential bias by remaining participant centred and asking open questions. Importantly, some therapist participants became work colleagues in my final clinical placement so I reflected with my research supervisors on managing the interface between the research and clinical placement.

### *3.3.3 Grounding of interpretations*

In line with Stile's (1993) principles, the grounding of interpretations has been demonstrated through a transparent and systematic approach. I have outlined the steps of my data analysis in Table 3. To demonstrate that the findings are grounded in the data, I have also included examples of my detailed analysis from one extract of a transcript, as recommended by Meyrick (2006) (see Appendix I). Within the analysis section, there are also extracts of the participants' accounts.

### *3.3.4 Validity*

I used regular supervision meetings to discuss the interpretation process with my research supervisor who has in-depth knowledge and experience of IPA. An IPA peer supervision group also provided further validity checks.

### *3.4 Ethics*

This study was given favourable ethical opinion for conduct in the NHS by a local Research Ethics Committee.

### *3.5 Recruitment*

Initially, I introduced the research to all therapists at the Psychotherapy service. Out of the 10 therapists at the Psychotherapy service, four therapists agreed to participate in the study. Therapist participants were given an information sheet (see Appendix J), signed the consent form (see Appendix K) and asked to identify potential client participants. When the therapist had identified a potential client participant, a research participation letter (see Appendix L) was given to the client prior to being discharged. Out of the five clients given a research participation letter, one client declined to take part. If the client signed the research participation letter, an information sheet and consent forms about the research project was posted to them after being discharged from therapy. Once the consent forms were returned to the researcher, the client participants were contacted directly to arrange an interview date and answer any final questions.

### *3.6 Participants*

Eight participants were recruited to take part in this study, including four dyads of client and therapist participants. Dyads were used to gain a parallel account of therapeutic rupture and repair within the therapeutic relationship. Table 2 summarises the inclusion and exclusion criteria.

Table 2: Participant inclusion and exclusion criteria

	<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
Client participants	English speaking Over 18 years old Discharged from Psychotherapy Service Completed at least 1 year of psychodynamic therapy Assessed as having ‘reoccurring problems’ and ‘interpersonal relationship problems’ on the Clinical Outcome for Routine Evaluation (CORE) assessment	Not assessed as having ‘interpersonal relationship problems’ and ‘reoccurring problems’ on the CORE assessment. Less than a year with the therapist was excluded from the study, as it was felt that their therapeutic relationship may not have had the opportunity to fully develop within the psychodynamic model.
Therapist participants	Had to have core mental health training and had completed or currently undertaking psychoanalytic training.	Less than one year of experience in psychodynamic therapy
In therapy	Experienced a therapeutic rupture according to the definition documented by Safran, Muran and Proskurov (2009) as a strain or breakdown in the collaborative process between client and therapist, a deterioration in the quality of the relatedness between the client and therapist, a deterioration in the communicative situation or a failure to develop a collaborative process from the outset. This can also be referred to as a therapeutic strain, alliance rupture or therapeutic difficulty.	Not experienced a therapeutic rupture

Tables 3 and 4 provide some demographics and brief contextual details about the client and therapist participants. All participants were aged between 20 to 50 years old and there were six females and two males. All participants were allocated gender-neutral pseudonyms.

*Table 3: Table of client participant information*

<b>Client Participant</b>	<b>Duration of sessions</b>	<b>Years in mental health services</b>	<b>Relevant contextual information</b>
Sam	24 months	4 years	Intermittent depression
Ashley	12 months	4 years	Depression
Alex	20 months	5 years	Self harm and low self esteem
Morgan	24 months	4 years	Social anxiety and depression

*Table 4: Table of therapist participant information*

<b>Therapist Participant</b>	<b>Years working in mental health service</b>
Jessie	4 years
Fran	15 years
Charlie	20 years
Pat	15 years

### **3.7 Risk**

As client participants were discharged from the Psychotherapy Service, I accessed their clinical files for potential risk issues. All participants were aware that they do not have to answer questions they find too distressing. They were fully debriefed by the researcher at the end of the interview to explore any distress and the support available. For clients, an optional brief discussion with a therapist at the Psychotherapy Service (not their previous therapist) was offered and they were signposted to counselling services within the NHS. For therapists, they were encouraged to access clinical supervision on clinical issues raised from the interviews. None of the participants needed to take up this option and the majority of the participants found that the interviews were a useful experience.

### **3.8 Procedure**

Once informed consent had been obtained, first-person accounts were elicited from client-therapist dyads. In-depth, semi-structured interviews were conducted individually with each participant. These were recorded onto a digital Dictaphone and later transcribed verbatim.

### *3.8.1 Interviews*

Semi-structured interviews were conducted in a private room. The interviews were audiotaped and lasted between 38 and 100 minutes. A copy of the interview schedule (with prompts) may be seen in Appendix M, but the key topics addressed included:

- The first impressions of their client/therapist
- The development of their therapeutic relationship
- Expectations of their therapy/ therapist
- Details about difficulties in their therapeutic relationship
- Details about whether these difficulties were resolved in the therapeutic relationship
- Details about their experiences of breaks and the ending process of therapy
- Reflections and current feelings about their therapy/ therapist

### *3.8.2 Data organisation*

The interviews were transcribed verbatim and anonymised. The data were handled in an atypical way, because the gender, age and ethnicity of participants have not been disclosed here to protect anonymity. As there was a possibility that the clients and therapists may be able to identify each other from quotes included in the research, participants had the opportunity to review their transcript.

### *3.8.3 Data analysis*

Data were analysed according to the process and procedures of IPA, which follow an iterative and inductive cycle (Smith, 2003). Initially, all transcripts were read in detail and line-by-line coding was conducted from a descriptive, linguistic and conceptual level. Initial codes and emergent themes were developed for each transcript, which were then transferred into an Excel spreadsheet. Each participant had an Excel spreadsheet documenting initial codes, emergent themes, all identified quotes and line numbers. In terms of the order of the analysis, the clients' interviews were analysed first followed by the therapists' interviews to draw out any client-specific or therapist-specific themes. To include a dyadic component to the analysis, the client-therapist dyads were then analysed together to explore similarities and differences in their experiences. Following this, emergent themes were identified across the clients' and therapists' transcripts and drawn together under a superordinate theme. See

Appendix N for a breakdown of the emergent themes and how they were clustered into super-ordinate themes. Table 5 provides further details of each stage of analysis.

*Table 5: Stages of data analysis*

Stage	Process and procedure	Credibility checks
1	Transcripts were initially read through twice whilst listening to the recordings of the interviews. This ensured that participants' emotion and meaning was not lost and allowed for a deeper familiarity with each participant's individual account to be developed. Further readings of the text followed. Systematic, line-by-line coding of the experiential claims, concerns and understanding were noted in the right-hand margin.	Throughout the cyclical process, interpretations were checked through the following mechanisms: <ul style="list-style-type: none"> <li>- Regular discussions with supervisors</li> <li>- Peer support with the use of an IPA group for peers conducting research using IPA.</li> </ul>
2	Emergent patterns of commonality were noted in the left hand margin. These themes were the important experiential claims made by the participants, from the perspective of the researcher.	
3	An Excel workbook was developed for each participant. Each sheet within the workbook was labelled with the code it represented and all of the identified quotes and line numbers that corresponded to that theme were entered into the sheets. This resulted in 8 separate workbooks containing each participant's themes and quotes. The clients were analysed, followed by the therapists and then the dyads. This allowed for a number of levels of analysis, including the exploration of similarities and differences within and between dyads as well as between the clients and the therapists.	
4	Cluster of themes were identified across the analyses of individual transcripts and drawn together under a super-ordinate concept.	
5	Themes that were not relevant to the research question were removed.	
6	A table of super-ordinate themes were produced with quotes from each participant in order to show both commonalities and differences between participants.	

## **4.0 Findings**

### ***4.1 Description of dyads***

In the analysis of the findings, the therapists' and clients' interviews will be explored together to demonstrate similar and differing experiences. A brief description of the experience of each dyad is detailed, including the main difficulties in their therapeutic relationship and how this was resolved (see Appendix O for an extendable version of the dyad descriptions).

#### *4.1.1 Dyad one (Client Sam and Therapist Jessie)*

Dyad one both described a positive therapeutic relationship, which fluctuated at some points in therapy. The main problem described by both Sam and Jessie was the difficulty emotionally connecting in their therapeutic relationship. Sam used the image of the Tinman from the Wizard of Oz to describe their difficulty in identifying and expressing emotions with another person. Through therapy, Sam talked about being able to connect and share emotions with Jessie more openly.

#### *4.1.2 Dyad two (Client Ashley and Therapist Fran)*

Dyad two both commented on difficulties gaining and maintaining emotional contact with each other throughout therapy. Ashley used the metaphor of a cupboard in which unexpressed emotions were stored and Fran helped to process feelings in the cupboard. Ashley described this as a painful process, like a root canal, in which Ashley craved for reassurance from Fran. The lack of reassurance created tensions, which fluctuated throughout therapy. Increased trust and a sense of togetherness between the dyad helped to maintain contact in their relationship.

#### *4.1.3 Dyad three (Client Alex and Therapist Charlie)*

Dyad three talked about the struggle of remaining in emotional contact with each other, because Alex tended to forget material from the session and avoid emotional reaction. Alex described this as an "etch-a-sketch moment" in which Alex would wipe away and remove feelings from the session. There was a stalemate in the therapeutic relationship that was resolved by increasing the frequency of sessions each week. Through this, Charlie talked about the tempo increasing and emotional contact being more available between the dyad.

#### *4.1.4 Dyad four (Client Morgan and Therapist Pat)*

Both Morgan and Pat talked about peaks in the strength of their relationship when Morgan was more emotionally involved in therapy. When less emotionally involved, there seemed to be more distance in their relationship in which Morgan perceived Pat more negatively. During these times, Morgan described finding it difficult to fully open up in therapy and referred to this as “the elephant in the room.” Over the course of therapy, both Morgan and Pat were able to make emotional contact and Morgan talked about a “sentimental attachment” to Pat.

#### ***4.2 Analysis and interpretation***

The analysis resulted in five overarching themes, within which emerged six sub-themes that reflect the key experiences and concerns of the participants.

##### **1. Emotions as dangerous [client’s experience]**

##### **2. The therapeutic discovery**

- a) Gradual and painful
- b) To and fro

##### **3. The struggle**

- a) Not knowing
- b) Control and power

##### **4. Positive connection**

- a) Emotional sensitivity
- b) Shining a light

##### **5. Leaving and being left**

All of five themes identified reflect interrelated aspects of the clients and therapists’ subjective experience of psychodynamic therapy and the rupture and repair in their

therapeutic relationship. They will be described in sequence, but it is important to explore how the themes interlink to help understand the complexity of the participants' experience.

### **1. Emotions as dangerous**

Throughout clients' narratives, there were many negative descriptions about emotional experience. These emotional experiences were presented as the context for clients seeking therapy and therefore only expressed by clients. There was a strong discourse relating to emotions being dangerous and Sam used the analogy of emotions being like a bomb:

*"It felt like a bomb had gone off. Everything's all going on in my head, don't know what to do, how to do it all and what to do for the best."* Sam, L623

The bomb was described by Sam as an explosion in the head and felt confused and lost about how to manage this. There was also a description of emotions rotting and festering, because they had not been dealt with or processed for a long time:

*"I just put it to one side and left it there to fester. It was quite scary to deal with those things because it made me realise that in a lot of ways I'd stopped emotionally developing as a teenager."* Ashley L451

In line with the idea of emotions being dangerous, all client participants described how they developed ways to protect themselves from this danger. This included descriptions of various barriers to emotions, such as armour, walls, cupboards and developing a stiff upper lip:

*"It was just a method of self-preservation, you know, it's like what you do to stop getting absolutely hammered, you put a wall up. I mean it was just a self defence mechanism."* Ashley L743

Ashley also spoke about the fear of changing this barrier to emotion and described the idea of collapsing and being overwhelmed by emotions. The investment of time and energy in maintaining the barrier and not dealing with emotions was also acknowledged:

*“In opening the cupboard and dealing with everything it was like, can I actually do this? Can I actually function with the cupboard open or will I collapse in a little heap and give up? It was very scary dealing with it because I’d spent so much time and energy not dealing with it.” Ashley L451*

Another protective strategy for some clients was withdrawing or pulling away from emotional experiences. In particular, Alex spoke about wiping one’s brain when feeling tearful:

*“If I felt like crying then my tears would stop at that point and sort of pull back. And you know almost, we would call it an etch-a-sketch moment, I would sort of wipe my brain and stop talking about it and pull away.” Alex 362*

As a result of these barriers, Sam spoke about questioning one’s ability to feel difficult emotions at all. Sam had the experience of being separate and isolated from the rest of the world in a lonely, unfulfilled position. Sam used the image of the Tinman from the Wizard of Oz with no feelings to describe this:

*“I was like the Tinman, I just had no feelings. I thought that was the case, but I wasn’t thinking about it....it wasn’t nice to feel dead to the world so to speak.” Sam L371*

It seemed that clients’ emotional experience felt uncontained and frightening at times. The fear of emotional expression tended to be controlled by the use of various protective barriers and defences for the client. However, it was acknowledged by clients that these barriers leave them feeling unfulfilled with their lives, which seems to be one of the drivers for seeking therapy. The next super-ordinate theme, *the therapeutic discovery*, explored the process of therapy and how some of these fears and barriers are demonstrated within the therapeutic relationship.

## **2. The therapeutic discovery**

This theme addresses issues pertaining to the overall experience of therapy for both clients and therapists. Throughout the narratives of participants, there was reference to therapy

being like a process of discovery. This involved discovering how to work together and gain an understanding of the clients' world within the framework of psychodynamic therapy.

As part of this theme, the following sub-themes emerged from the participants' accounts, which related to the therapeutic discovery. This included *the therapeutic discovery* being *Hard work and a gradual process* and involving a *To and fro* progression.

*a) Hard work and a gradual process*

Universally, there was a shared experience of therapy being hard work for both clients and therapists. It was compared to the experience of completing a puzzle, having a root canal and playing a game. All three metaphors suggested a challenging process that ultimately aimed to have a positive or rewarding outcome. Ashley likened therapy to a crossword:

*“My mum does crosswords.... She often she does half of it and then there is one she's stuck on so she will leave it and lets it chunter away at the back of her brain then will come back to it and she'll be like ah I know what that is and fill it in. And therapy is a bit like that ....it kicks starts everything and it does chunter. It sort of works away....I would go back the next week and be like I have been thinking about this. I don't think I was prepared for that...I thought it was kinda a nice hour a week and it would be fine. ” Ashley L711*

This suggested that therapy continuously plays in the back of one's mind between sessions in the hope to discover the way to progress with therapy. It seemed that the processes of discovery can “chunter” outside of the client's awareness on an unconscious level. In the same vein as the crossword, Charlie likened therapy to game playing similar to a childhood game of tag or cat and mouse:

*“There was this almost....game playing...like playing tag or tig, you know in the playground. There was a come and catch me.” Charlie L47*

Rather than the crossword, this quote suggested a game involving an interaction between the dyad in which the therapist is being chased or is chasing the client. Therefore the client or

therapist was leading the discovery at different points in therapy. The therapist seemed to be discovering how to keep in tune with the client's experience.

For many clients, therapy was described as a painful, emotionally exhausting process, which made them feel worse at times. Ashley likened therapy to having a root canal in terms of the emotional cost of therapy:

*“If someone gives you a root canal, the next day you are going to be a bit sore. If you are digging at bits that are not very nice and quite painful, it's going to take it's toll. [Therapy] was very difficult and it was emotionally completely exhausting.”* Ashley L481

In this analogy, Ashley described their therapist, Fran, digging deep in painful areas, which remained sore after the session had ended. Like being treated by the dentist, the client may want to avoid this, but it is deemed a necessary process to avoid further pain and damage. This analogy is linked to the participants' experience of different levels during the difficult, painful *therapeutic discovery*. In participants' narratives, there was an experience of therapy having depth and becoming more challenging as it deepens to different levels. This is in line with the analogy of a crossword, game or dental operation that becomes harder as you advance to the next stage. Fran described how this process seemed to generate mixed feelings in therapy for client Ashley:

*“We got to a point where...[the client] was managing their life better...my sense was, sort of, getting into the work more deeply [the client] was ambivalent about...we spent quite a long time talking about that.”* Fran L192

Therapist Jessie also reflected on the idea of emotional pain during therapy in which one could be left with the client's unexpressed emotions. This suggested that the emotional pain of therapy was often a two way process:

*“I felt quite tearful when [the client] left some sessions, I think they left me with a lot of unexpressed emotion.”* Jessie L168

Given this emotional experience, many therapists described the difficulty of digesting and metabolising the therapeutic material brought by the client. The use of supervision aided this process for Therapist Morgan to understand this material and the processes in the therapeutic relationship:

*“I think it took me being able to think about it in supervision and think about what is happening...I think it took quite a lot to metabolise all of that and make sense of all of that.”*  
Morgan L554.

Intrinsically linked to this *hard work* was the gradual process of therapy in which emotions are experienced and understood over time within the dyad. In order for clients to trust their therapist and open up about their emotional experience, it seemed to take time. Sam felt that if rushed then it would result in withdrawal from their therapist:

*“As soon as I felt like I was being pressured and forced into it then that would have been it, I would have backed off.... it was good I could do this in my own time....I don’t like being pressed to talk, it’s something I react quite strong against.”* Sam L440

At the same time, some clients spoke about their frustration about therapy not being quicker and more immediate:

*“I wanted them to say more and perhaps ask more questions...but equally [the therapist] was unwilling to do that as it was meddling with the process almost....but I certainly felt perhaps if [the therapist] had asked more leading questions at times, we might have got to things quicker.”* Alex L394

Perhaps for some clients, there was a desire for therapy to be a quick experience, as they perceive *emotions as dangerous* and it is *hard work* to discuss their feelings. However, both clients and therapists acknowledged the *gradual process* of therapy helped to make sense of painful, difficult emotions within *the therapeutic discovery*.

b) *To and fro*

This sub-theme encompasses the polarities within the therapeutic relationship when the dyads were able to discover more or less. As opposed to a steady linear *therapeutic discovery*, some participants described it as a cyclical, changing process. This seemed to be related to the strength of the therapeutic relationship:

*“I would go through a period where it was ok for a few weeks and every session was pretty good and useful and then a few weeks of it being annoying....so it was changeable between the two.”* Morgan L1285

Therapist Fran described this as an evolving process, which fluctuated between the client sharing and hiding their vulnerable feelings. When the client shared more emotion with Fran, there was more opportunity for *therapeutic discovery*. The term “blossoming” was used to demonstrate the emotional bond with the therapist, perhaps signifying a personal growth and development:

*“I think it was just an evolving process that continued...there were hints of [the client] sort of blossoming a bit more emotionally... equally there was a sort of to and fro process...when we saw none of [the client’s] more vulnerable self.”* Fran L54

In a similar vein, Morgan felt the therapeutic relationship was stronger when more emotionally involved, but this fluctuated throughout the course of therapy:

*“The more upset and involved I was, the more I felt kinda like a proper connection with [the therapist]. If it was just something I was talking about, like a daily struggle then I felt a little bit patronised. And that kinda fluctuation went all the way through the two years.”* Morgan L216

As well as polarities within the therapeutic relationship, there seemed to be a *To and fro* within the client’s experience of themselves during the course of therapy. There was an experience of ambivalence with some clients, in which they described some parts of their personality being in conflict:

*“I had a very split position about whether or not I even wanted [the therapist] to care for me....it made me uncomfortable that [the therapist] cared about me and my well-being because I was so vulnerable at times, I almost wanted [the therapist] to be objective and just look at it from a neutral standpoint and not really care...but then equally I really wanted it as well, I wanted this idea that somebody cared about me and what I was thinking and feeling.” Alex L589*

This highlighted a conflict about being cared for by the therapist, which resulted in discomfort for the client. There was a pull in two directions, which seemed part of the *therapeutic discovery*.

*The therapeutic discovery* encompassed the process of psychodynamic therapy and how this is experienced between the client and therapist. As clients viewed *emotions as dangerous*, the process of discovery was often a *hard*, painful and *gradual process* for the dyads. Due to the hard, gradual nature of *therapeutic discovery*, there were fluctuations both in the therapeutic relationship and in the progression of therapy.

### **3. The struggle**

This super-ordinate theme encompasses the particular claims and concerns of clients and therapists regarding the struggles in their therapeutic relationship. This was clearly linked to the experience of *To and fro* in *the therapeutic discovery*, but more focused on difficulties and tensions within the dyad. Participants described this struggle as a disappearance, a holding back or clamming up. This seemed unsurprising as clients perceived *emotions as dangerous* to express to others. All descriptions of the struggle suggested a lack of contact emotionally and physically, which led to feelings of frustration and despair in the dyad. This comes across by Therapist Charlie’s accounts:

*“We sort of recognised the way [the client] started disappearing...what we recognised was we would meet week in, week out with this sort of empty, sort of bleak state and I’d push and push and you know we would be getting somewhere and the session would end. And the next week we would start over again.” Charlie L177*

Similar to the *To and fro* of therapy, some participants discussed the idea of struggles in therapy being repetitive and going around in circles. Therapist Jessie described this as “going through the motions”:

*“It felt like we were just going through the motions....there was nothing new happening, [the client] was going around the same circles...it felt a bit repetitive and a bit flat and stale.”*

Jessie L346

The following sub-themes demonstrated specific struggles between the client and therapist during psychodynamic therapy: *not knowing* and *control and power*.

*a) Not knowing*

The struggle of *not knowing* and uncertainty was discussed in both the clients’ and therapists’ narratives. For clients, their uncertainty was linked to the use of silence and lack of reassurance by their therapist. Sitting with not knowing seemed to be a key part of the psychodynamic model. Some clients found the use of silence very difficult to tolerate and this led them to hypothesize what the therapist was thinking about them:

*“I never knew what [the therapist] was thinking, I never knew whether [the therapist] was thinking pull yourself together, what am I having for dinner, I mean, because you know [the therapist] didn’t speak...I don’t know what is going on in your head whether you think I’m a silly little person or whether you think ok right this is a problem we can deal with this as such.”* Ashley L577

Ashley also spoke about the shades of grey in therapy in which there were no right answers or gold stars, which was difficult to accept at times:

*“I didn’t know if I was saying the right thing, the wrong thing, was there something specific [the therapist] wanted me to say and that I found very difficult because you know, I’m one of those people, you know, ‘I like well done, two gold stars’.”* Ashley L610

It seemed Ashley had an expectation that the therapist's silence indicated a negative, absent response. Similarly, Morgan described a craving for reassurance from the therapist, which was not fulfilled:

*“What I was craving was a response like you’re doing ok, you’ve made loads of progress you might not realise it. Even if it was a lie, it would have been nice to hear it...I think that might have motivated me.”* Morgan L1164

Morgan's quote highlighted *the struggle of not knowing* whether the therapist believed Morgan was making progress. The desire for positive feedback suggested that some clients believed therapists had answers to the *therapeutic discovery*, similar to the pupil-teacher dyad. As this reassurance is not provided, it resulted in a struggle and negative experience in the dyad.

Linked to the uncertainty of therapy, many clients experienced the therapeutic relationship was a unique relationship, which was one-sided and artificial compared to other two-way relationships:

*“It felt a bit weird and I didn’t know what to say or how to behave....[the therapist] had been like such an important person you know, and it is quite an artificial situation really. You wouldn’t have that happen in a normal situation”* Alex L712

For therapists, the uncertainty in therapy differed to the clients' experiences and was not related to silence or feedback. Instead, it was linked to the idea of “unfinished business” in therapy, which was not fully addressed in some of the dyads. This seemed to be attributed to the timing of therapy and the readiness of the client.

*“I think it’s important I can hold on to that there was probably unfinished business, but there is always going to be. At the end of therapy, it is always going to be, years later oh we never really talked about that.”* Jessie L642

However, Jessie felt that this was a natural process because it may not be possible to address all areas in therapy.

*b) Control and power*

This sub-theme encompassed a range of struggles in the therapeutic relationship in relation to the experience of *control and power* between the dyad. As part of *the struggle*, there seemed to be an experience within the dyad of negotiating their roles and responsibilities during therapy.

Some clients struggled with the position of being looked after by their therapist. Morgan described feeling patronised and pathologised at times by the therapist:

*“[The therapist] was like a teacher. Like a bit patronising....that doesn’t mean [the therapist] was mean or bad or anything...[the therapist] would relate to me being a little child....it would start to make me feel a bit patronised and spoken down to.”* Morgan L206

When there were struggles in the therapeutic relationship, Morgan described the experience of being treated like a child by a teacher. This suggested the experience of a power imbalance in favour of the therapist over the client, which generated feelings of anger and frustration. This experience seemed to heighten at times when Morgan felt emotionally vulnerable or perhaps threatened by the therapist’s interpretations. Morgan followed this up by saying:

*“I think partly maybe some of the time [the therapist] was saying things that were reasonable and true but I kinda took them, I might’ve took them as patronising if I wasn’t in the best mood.”* Morgan L738

Therapist Charlie also described a similar tension with *control and power* in their therapeutic relationship in which the client attempted to do their own therapy. This led to a feeling of exclusion for Charlie and a sense of self-doubt about one’s role as a helping professional in a therapeutic relationship:

*“[The client] would talk about their feelings as if they were the therapist, which was effectively excluding me, making me redundant, [the client] does their own sort of therapy in the room....it’s quite a bleak a sort of bleak experience and...feeling have I got it all wrong? Even to the point of questioning my capacity to function as a psychotherapist, you know am I crap at my job?....Am I completely missing something here?”* Charlie L100

The difficulties with *control and power* in the therapeutic relationship seemed to be a linked to the threat of the therapist accessing the client’s vulnerable feelings. This seemed difficult for clients because many perceived *emotions as dangerous*. Perhaps initially it felt safer for clients to have complete control over their emotions rather than share them with their therapist. For Morgan, it was too difficult to share some feelings openly with the therapist for fear of causing offence. Despite struggling with therapy and at times feeling disillusioned, the client was reluctant to share this and described this as the “elephant in the room”:

*“It was just almost like an elephant in the room....it was so awkward....but I would never really say in case it offended [the therapist]. And then we wouldn’t even really, we wouldn’t really pursue it to find out why I was struggling.”* Morgan L530.

This related to the idea of *control and power*, as Morgan seemed to defer to the therapist for fear of criticising them. However, this continual deference seemed to result in growing tension and frustration in their relationship therefore playing a part in *the struggle*. Therapist Pat described these tensions and difficulties in their relationship as an opportunity to bring emotions to the surface to think about. This suggested that *the struggle* in the therapeutic relationship was needed in order to make sense of the client’s difficult feelings:

*“I suppose it helped something come to the fore that had been hidden for such a long time and we were able to think about that.”* Pat L138

Another example of *the struggle* in the therapeutic dyad was Ashley’s tension between psychological and biological explanations of mental distress. These differing explanations were associated with either internal or external loci of *control* and responsibility for Ashley.

Ashley felt therapy was a difficult process as it increased a sense of *control* and responsibility over their difficulties, which created tension in the therapeutic relationship:

*“I sort of started therapy...my depression is biological, it’s genetic, there is nothing I can do about it. And then sort of as I went through therapy, it’s kinda like, hmmm, maybe there is some other stuff to it...I kinda went from going it’s all biological and genetic and therefore it is not my fault to there is some other stuff to it...if I had dealt with that better then maybe I wouldn’t have got depressed....therefore it’s my fault.”* Ashley, L195.

*The struggle* in the therapeutic dyad seemed to be a necessary part of the psychodynamic therapeutic process. As *therapeutic discovery* progresses, it was likely to discover painful, difficult areas, which may feel unsafe and dangerous to explore for the client. As a result, *the struggle* involved a sense of *not knowing* what to expect and an experience of changes in *control and power* within the therapeutic relationship. Such struggles were associated with the *To and fro* process of therapy, which can be worked through and understood within the dyads.

#### **4. Positive connection**

This super-ordinate theme explores *the positive connection* between clients and therapists following the survival of *the struggle*. Participants described this connection in various ways, such as making contact, revealing something and developing a sentimental attachment within the dyad. Charlie used an interesting image to depict this connection:

*“The image that is coming into my mind is an image of [the client]...[the client] could hide behind their hair, you know their hair being like a curtain and being sort of drawn back to see them, their face and some sort of contact was made.”* Charlie L66

The following sub-themes demonstrated more specific aspects of *the positive connection* between the client and therapist during psychodynamic therapy: *emotional sensitivity* and *shining a light*.

a) *Emotional sensitivity*

Emotional sensitivity encapsulates a number of ideas described within the participants' narratives, including being emotionally in tune, setting an optimal pace in therapy and the therapist providing care and containment. When more emotionally involved in therapy, Morgan felt more connected with the therapist and felt the therapist understood them. In line with the *To and fro* of therapy, this appeared to change during the course of therapy with a peak in their connection in the middle phase:

*“There were times when we had the emotion in the room and I felt, it felt really helpful, even though I was obviously upset and hurting at the time, it felt [the therapist] was there and understanding...so I suppose there was a peak in the middle of talking about these really emotional things and feeling a better connection with [the therapist].”* Morgan L230

Some participants described their feelings of care in the therapeutic relationship and an experience of intimacy with the other person. Specifically some clients spoke about the care and protection they experienced from the therapist, which were beyond their expectations. In particular, Sam described this:

*“We talked about certain goals that I was looking at pursuing and [the therapist] said they would feel themselves wanting to tell me not to do it. [The therapist] was concerned and caring about me. I guess I was flattered by it to be honest. It makes you sit there and think, well you know, it is not a job [the therapist] was shutting off and not showing their emotions to. I guess some people who are used to doing their job...they can get emotionally tough to it all, be able to disconnect from the job and I didn't think that was the case, not just a job, which makes you feel like you put in that bit more effort.”* Sam L568

The term “not just a job” suggested that Sam might have expected the therapist to communicate on a clinical, detached level, which was not the case. Perhaps by Therapist Jessie demonstrating concern and care helped the client to feel more comfortable to open up emotionally.

In line with this, some clients felt their therapist was able to read them verbally and non-verbally by being in tune with subtle emotional changes. Some therapists echoed this and in particular Jessie felt picking up on subtle emotional changes in the client helped to strengthen their connection:

*“Well, [the client] said they noticed if my voice changes, so sometimes my voice would go softer when I was talking to the child part of [the client] rather than the adult part of [the client]....they picked up on it, your voice sounds different and we were able to think about why that might be.”* Jessie L831

Part of the *emotional sensitivity* theme was the idea of timing and the importance of the therapist finding the right pace for the client. Finding an optimal pace seemed to help strengthen the connection within the dyads. Therapist Fran felt it was important to work backwards and slow down the pace when the client became more fixed in her position:

*“Sometimes [the client] became more fixed in their position really, and then me having to sort of, you know, me sort of having to almost work backwards. So them becoming more clear in their position and me having to sort of say, hang on a minute, what’s happened here.... and work backwards really.”* Fran L127

Alternatively, Charlie felt the tempo of the sessions needed to increase to enable the client to remain emotionally open. Therefore the frequency of sessions increased and Charlie described the impact of doing this:

*“The turn around of the cycle if you like was much quicker, we could get into the difficulty...it wouldn’t take the whole session and get lost again so the rhythm increased basically, the rhythm picked up tempo.”* Charlie L191

There was also discussion about being emotionally sensitive to the need for security and consistency within the therapeutic relationship, such as maintaining the same time and day for sessions. Morgan likened this experience with their therapist to a safety net:

*“During the peak, during those times when I was feeling really bad, I was able to, I got used to [the therapist], I was able to express myself in front of them...it was hard to say what it really felt like, but I suppose like a safety net. Quite a safe feeling when I was feeling absolutely awful, Uni was going to pieces...I still felt [the therapist] had a kinda safe feeling and a kinda suppose understanding.”* Morgan L332.

This quote suggested that this consistency aided Pat’s connection with Morgan’s emotional experience and strengthened their therapeutic relationship. Through *the emotional sensitivity* within the dyad, both clients and therapists described a sense of togetherness and shared experience in therapy. Therapist Fran highlighted this experience:

*“I think [the client] felt the beginnings of attachment to me...there was a bit of [the client] that was attached...there were moments of, sort of, emotional contact when I said [the client] was making jokes and reviewing the work, there was a sense of being together in thinking together about the fact [the client] had come some distance.”* Fran L349

*b) Shining a light*

Within the theme of a *positive connection*, there was also emphasis on the importance of asserting and commenting upon patterns of behaviour in the dyads. Charlie likened this to *shining a light* on the client’s interactions. By the therapist shining this light, it seemed to aid *therapeutic discovery*, but at times led to a game of cat and mouse between the dyad:

*“I pointed it out as it was going on....[the client] wasn’t conscious of being like that...but with enough, you know enough light shone on that by me and probably some sort of cat and mouse you know well, you said this, you said this...I helped [the client] to become conscious of it because I pointed it out.”* Charlie L529

The description of a cat and mouse suggested a tiring process in which the therapist is trying to make sense of the client’s experience. As Charlie shone a light, it seemed the client might accept it or run away from it. This theme linked to the idea of *therapeutic discovery* being *hard work* and a *gradual process* for the dyads.

Many therapists described *shining a light* as a necessary part of the therapy to avoid clients' repeating patterns being played out in the therapeutic relationship:

*"I realised at some point that I was being, I thought, I was being recruited to enact some sort of problem of [the client's] so I kept, sort of trying to draw attention to and question what [the client] was doing."* Charlie L394

For some clients, this experience of *shining a light* on their patterns of relating was very emotionally demanding. However, Charlie's client, Alex spoke about this helping to understand their difficulties and make changes to their relationships:

*"I think a lot of it was trying to break it all down and see what was actually going on. Often sentence by sentence at times....so sort of looking at the dynamic of what was happening in depth to sort of be aware what was going on. And I think more about what I was saying and doing and perhaps how I could change that."* Alex L303

By *shining a light* on these patterns, all clients described an increased insight into themselves and an ability to reflect on their patterns of relating to others. Sam talked about their experience of this:

*"It has made a big difference. Like I say, insight into yourself, your behaviour and when your reacting and why. But it also helps you to try, you know, question other people, while before I would just dismiss it...While at least now, I try figure out what is going on and why. You know, perhaps there is a bit more to this situation than I realise."* Sam L485

Similarly, therapists noticed an increase in clients' emotional understanding and acknowledgment of their feelings. Therapist Jessie spoke about the therapeutic journey to help Sam develop emotional understanding and linked this to the analogy of the Tinman:

*"This image of a Tinman....[the client] had been on a journey to try and find out if they had a heart...I was able to say that actually the whole point was that [the client] had a heart all along and just didn't know it and that a lot of the work we had been doing was connecting*

*up feelings was letting [the client] know that they had those feelings, [the client] was human underneath.”* Jessie L411

Following *the struggle* within the therapeutic dyads, *the positive connection* was the reconciliation in which the client has an opportunity to grow and make positive changes and discoveries. *The positive connection* between the dyad seemed to involve a delicate balance between demonstrating *emotional sensitivity* (such as care, consistency and being in tune with each other) and *shining a light* on helpful and unhelpful patterns of relating. Without this balance, further struggles in the therapeutic relationship seemed likely.

### **5. Leaving and being left**

The final theme explored the emotional impact of leaving the therapeutic relationship, either during a break or at the end of therapy, and how both clients and therapists manage this.

For clients, there were mixed feelings about leaving the therapeutic relationship, including fear, anger and a sense of acceptance and gratitude. During breaks, there were client descriptions of anger at the therapist leaving and an anxiety about coping without therapy sessions. Ashley shared these feelings when their therapist had left for a summer break:

*“I think one of the hardest bits was the fact that, completely not [the therapist’s] fault, but it was just horrendous timing. [The therapist] was taking their summer break for about 2 or 3 weeks....I think a friend of mine died....and it was sort of like, you should be here, you are meant to be here to help me with these things, where the fuck are you...that was quite difficult....I didn’t have that outlet, I just had therapy and it wasn’t there.”* Ashley L271

This quote highlighted Ashley’s frustration and fear in the absence of the therapist to contain painful feelings. A sense of anxiety during breaks was also shared by some of the therapists. Therapist Pat discussed their anxiety of not knowing about the client’s well-being during breaks and a sense of responsibility as a caretaker for their safety:

*“I found myself getting very, very worried about what [the client] might do over the Christmas break and that my role as caretaker....was [the client] going to go away and hurt themselves?” Pat L49*

During the ending phase of therapy, anger was a clear pattern highlighted in some client interviews. At the time of the ending, some experienced it as premature and described feeling resentful for this, such as Alex:

*“[The ending] was very difficult...I thought [the therapist] could have picked a better time to end....I was always aware that there would have to be an ending and that it would end at some point. But I dunno I think I had a bit of denial about it still. It was difficult for me to hear and I guess I reacted like, well [the therapist] obviously doesn't care that much if [the therapist] is going to leave me when I have got all this still going on.” Alex L544*

This quote suggested Alex initially felt angry with Charlie and perhaps a sense of rejection for the timing of the ending. However, Alex described how this was discussed openly with Charlie and later accepted and understood.

There was also a fear for some clients about their mental health in the absence of therapy and whether they would deteriorate without the security of their therapist. Ashley spoke about fears of “released as a sane person”:

*“I mean sort of towards the end of therapy it was difficult....me trying to work out you know what happens when it finishes, what happens if something goes wrong, am I going to be able to cope on my own....I had to just talk through it and then it was, ok well can I actually do this on my own. That was quite scary, it felt a little bit like I was being released as a sane person.” Ashley L271*

In some of the dyads, both the clients and therapists spoke about their grief after therapy had ended and sadness for the loss of the therapeutic relationship. Alex shared their sadness after therapy had ended:

*“I was sad actually. It was quite emotional, losing someone in a very strange way. There was definitely a sense of loss there” Alex L752*

In a similar way, some of the therapists spoke about the personal impact of ending the therapeutic relationship and how they missed their contact with their clients after therapy had ended. One therapist used supervision and personal therapy to understand their strong emotions following the end of the therapeutic relationship. Alongside these emotions, both clients and therapists voiced many positive feelings and expressions of gratitude about ending therapy. Some clients spoke about their sense of pride for achieving the milestone of ending therapy and also having a different ending to other relationships in their life:

*“It was a good ending. We had planned the ending quite far in advance that we had worked towards. It was the best ending I had had in my life because for other things I just tend to just leave and burn bridges and stuff. Whereas with that [the therapist] had really talked about how the door is always open for me to come back if I needed to.” Morgan L1094*

It seemed helpful for Morgan to know the therapist could hold Morgan in mind and return to therapy if their mental health deteriorated in the future. In a similar way, Sam spoke about their appreciation towards the therapist and Sam had achieved what they wanted from therapy:

*“To have someone sat there once a week for a couple of years....there is a good connection there. I was keen to leave the therapy because I was thinking, I had figured out what I needed to and just wanted to, to an extent leave it behind and move forward with your life. But at the same time, you know, appreciating how people have helped you.” Sam L700*

Therapists also described their sense of hope following the end of therapy and how the client could continue to grow emotionally in their relationships in the future:

*“There was a chink of something more grown up about [the client] and they, they were able to talk in a hopeful way about [the client’s] relationships....about their future....being able to think more about what could I have rather than what I can’t have.” Pat L603*

Given the *To and fro* of the *therapeutic discovery* with the experience of the *struggle* and *positive connection* in the therapeutic relationship, it was understandable that leaving therapy would stir up many feelings within the therapeutic dyad. For many participants, leaving therapy was another *struggle* in the therapeutic relationship, which was difficult to overcome. In spite of the difficult feelings of ending therapy, leaving the therapeutic relationship also generated hope and appreciation for their joint experience. For many clients, holding onto such experiences and connections with their therapist may have helped them act as a model for future relationships.

## **5.0 Discussion**

### ***5.1 Summary of findings***

This qualitative study aimed to explore the clients' and therapists' experience of therapeutic rupture and repair during long-term psychodynamic psychotherapy. Initially, clients described experiences of their emotions being dangerous (*emotions as dangerous*), which seemed to be the driver for them seeking help. Both clients and therapists talked about their experience of discovery during therapy (*therapeutic discovery*). This discovery was a difficult and gradual process (*gradual and hard work*) and involved fluctuations in the therapeutic relationship and the progression of therapy (*to and fro*). Within the discovery, participants experienced ruptures in their therapeutic relationship (*The struggle*). During these times, the dyads had difficulty making emotional contact and clients struggled to connect with feared emotions. Participants had specific ruptures comprising themes of uncertainty and control and power (*not knowing; control and power*). These struggles in the relationship seemed to be followed by a good connection in the dyads (*The positive connection*). Specifically, confronting unhelpful repeating patterns (*shining a light*) and staying emotionally in tune with each other (*emotional sensitivity*) helped to repair ruptures. After intense contact in the therapy, it inevitably comes to an end, which brought about mixed feelings in the dyads, including loss and a sense of gratitude (*leaving and being left*). These themes can be explored in terms of the emotional experience of therapeutic rupture and repair and the process of attunement and reciprocity in psychodynamic therapy.

### ***5.2 Role of emotional experience***

The emotional experience of psychodynamic psychotherapy for both therapists and clients is a clear thread in the analysis. Prior to therapy, many clients spoke about their experience of *emotions as dangerous* and not easily contained by another person. These concerns could be linked to the absence of containment as conceptualised by Bion (1959). Containment involves a person being able to receive the feelings of another without being overwhelmed and being able to communicate their understanding of these feelings. If emotions are not 'detoxified' and contained by a parental figure in early life, infants often experience a state of nameless dread, which can continue to adulthood. As a result, emotions may appear overwhelming and not easily understood. To cope with this, some client participants spoke about avoiding overwhelming emotions by drawing on various metaphorical barriers, such as

armoury, cupboards and walls. This is akin to Freud's (1894) concept of defence mechanisms, which are seen as ways to cope with unbearable, painful feelings. The findings of this study extended upon this and demonstrated that clients perceive emotions as fearful and even destructive in the absence of these barriers.

The experience of *therapeutic discovery* in the dyads conjured up interesting images of archaeological discovery in which the therapist digs to find layers of psychological distress, which may be out of the client's awareness. This corresponds to Freud's (1900) archaeological metaphor for the mind in which therapists uncover hidden experiences and fragments of the past and place them in a living context. As described by the dyads in this study, this can result in long periods of frustration (*gradual and hard work; the struggle*), but also periods of excitement and satisfaction (*the positive connection*).

The cyclical emotional experience between the dyads throughout therapy was clearly described in the interviews. As suggested by the themes *to and fro* and *the struggle*, there were rupture-repair processes described both in the therapeutic relationship and the progress of therapy. From a Kleinian psychodynamic perspective, this *to and fro* process can be conceptualised as continual fluctuations between depressive, intersubjective mode of functioning and a more egocentric, paranoid-schizoid mode of functioning (Joseph, 1989). Like a parent, the therapist works through the experience of being overwhelmed and threatened by the disintegration of the client (Pick, 1985). Through this process, the paranoid-schizoid position can be gradually replaced by the depressive position with the relinquishment of egocentricity in favour of the intersubjective experience (Meltzer, 1988).

*The struggle* between the dyads can be understood in psychodynamic terms as negative transference. Freud (1914) suggested that a struggle develops due to the client's compulsion to repeat early experiences in the transferential relationship. This repetition occurs under the conditions of resistance in the therapeutic relationship and activates the "*armoury of the past, the weapons with which he defends himself against the process of the treatment*" (p.151). Altering attitudes towards the therapist may be due to early anxieties being repeated and defended against in the therapeutic relationship (Klein, 1952; Freud, 1914). Freud (1914) emphasised that it is only at the height of the client's resistance that the therapist can slowly

take down these weapons, curb their compulsion and help work through their difficulties. The findings of this study suggested that these struggles or ruptures were necessary ingredients of therapeutic work in psychodynamic therapy, as they provided insight into the client's emotional experience if repaired. As Horvath (2000) stated, therapeutic ruptures can provide opportunities for the client to address repeating patterns of behaviour and practice new productive interpersonal behaviours.

Interestingly, the findings demonstrated specific types of therapeutic ruptures, which were not explored fully in previous qualitative research in this area. Clients and therapists described a specific struggle of *power and control*, which at times led to clients deferring to their therapist in an attempt to preserve their therapeutic relationship and avoid disagreement. This relates to Rennie's (1994) concern that deference in psychotherapy develops out of a fear of criticising the therapist. Some clients deferred to the therapist to avoid an emotional interaction, but paradoxically this created more emotional tension in the dyads. Attempts to recognise and address client's negative emotions helped to bring feelings to the surface (*shining a light*) and helped to strengthen the therapeutic relationship.

Another therapeutic struggle was the anxiety of *not knowing*, which had different meanings within the dyads. For clients, it related to the uncertainty of silence and lack of reassurance while for therapists, it was the anxiety about unfinished therapeutic work. Bion (1974) described the need for openness to the unknown in every individual during psychotherapy. He stated, "*In every consulting room, there ought to be two frightened people; the patient and the psychoanalyst. If they are not, one wonders why they are bothering to find out what everyone knows*" (p. 13). As suggested by the findings of this study, by sitting with the discomfort of not knowing, it helped to create something emotionally meaningful in the therapeutic relationship rather than drawing on predetermined theories and approaches (Casement, 1995).

This study was the first to explore qualitative accounts of therapeutic dyads in psychodynamic therapy and the findings demonstrated a relational, intersubjective experience between clients and therapists. Interestingly, there were similar descriptions in the dyads about *the therapeutic discovery*, the experience of struggles in the therapeutic

relationship and how these were overcome. Rather than the therapist being external to the process, it seemed that both clients and therapists contribute to these struggles and ultimately the rupture-repair process. In psychodynamic therapy, it is clear that the experience of negative emotions and repairing therapeutic ruptures is at the heart of the therapeutic work and viewed as one of the ingredients for meaningful, psychological change. Although this is recognised within psychodynamic theory, this study highlighted the experience of this process from client and therapist perspectives.

### ***5.3 Attunement and reciprocity***

When dyads had achieved a *positive connection*, they described being emotionally in tune with one another and forming a reciprocal relationship. Similar to parenting, attunement is an essential part of therapy in which the therapist empathically responds to the client's emotional state and uses their feelings to guide the therapeutic process (Holmes, 2001; Wolf, 1993). This study demonstrated that attunement fluctuated throughout therapy (*To and fro*) similar to a dance. Like the parent-child dyad, there was a continuous oscillation between affective miscoordination and interactive repair, which could develop the expectation that ruptures can be reconciled and negative emotions transformed into positive ones (Safran et al., 1990).

This study showed that participants experienced a mirroring process when achieving a *positive connection* in their therapeutic relationship. Winnicott (1967) developed the notion of maternal mirroring in which the attuned mother helps the infant identify feelings by mirroring their behaviour with marked exaggeration. The maternal mirror acts as the basis for the inner mirror to emotional experience, which is part of the task of therapy (Holmes, 2001). Similarly, Meltzer (1976) suggested the therapist modulates the temperature of the communication and the emotional atmosphere as well as the distance between the therapeutic dyad with the use of language, vocabulary and content. By doing this, the therapist's language mirrors the client's expression of different parts of themselves brought into the transference.

Along with *emotional sensitivity*, the importance of the therapist *shining a light* on client's repeating patterns and the processes in the therapeutic relationship was discussed. Rhodes

and colleagues' (1994) suggested the need for therapist's willingness and assertiveness to discuss ruptures in order to successfully repair them. Translating non-verbal or unconscious communications into verbal constructions can provide an opportunity for therapeutic understanding and repair (Kantrowitz, 1992). As shown in this study, verbalising a struggle in therapy welcomes an invitation to explore negative feelings towards the therapist and improve the therapeutic relationship.

Many participants perceived the separation in the therapeutic relationship as another therapeutic struggle (*leaving and being left*). This study found a shared, reciprocal acceptance of sadness about the ending, but also an acknowledgement of positive feelings. Roe, Dekel, Harel, Fennig and Fennig (2006) also highlighted an intersubjective experience of the end of psychodynamic therapy, including both positive and negative feelings for clients and therapists. From a Kleinian perspective, separation in therapy can provide a key opportunity for the integration of positive and negative feelings towards the therapist (Klein, 1975). This integration and reparation at the end of therapy was described within participant interviews when they reflected on the journey of therapy and started to consolidate therapeutic gains.

Through the process of attunement and reciprocity in the dyads, there was a tension between being emotionally sensitive (*emotional sensitivity*) and being able to confront clients with their repeating patterns (*shining a light*). Through managing this tension, it seemed possible to repair ruptures and maintain a *positive connection*.

#### ***5.4 Reflections***

As transference and counter-transference enactments are central to the psychodynamic approach, I felt it would be useful to reflect on my own feelings on the research process. Midgley (2006) suggested that exploring the researcher's emotional reactions provides a deeper level of understanding of the research context.

I experienced a sense of discomfort at times when listening to the different accounts of the therapeutic dyads about their experience of rupture and repair. I felt this discomfort was about feeling like an intruder on the therapeutic experience. Although I was trying to make

sense of the participants' experience, I was asking questions about a very intimate, two-way process between the client and the therapist. Understandably, some clients were reluctant to discuss personal details about their backgrounds and what brought them to therapy. I also felt that the research process helped to develop a third perspective on therapy outside of the client-therapist dyad, similar to a supervisory capacity. Having this third perspective, I aimed to encapsulate participants' experience and enrich our understanding of the therapeutic journey in psychodynamic therapy.

There have been criticisms about using a psychodynamic approach in qualitative research, as it makes theoretical assumptions about human experience (Billig, 1997). In this research, I have experienced both benefits and tensions of negotiating IPA with a psychodynamic understanding. As Hollway and Jefferson (2000) described, a psychodynamic perspective helped me to focus on the emotional aspects from the qualitative interview and consider the anxieties and defences of participants underlying their narratives. Personal tensions appeared when analysing the data and trying to avoid psychodynamic theory influencing the themes generated, as it was important to capture the participants' experiences. As Smith (2004) suggested, I used psychodynamic theory to inform the interpretation following the close textual analysis of the participants' interviews. Having done this, I felt the two approaches worked together, as they shared the process of identifying repeating patterns and themes within client narratives. By incorporating both a phenomenological and psychodynamic perspective of participants' experience, it helped to develop a more complete understanding of therapeutic rupture and repair.

### ***5.5 Limitations***

This qualitative study had a small sample size of eight participants. Using an IPA approach, the intention of this study was to explore the lived experience of participants using a detailed interview and analysis. This level of analysis would not have been possible with a larger sample size.

To maintain an exploratory approach, participants were not restricted to discuss a type of rupture nor were the dyads asked to discuss the same rupture in their relationship. However, it did mean that the ruptures described by participants ranged from minor problems (e.g.

feeling frustrated by silence in therapy) to more complicated difficulties (e.g. wanting to end therapy) in the therapeutic relationship. Although there were individual differences in experiences of therapeutic rupture, it was interesting to see many similarities in the themes that ran through each narrative.

Using therapist participants provided an invaluable perspective on the experience of rupture and repair. However, it seemed that the therapists had two interlinking roles in the interview: a participant and a mental health professional. As a result, many therapist participants focused on their views of the client's experience and the psychodynamic formulation rather than their personal experience of the therapeutic process. There may have been anxieties about revealing more personal experiences for fear of being identified by the client and threatening the integrity of therapy. Although every effort was made to preserve confidentiality when analysing the interviews, this is an understandable concern.

As the interviews were completed after therapy had ended, it relied on the retrospective recall of participants' experiences. For some participants, they were interviewed six months after therapy and were asked to talk about experiences during long-term therapy. It was a struggle for some participants to recall specific incidents of rupture and repair in detail. However, all participants were able to talk about their general experience of difficulties in the therapeutic relationship with some interesting examples and reflections.

### ***5.6 Clinical, training and supervision implications***

Clinically, this research has important implications in understanding the ingredients of change in psychodynamic therapy. Experiencing a repaired rupture appeared to be a mechanism for therapeutic change for clients in this study. The survival of therapeutic struggles helped clients to tolerate emotional expression, develop a sense of closeness and intimacy with another person and develop their insight into their difficulties and repeating patterns. It demonstrated the importance of therapists being able to work with negative transference in the therapeutic relationship. Importantly, this may undermine the collaborative stance between the client and therapist at times, which is heavily emphasised in other therapeutic models. Based on these findings, fluctuations in the therapeutic relationship are to be expected in long-term therapy and can be important therapeutic events for change.

Participants described the experience of *hard work* and a *gradual process* of therapy that involved fluctuations in the therapeutic relationship (*to and fro*). For therapists, it is important to have an open discussion about therapeutic rupture and repair within supervision and during the course of therapy. It should also be an important part of the assessment process to explore whether the client can tolerate the experience of therapeutic rupture and repair. As an introduction to psychodynamic therapy, the experience of therapeutic rupture and repair could be normalised in order to structure the expectations of clients.

Considering the ubiquitous nature of therapeutic rupture and repair, it is necessary to train therapists on managing such difficulties. The findings demonstrated different types of ruptures and how they can be resolved through a careful balance of *emotional sensitivity* and confronting unhelpful repeating patterns (*shining a light*). Understanding and responding to these struggles is an important therapeutic skill, which is often overlooked on clinical training courses. Therefore training courses for therapists and psychologists may need to consider teaching and practicing these skills as part of the curriculum and encouraging trainees to discuss ruptures in reflective practice groups.

From wider perspective, a growing emphasis on meeting targets and offering time-limited psychotherapy in the NHS may obstruct the therapist's ability to reflect on and work with ruptures. Maintaining space and time to work with therapeutic ruptures is necessary within the NHS, especially for clients with complex relational problems in which emotions may be perceived as dangerous. There is also little information in the NICE guidelines on the occurrence of therapeutic rupture and how this can be repaired for clients with complex psychological problems. It is important to provide guidance to clinicians on managing deterioration in the therapeutic relationship in order to help avoid high attrition rates. Well-skilled clinicians are needed to deliver bespoke interventions for individuals with complex difficulties, which takes account of rupture and repair processes.

### ***5.7 Future directions***

Future research could investigate the experience of therapeutic rupture and repair with different client groups, including different ages, cultural backgrounds and different psychological difficulties. According to Blatt and Ford (1994), clients with different attachment styles may experience therapeutic interventions differently. They described anaclitic or introjective clients who either respond to relational or interpretative aspects of the therapeutic process respectively. It could be that individuals have different experiences of rupture and repair due to their pattern of relating, which could be further explored in a qualitative study.

It may be interesting to explore therapeutic rupture and repair within different therapeutic models. Muran and colleagues (2009) found that therapeutic rupture varies between cognitive-based and dynamic-based therapies, in terms of the nature and frequency of this process. The experience of rupture and repair within the therapeutic dyad during cognitive-based therapy could be explored. The findings demonstrated some specific ruptures in psychodynamic therapy related to *not knowing* and *control and power*, so it may be useful to explore specific therapeutic ruptures in different models and how they can be resolved.

Rather than retrospective accounts, exploring clients' and therapists' experience of rupture and repair during the process of individual or group therapy is important. The dyads may be able to recall the same rupture in more detail and how it was repaired. However, participating in research alongside psychodynamic therapy may impact on the transference and counter-transference relationship. There were also concerns from some therapist participants about being identified by their clients. Although the dyadic component of the research was valuable, future research could consider *not* matching clients and therapists to avoid risk of mutual identification.

As the majority of research into rupture and repair are outcome studies, the qualitative experience of this process deserves more attention. By understanding the experience of therapeutic rupture and repair, it starts to illuminate the key processes of change in psychodynamic therapy. This study has implications for clients' expectations of therapy, therapist training and the wider service context.

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## **Public Dissemination Document**

### **Literature Review Following a Systematic Approach:**

**What is the evidence base for using psychodynamic therapy with individuals diagnosed with personality disorder?**

**&**

**What are the experiences of therapeutic rupture and repair for therapists and clients within long-term psychodynamic therapy?**

This thesis was submitted in partial fulfilment of the requirements of a Doctorate in Clinical Psychology. This document describes Volume I, which includes a literature review on the evidence base of psychodynamic therapy for individuals diagnosed with personality disorder and a qualitative study exploring the clients' and therapists' experiences of therapeutic rupture and repair in long-term psychodynamic therapy.

### **Study 1: Literature Review**

Psychodynamic psychotherapy has been criticised for a lack of evidence base that would justify its use (Galatzer-Levy, Bachrach, Skolnikov & Waldon, 2000). Due to the historical reluctance of psychodynamic practitioners to engage with controlled research, many researchers within the scientific community have dismissed psychodynamic therapy as ineffective (Shelder, 2010; Anestis, Anestis & Lilenfeld, 2011). In the last decade, empirical studies have responded to this deficit in psychodynamic research and many have focused on personality disorder (Lewis, Dennerstein & Gibbs, 2007). A number of literature reviews have summarised the favourable outcomes of psychodynamic psychotherapy for personality disorder, which are comparable to cognitive behavioural therapy (Fonagy, Roth & Higgitt, 2005; Bateman & Tyrer, 2004; Leichsenring & Leibing, 2003).

This review aimed to provide an understanding of the current evidence base for the use of psychodynamic therapy with individuals diagnosed with a personality disorder. Since the last review by Fonagy and colleagues (2005), research in this area has continued to grow rapidly. It seems beneficial to appraise the growing literature in this area and explore whether any more detailed conclusions can be drawn. A systematic review of 18 studies investigating the evidence base of psychodynamic therapy for personality disorder was undertaken.

Out of the Randomized Controlled Trials (RCTs), 12 studies demonstrated superior results for the effectiveness and efficacy of psychodynamic therapy for individuals with personality disorder. This included four studies that compared psychodynamic therapy with another type of therapy. However, two RCTs found the cognitive-based therapies demonstrated superior results to dynamic therapies. In terms of non-RCTs, there were more mixed findings with two studies demonstrating positive results for psychodynamic-based therapy and one study

demonstrating less favourable findings for the psychodynamic approach. There were also good outcomes when using psychodynamic therapy for individuals with personality disorder on a short-term and long-term basis in a range of settings. However, the longevity of dynamic therapy seemed to depend on the severity of the personality disorder and individual's level of risk. Future research should address methodological issues of previous dynamic research, including the use of active comparator group, a range of assessment measures and follow up periods, to understand the ingredients of therapy that seem to generate change in individuals with personality disorder.

## **Study 2: Research Study**

There is a lack of qualitative research on the experience of difficulties and ruptures in the therapeutic relationship and how they are repaired during the course of therapy. This study aimed to explore parallel accounts of clients and therapists of therapeutic ruptures in their relationship during long-term psychodynamic therapy. Interviews were conducted with eight participants, including four client-therapist dyads, recruited through a regional psychotherapy service. The data were analysed using a qualitative method called Interpretative Phenomenological Analysis (IPA). Five overarching themes and six sub-themes emerged from the data are presented. Participants described a range of experiences and discourses when making sense of therapeutic rupture and repair in long-term psychodynamic therapy. These included: clients' experience of the danger of emotional experience (*emotions as dangerous*); accounts of discovery in therapy being a difficult and gradual experience of therapy (*therapeutic discovery; gradual and hard work; to and fro*); the experience of the hurdles and problems within the therapeutic relationship (*the struggle; not knowing; control and power*); followed by a connection within the relationship (*the positive connection; emotional sensitivity; shining a light*); and the experience of the end of the therapeutic relationship (*leaving and being left*).

The results are discussed in relation to the emotional experience of psychodynamic therapy. For both the clients and therapists, there were narratives about the emotional impact of the therapeutic process, including a number of struggles as well as joint positive experiences. Further to this, the findings demonstrated the importance of attunement and reciprocity within the therapeutic relationship emerged to help maintain a positive connection between

the dyads. Through the process of optimal attunement and reciprocity in the therapeutic dyads, there was a dialectical tension between being emotionally sensitive (*emotional sensitivity*) and being able to confront the client with their repeating patterns (*shining a light*).

### **Clinical, training and supervision implications**

Several implications result from the findings of these two studies. At a clinical level, the literature review highlights the evidence base of psychodynamic therapy for personality disorder that is comparable to Cognitive Behavioural Therapy (CBT). Although Dialectical Behaviour Therapy (DBT) is the treatment of choice within the National Institute of Clinical Excellence guidelines for BPD (NICE, 2009) and across many services within the NHS, there is also evidence to suggest the clinical effectiveness of other dynamic-based therapies. Based on the research study, the experience of therapeutic rupture and repair seemed to be a frequent process and deemed as one of the mechanism for change in psychodynamic therapy. For therapists, open discussions about the experience of rupture and repair as part of supervision is essential. Within the assessment process, it is also important to explore whether the client can tolerate the experience of therapeutic rupture and repair.

From a service perspective, there is increasing emphasis on using time-limited, evidence based therapies, especially the agenda for Payment by Results being introduced in the NHS. The literature review highlights the short-term and long-term benefits of dynamic-based therapies for a range of personality disorders in comparison to other validated cognitive-based therapies, especially for BPD. The research study highlights the complex interactions and struggles between clients and therapists within long-term psychodynamic therapy. Given the growing emphasis on time-limited therapies in the NHS, it may limit the therapist's ability to reflect on and work with ruptures. Both papers emphasize the need to maintain a space for non-manualised, long-term psychodynamic therapy is necessary within the NHS for more complex relational problems.

Other implications for training include an emphasis on noticing and handling therapeutic rupture and repair. Understanding and responding to these ruptures is an important therapeutic skill and should be integrated into the curriculum on training courses for

therapists and psychologists. The literature review demonstrated some positive findings for dynamic therapies, but it seems misleading for one brand name to monopolise the treatment of personality disorder. The importance of understanding process issues within therapies, such as rupture and repair, may be more important to help develop therapeutic change.

### **Future directions**

The literature review highlighted the need to address some of the methodological problems within the existing psychodynamic research in order to continue to enhance the credibility of dynamic research in line with other psychotherapies. As well as exploring the evidence base of group psychodynamic therapy, examining the specific process variables in dynamic therapies for personality disorder may help to understand the ingredients of therapy that seem to generate change for these individuals.

Given the lack of qualitative research on therapeutic rupture, it might be beneficial to investigate the experience of rupture and repair for different client groups, including different ages, cultural backgrounds and clients with different psychological difficulties and attachment styles. It may also be interesting to explore the experience of therapeutic rupture and repair within different therapeutic models and within group settings. By understanding the experience of therapeutic rupture and repair, it starts to illuminate the key processes of change in psychodynamic therapy.

## **APPENDICES OF RESEARCH COMPONENT**

## **Appendices**

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## Appendix A: Previous literature reviews

<b>Study</b>	<b>Date</b>	<b>Description of study</b>	<b>Results</b>
Fonagy, Roth & Higgitt	2005	They explored the outcome of psychodynamic psychotherapy for psychological disorders and included a wide range of studies focusing on the treatment of PDs.	The limited number of studies, compounded heterogeneity of clinical populations and methods applied, suggested a meta-analysis would be premature. Notwithstanding such limitations, both psychodynamic and CBT treatments were effective for PD
Leichsenring & Leibing	2003	They conducted a meta-analysis to address the effectiveness of psychodynamic therapy and CBT in the treatment of personality disorders, but this reviewed published studies from 1974 and 2001.	Both psychodynamic and CBT were both effective treatments for PD. Further studies are necessary that examine specific forms of psychotherapy for specific PDs that use measures of core psychopathology. Both longer treatments and follow up studies should be included.
Abbass, Hancock, Henderson & Kisely	2009	A more recent systematic review by focused on short-term psychodynamic psychotherapies for common mental disorders, which was published on the Cochrane database. However, due to the strict inclusion and exclusion criteria for their review, only two studies exploring PD were included.	Outcomes for most categories of disorder suggested significantly greater improvement in the treatment versus the control group, which were generally maintained on a medium and long-term follow up.
Leichsenring,	2004	A meta-analysis of short	Short term

Rabung & Leibing		term psychodynamic psychotherapy in specific psychiatric disorders	psychodynamic psychotherapy proved to be an effective treatment in psychiatric disorders in terms of target problems, general psychiatric symptoms and social functioning. Effectiveness studies could be included in future studies.
Leichsenring & Rabung	2008	A meta-analysis of the effectiveness of long term psychodynamic psychotherapy in complex mental disorders, including PD, chronic mental disorders, multiple mental disorders and complex depressive and anxiety disorders.	There was evidence that long term psychodynamic psychotherapy is an effective treatment for complex mental disorders in overall effectiveness, target problems and personality functioning.

## Appendix B: Search syntax

*The Cochrane Library (11/02/11)*

((psychodynamic\*) OR (psychoanaly\*)) AND (personalit\*) AND ((disorder\*) OR (problem\*) OR (diagnos\*) OR (issue\*)) AND ((therap\*) OR (treatment\*) OR (intervention\*) OR (analy\*))

Results: 39

Relevant: 2

*Web of Science (26/03/11)*

((psychodynamic\*) OR (psychoanaly\*)) AND (personalit\*) AND ((disorder\*) OR (problem\*) OR (diagnos\*) OR (issue\*)) AND ((therap\*) OR (treatment\*) OR (intervention\*) OR (analy\*))

Results: 352

Relevant: 58

*Cumulative Index to Nursing and Allied Health Literature (CINAHL) (26/3/11)*

((psychodynamic\*) OR (psychoanaly\*)) AND (personalit\*) AND ((disorder\*) OR (problem\*) OR (diagnos\*) OR (issue\*)) AND ((therap\*) OR (treatment\*) OR (intervention\*) OR (analy\*))

Results: 130

Limit from 2005-Current: 73

Relevant: 15

*EMBASE (13/03/11)*

1. (psychodynamic\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 5544
2. (psychoanaly\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 16785
3. 1 or 2 = 20799
4. (personality\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 49316
5. (disorder\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 772050
6. (problem\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 442771
7. (diagnos\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 1373910
8. (issue\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 242317
9. 5 or 6 or 7 or 8 = 2424193
10. (therap\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 1529214
11. (treatment\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 2337219
12. (intervention\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 409810
13. (analy\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 336588
14. 10 or 11 or 12 or 13 = 5659786
15. 3 and 4 and 14 = 1236
16. 2005 to current articles = 457

Results: 457  
Relevant: 33

*PsycInfo (including journals@OVID full text from 2002- current) (11/02/11)*

1. (psychodynamic\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 6805
2. (psychoanaly\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 23475
3. 1 or 2= 28416
4. (personality\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 48982
5. (disorder\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 191346
6. (problem\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 131193
7. (diagnos\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 82889
8. (issue\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 126370
9. 5 or 6 or 7 or 8= 434203
10. (therap\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 135325
11. (treatment\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 180363
12. (intervention\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 102609
13. (analy\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 294259
14. 10 or 11 or 12 or 13 = 521847
15. 3 and 4 and 14= 8425
16. 2005 to current articles= 4740

Results: 4740  
Relevant: 41

*MEDLINE (26/03/11)*

1. (psychodynamic\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 1771
2. (psychoanaly\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 7995
3. 1 or 2= 9094
4. (personality\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 45867
5. (disorder\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 607008
6. (problem\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 329689
7. (diagnos\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 890637
8. (issue\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 184213
9. 5 or 6 or 7 or 8= 172217
10. (therap\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 1054448
11. (treatment\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 1634365
12. (intervention\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 313126
13. (analy\$).mp.[mp=ti, ab, tx, ct, hw, tc, id] = 2163490
14. 10 or 11 or 12 or 13 = 3871932
15. 3 and 4 and 14= 870
16. 2005 to current articles= 315

Results: 315  
Relevant: 38

### Appendix C: Inclusion/ Exclusion form

	<b>Inclusion</b>	<b>Exclusion</b>
<b>Population</b>	Clients and therapists who have engaged in short term or long term individual psychodynamic psychotherapy within community, hospitalised or therapeutic community populations Clients with a diagnosis of personality disorder. Clients aged 16 and above. Studies from 2005 onwards	Purely group interventions Non-psychodynamic therapy Clients without a diagnosis of personality disorder Clients under the age of 16 Studies before 2005
<b>Intervention/ Exposure</b>	Psychodynamic psychotherapy Including: Mentalisation based psychotherapy Transference based psychotherapy Psychoanalysis Dynamic therapy	Non-psychodynamic psychotherapy
<b>Comparator</b>	Non-psychodynamic psychotherapy No therapy/ waiting list controls Medication No comparison group	N/A
<b>Outcomes</b>	Effectiveness and efficacy outcomes Quality of life Social functioning Symptomology Object relations measure Attachment measures Service utilisation outcomes, such as admissions, self harm or suicide attempts.	N/A
<b>Study Design</b>	RCT; cohort, case control, naturalistic	Reviews, opinion papers, commentaries, editorials, non-English language papers, non-published

		papers and case series
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**Appendix D: List of studies excluded following application of Inclusion/ Exclusion criteria**

Studies	Reason for exclusion
Andreoli, A., Burnand, Y., Cochenec, M.F., Marie, D., DiClemente, T. & Ohlendorf, P. (2009). Psychoanalytic psychotherapy and venlafaxine among acutely suicidal borderline patients: A randomized clinical study	Not in English
Chiesa, M., Fonagy, P. & Holmes, J. (2006). Six-year follow-up of three treatment programs to personality disorder. <i>Journal of Personality Disorders</i> , 20, 493-509.	Exposure: Not comparing treatment models/ Unclear treatment used
Levy, K.N., Clarkin, J.F., Yeomans, F.E., Scott, L.N., Wasserman, R.H. & Kernberg, O.F. (2006). The mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy. <i>Journal of Clinical Psychology</i> , 62, 481-501.	Not experimental study
Puschner, B., Kraft, S., Kachele, H. & Kordy, H. (2007). Course of improvement over 2 years in psychoanalytic and psychodynamic outpatient psychotherapy. <i>Psychology and Psychotherapy: Theory, Research and Practice</i> , 80, 51-68.	Population: Not personality disorder
Kenkt, P., Lindfors, O., Harkanen, T., Valikoski, M., Virtala, E., Laaksonen, M.A., Marttunen, M., Kaipainen, M., Renlund, C. & the Helsinki Psychotherapy Study Group (2008). Randomized trial on the effectiveness of long- and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow up. <i>Psychological Medicine</i> , 38, 689-703.	Population: Not personality disorders
Gregory, R.J., Chlebowski, S., Kang, D., Remen, A. & Soderberg, M. (2006). Psychodynamic therapy for borderline personality disorder and co-occurring alcohol use disorders: A newly designed ongoing study. <i>Journal of the American Psychoanalytic Association</i> , 54, 1331-1334.	Study protocol
Gregory, R.J. & Remen, A.L. (2008). A manual-based psychodynamic therapy for treatment-resistant borderline personality disorder. <i>Psychotherapy: Theory, Research, Practice, Training</i> , 45, 15-27.	Case studies
Leirvag, H., Pedersen, G. & Karterud, S. (2010). Long-term continuation treatment after short-term day treatment of female patients with severe personality disorders: Body awareness group therapy versus psychodynamic group therapy. <i>Nordic Journal of Psychiatry</i> , 64, 115-122.	Exposure: Purely group intervention

Leichsenring, F., Biskup, J., Kreische, R. & Staats, H. (2005). The Gottingen study of psychoanalytic therapy: First results. <i>International Journal of Psychoanalysis</i> , 86, 433-455.	Population: Not personality disorder
Goldman, G.A. & Gregory, R.J. (2010). Relationships between techniques and outcomes for borderline personality disorder. <i>American Journal of Psychotherapy</i> , 64, 359-371.	Not outcome study- exploring techniques
Beretta, V., de Roten, Y., Drapeau, M., Kramer, U., Favre, N. & Despland, J.N. (2005). Clinical significance and patients' perceived change in four sessions of brief psychodynamic intervention: Characteristics of early responders. <i>Psychology and Psychotherapy: Theory, Research and Practice</i> , 78, 347-362.	Population: Not just PD but also mood disorders
Chiesa, M., Fonagy, P., Bateman, A.W. & Mace, C. (2009). Psychiatric morbidity and treatment pathway outcomes of patients presenting to specialist NHS psychodynamic psychotherapy services: Results from a multi-centre study. <i>Psychology and Psychotherapy: Theory, Research and Practice</i> , 82, 83-98.	Population: Not personality disorder
Chiesa, M. & Fonagy, P. (2003). Psychosocial treatment for severe personality disorder: 36 month follow up. <i>British Journal of Psychiatry</i> , 183, 356-362.	Pre 2005 and in Fonagy review
Meares, R., Stevenson, J. & Comerford, A. (1999). Psychotherapy with borderline patients: A comparison between treated and untreated cohorts. <i>Australian and New Zealand Journal of Psychiatry</i> , 467-472.	Pre 2005
Bateman, A. & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: An 18 month follow up. <i>American Journal of Psychiatry</i> , 158, 36-42.	Pre 2005 and in Fonagy review
Bateman, A. & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. <i>American Journal of Psychiatry</i> , 156, 1563-1569.	Pre 2005 and in Fonagy review
Dolan, B., Warren, F. & Norton, K. (1997). Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. <i>British Journal of Psychiatry</i> , 171, 274-279.	Pre 2005 and in Fonagy review
Bateman, A. & Fonagy, P. (2003). Health service utilization costs for borderline personality disorder patients treated with psychoanalytically orientated partial hospitalization versus general psychiatric care. <i>American Journal of Psychiatry</i> , 160, 169-171.	Pre 2005 and in Fonagy review
Chiesa, M., Fonagy, P., Holmes, J. & Drahorad, C. (2004). Residential versus community treatment of personality disorders: A comparative study of three treatment programs. <i>American Journal of Psychiatry</i> , 161, 1463-1470.	Pre 2005 and in Fonagy review

Svartberg, M., Stiles, T.C. & Seltzer, M.H. (2004). Randomised, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for cluster C personality disorders. <i>American Journal of Psychiatry</i> , 161, 810-817.	Pre 2005 and in Fonagy review
Clarkin, J.F., Foelsch, P.A., Levy, K.N. (2001). The development of psychodynamic treatment for patients with borderline personality disorder: A preliminary study of behavioral change. <i>Journal of Personality Disorders</i> , 15 487-495.	Pre 2005
Junkert-Tress, B., Schnierda, U., Hartkamp, N., Schmitz, N. & Tress, W. (2001). Effects of short-term dynamic psychotherapy for neurotic, somatoform and personality disorders: A prospective 1 year follow up study. <i>Psychotherapy Research</i> , 11, 187-200.	Pre 2005
Goldman, G.A. & Gregory, R.J. (2010). Relationships between techniques and outcomes for borderline personality disorder. <i>American Journal of Psychotherapy</i> , 64, 359-371.	Not outcome study
Gregory, R.J. & Remen, A.L. (2008). A manual-based psychodynamic therapy for treatment-resistant borderline personality disorder. <i>Psychotherapy: Theory, Research, Practice, Training</i> , 45, 15-27.	Case Studies
Luyten, P., Lowyck, B. & Vermote, R. (2010). The relationship between interpersonal problems and outcome in psychodynamic hospitalization-based treatment for personality disorders: A 12 month follow-up study. <i>Psychoanalytic psychotherapy</i> , 24, 417-436.	Exposure: Purely group treatment Naturalistic design
Petersen, B., Toft, J., Ball Christensen, N.B.m Foldager, L., Munk-Jorgensen, P., Lien, K. & Valbak, K. (2008). Outcome of a psychotherapeutic programme for patients with severe personality disorders. <i>Nordic Journal of Psychiatry</i> , 62, 450-455.	Exposure: Purely group treatment and therapy not just psychodynamic
Karterud, S., Vaglum, S., Friis, S., Irion, T., Johns, S. & Vaglum, P. (1992). Day hospital therapeutic community treatment for patients with personality disorders. <i>The Journal of Nervous and Mental Disease</i> , 180, 238-243.	Pre 2005 Exposure: Purely group treatment
Sachsse, U., Vogel, C. & Leichsenring, F. (2006). Results of psychodynamically orientated trauma-focused inpatient treatment for women with complex posttraumatic stress disorder and borderline personality disorder. <i>Bulletin of the Menninger Clinic</i> , 70, 125-144.	Exposure: Combined psychodynamic and EMDR treatment

## Appendix E: Quality Assessment Forms

### a) Randomised Controlled Trial

QUESTION	Y	P	N	U	COMMENTS
INITIAL SCREENING					
Has the study addressed a clearly focused issue?*					
Is the study addressing psychodynamic therapy for personality disorder?*					
STUDY DESIGN					
Has the study addressed the question being asked?*					
Is a RCT study an appropriate way of answering the question under the circumstances?					
Has the study addressed the question being asked?*					
SELECTION BIAS					
Is the study based on a representative sample selected from a relevant population? Were the cases representative of the defined population?*					
Were the controls representative of the defined population?					
Were the controls selected in a manner reducing bias?					
Was there a sufficient number of cases selected?					
Was there a sufficient number of controls selected?					
Did all individuals enter the study at a similar point?					
Are the criteria for inclusion explicit?					
Has the classification of groups been randomised and reliably assessed and validated?					
Are the group comparable with respect to demographic/potential confounding factors?					
Were potential confounding variables controlled for (by matching or through stats)?					
PERFORMANCE AND DETECTION BIAS					
Were the participants blind to the measure of exposure?					
Were the assessor(s) blind to participants' outcome?					
Has personality disorder been clearly defined and measured?*					
Has psychodynamic therapy been clearly defined and measured?*					
Was blinding incorporated where feasible?					
ATTRITION BIAS					
Were dropout rates and reasons for drop-out similar across groups?					
OUTCOME BIAS					
Was outcome measured in a correct way?*					
Were the measures valid and reliable for the defined population?					
CONFOUNDING FACTORS					
Were confounding variables considered?					
STATISTICS					
Was the statistical analysis used correct?*					
ARE THE RESULTS BELIEVABLE?					
Are results unbiased?*					
Are the results significant?					
Is the size of effect reasonable?					
Have limitations been discussed?					
APPLICABILITY OF FINDINGS					
Are the participants representative of a clinical population?					
Can results be applied to clinical population regardless of culture and size?					
Can the results be applied to the UK population?					

**b) Case control studies**

QUESTION	Y	P	N	U	COMMENTS
<b>INITIAL SCREENING</b>					
Has the study addressed a clearly focused issue?*					
Is the study addressing psychodynamic therapy for personality disorder?*					
<b>STUDY DESIGN</b>					
Has the study addressed the question being asked?*					
Is a case control study an appropriate way of answering the question under the circumstances?					
<b>SELECTION BIAS</b>					
Is the study based on a representative sample selected from a relevant population? Were the cases representative of the defined population?*					
Were the controls representative of the defined population?					
Were the controls selected in a manner reducing bias?					
Was there a sufficient number of cases selected?					
Was there a sufficient number of controls selected?					
Did all individuals enter the study at a similar point?					
Are the criteria for inclusion explicit?					
Has the classification of cases been reliably assessed and validated?					
Are the cases and controls comparable with respect to demographic/potential confounding factors?					
Were potential confounding variables controlled for (by matching or through stats)?					
<b>PERFORMANCE AND DETECTION BIAS</b>					
Were the participants blind to the measure of exposure?					
Were the assessor(s) blind to participants' outcome?					
Has personality disorder been clearly defined and measured?*					
Has psychodynamic therapy been clearly defined and measured?*					
Was blinding incorporated where feasible?					
<b>ATTRITION BIAS</b>					
Were dropout rates and reasons for drop-out similar across groups?					
<b>OUTCOME BIAS</b>					
Was outcome measured in a correct way?*					
Were the measures valid and reliable for the defined population?					
<b>CONFOUNDING FACTORS</b>					
Were confounding variables considered?					
<b>STATISTICS</b>					
Was the statistical analysis used correct?					
<b>ARE THE RESULTS BELIEVABLE?</b>					
Are results unbiased?*					
Are the results significant?					
Is the size of effect reasonable?					
Have limitations been discussed?					
<b>APPLICABILITY OF FINDINGS</b>					
Are the participants representative of a clinical population?					
Can results be applied to clinical population regardless of culture and size?					
Can the results be applied to the UK population?					

### c) Cohort studies

QUESTION	Y	P	N	U	COMMENTS
INITIAL SCREENING					
Has the study addressed a clearly focused issue?*					
Is the study addressing psychodynamic therapy for personality disorder?*					
STUDY DESIGN					
Is a cohort study an appropriate way of answering the question under the circumstances?					
Has the study addressed the question being asked?*					
SELECTION BIAS					
Was the cohort representative of the defined population?*					
Was a sufficient sample size used?					
Were the groups similar at base line such as demographics and background factors (age, ethnicity, etc.)?					
Were the groups comparable in all important confounding variables?					
Were any potential confounding variables controlled for?					
MEASUREMENT AND DETECTION BIAS					
Has personality disorder been clearly defined and measured?*					
Has psychodynamic therapy been clearly defined and measured?*					
Were the measurements for outcome objective?					
Was the outcome measure validated?					
Were the assessment instrument(s) for outcome (psychometrics/questionnaire) standardised?					
Was the outcome assessed in the same way across groups?					
Were the participants blind to the research?					
Were the assessor(s) blind to the exposure?					
ATTRITION BIAS					
Were dropout rates and reasons for drop-out similar across groups?					
OUTCOME BIAS					
Was outcome measured in a correct way?*					
Were the measures valid and reliable for the defined population?					
STATISTICS					
Was the statistical analysis used correct?					
Are the results believable?					
Are results unbiased?*					
Are the results significant?					
Is the size of effect reasonable?					
Are methods and design reliable?					
Have limitations been discussed?					
APPLICABILITY OF FINDINGS					
Are the participants representative of the clinical population?					
Can results be applied to the clinical population regardless of culture and size?					
Can the results be applied to the UK population?					

**d) Naturalistic/ non-controlled studies**

QUESTION	Y	P	N	U	COMMENTS
<b>INITIAL SCREENING</b>					
Has the study addressed a clearly focused issue?*					
Is the study addressing psychodynamic therapy for personality disorder?*					
<b>STUDY DESIGN</b>					
Has the study addressed the question being asked?*					
Is a cross sectional study an appropriate way of answering the question under the circumstances?*					
<b>SELECTION BIAS</b>					
Is the study based on a representative sample selected from a relevant population?*					
Was a sufficient sample size used?					
Did all individuals enter the survey at a similar point?					
Are the criteria for inclusion explicit?					
Were potential confounding variables controlled for (by matching or through statistics)?					
<b>MEASUREMENT AND DETECTION BIAS</b>					
Has personality disorder been clearly defined and measured?*					
Has psychodynamic therapy been clearly defined and measured?*					
Were the measurements for outcome objective?					
Was the outcome measure validated?					
Were the assessment instrument(s) for outcome (psychometric/questionnaire) standardised?					
Was the outcome assessed in the same way across groups?					
Was blinding incorporated where feasible?					
<b>ATTRITION BIAS</b>					
Were dropout rates and reasons for dropout similar across groups?					
<b>OUTCOME BIAS</b>					
Was outcome measured in a correct way?*					
Were the measures valid and reliable for the defined population?					
<b>STATISTICS</b>					
Was the statistical analysis used correctly?					
<b>ARE THE RESULTS BELIEVABLE?</b>					
Are results unbiased?*					
Are the results significant?					
Is the size of effect reasonable?					
Are methods and design reliable?					
Have limitations been discussed?					
<b>APPLICIABILITY OF FINDINGS</b>					
Are the participants representative of clinical population?					
Can results be applied to the clinical population regardless of culture and size?					
Can the results be applied to the UK population?					

Adapted from Critical Appraisal Skills Programme (CASP, 2000)|

\*= Fundamental criteria

**Appendix F: Table of quality assessment studies**

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
Vinnars, Barber, Noren, Gallop & Weinryb (2005) Sweden	RCT	<p>After 1 year of treatment, time-limited, manualised supportive-expressive psychotherapy would be more successful than community-delivered psychodynamic therapy in:</p> <ol style="list-style-type: none"> <li>1. Reducing both the prevalence of patients having a personality disorder diagnosis and the severity of the condition</li> <li>2. Decreasing the number of personality disorder features</li> <li>3. Diminishing psychiatric symptoms</li> <li>4. Improving global level of functioning</li> <li>5. Reducing the number of post-treatment visits.</li> </ol>	<p>156 participants with a range of personality disorder diagnoses. 80 participants in group 1 and 76 participants in group 2. Mean age: 35 years Unknown sex 35% avoidant personality, 24% borderline personality and 37% depressive personality</p>	<p>Group 1: 40 sessions of manualised, supportive-expressive psychotherapy Group 2: Community delivered, non-manualised psychodynamic therapy.</p>	<p>In both conditions, the global level of functioning improved and a decrease in personality disorder severity and psychiatric symptoms. During the follow-up period, the manualised psychotherapy made fewer visits to community mental health centres. Overall, the manualised approach was not superior to the non-manualised psychotherapy.</p>	<p>78% 9/10 fundamental criteria fulfilled</p>	<p><i>Strengths:</i> Well validated measures Measures both clinically and statistical change. 1 year follow up period</p> <p><i>Weaknesses:</i> Use of stratified randomisation, which match participants on prognostic variables. Authors are supportive-expressive therapists No control group/ placebo condition Excludes some co-morbidity, such as alcohol and drug dependency</p>
Emmelkamp, Benner, Kuipers, Feiertag, Koster	RCT	To compare the effectiveness of brief dynamic therapy and cognitive-behavioural	62 participants diagnosed with avoidant personality	Group 1: 20 weeks of brief dynamic psychotherapy	Cognitive behavioural therapy was superior to brief dynamic therapy on all primary	78% 8/10 fundamental criteria	<p><i>Strengths:</i> Use of placebo group Use of manual</p>

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
& van Apeldoorn (2006) The Netherlands		therapy as outpatient treatment for people with avoidant personality disorder.	disorder. 23 participants in group 1, 18 participants in group 2 and 18 participants in group 3. 30 men and 32 women Mean age: 34 years	Group 2: 20 weeks of cognitive behavioural therapy Group 3: Waiting list control group	measures, including the Lehrer Woolfolk Anxiety Symptoms questionnaire, the Personality Disorder Beliefs questionnaire (avoidant sub-scales), Social Phobia Anxiety Inventory and the Avoidance Scale. However, Brief Dynamic Therapy demonstrated significant improvements pre and post treatment on all measures. Both groups were superior to the waiting list control group. All results were maintained upon follow up.	fulfilled	based intervention on two treatment conditions.  <i>Weaknesses:</i> Unknown follow up period
Giesen-Bloo, van Dyck, Spinhoven, van Tilburg, Dirksen, van Asselt, Kremers, Nadort & Arntz (2006) The Netherlands	RCT	To compare the effectiveness of schema-focused therapy and psychodynamically based transference focused psychotherapy in patients with borderline personality disorder.	88 participants with borderline personality disorder. 44 participants in group 1 and 42 participants in group 2. Mean age: 30 40 women in group 1 and 40	Group 1: 3 years of schema-focused psychotherapy (2 sessions a week) Group 2: 3 years of transference focused therapy (2 sessions a week)	Using an intention-to-treat approach, statistically and clinically significant improvements were found on both treatments after 1, 2 and 3 year treatment periods. After 3 years of treatment, significantly more participants doing	84% 10/10 fundamental criteria fulfilled	<i>Strengths:</i> Use of intention to treat analysis Measurements on both transference focused and schema focused concepts Exploring both statistical and clinically

Authors/ Year/ Country of study	Study Type	Aims/ Hypotheses	Participants/ Sample Size	Comparison Group	Findings	Quality Assessment	Strengths and Weaknesses
			women in group 2		schema focused therapy recovered on the Borderline Personality Disorder Severity Index. They also showed more change in general psychopathologic dysfunction, quality of life and measures on schema focused and transference focused concepts, including Young Schema Questionnaire and Defence Style Questionnaire.		significant change Treatment integrity checks  <i>Weaknesses:</i> No follow up period No placebo/ control group
Levy, Meehan, Kelly, Reynoso, Weber, Clarkin & Kernberg (2006) North America	RCT	They hypothesised that the transference-focused psychotherapy will significantly increase reflective function and narrative coherence and significantly reduce lack of resolution of loss and trauma compared to dialectical behaviour therapy and psychodynamic supportive psychotherapy.	90 participants with borderline personality disorder. 31 participants in Group 1, 29 participants in Group 2 and 30 participants in Group 3. Age: 18-50 years 84 females and 6 males	Group 1: 1 year of transference focused psychotherapy Group 2: 1 year of dialectical behaviour therapy Group 3: Psychodynamic supportive psychotherapy	After 1 year of therapy, participants completing transference-focused therapy demonstrated significant difference in narrative coherence and reflective function compared to participants in groups 2 and 3. There are no significant changes in terms of resolution of loss or trauma across treatment groups. A significant increase in the secure attachment	84% 10/10 fundamental criteria fulfilled	<i>Strengths:</i> Use of intention to treat analysis Use of attachment assessments Use of simple randomisation rather than stratified or minimisation randomisation. Treatment integrity checks  <i>Weaknesses:</i> No follow up

Authors/ Year/ Country of study	Study Type	Aims/ Hypotheses	Participants/ Sample Size	Comparison Group	Findings	Quality Assessment	Strengths and Weaknesses
					state of mind for participants in the transference-focused therapy, but not in the other two treatments.		period when treatment was completed.
Clarkin, Levy, Lenzenweger & Kernberg (2007) North America	RCT	They examined three year-long outpatient treatments for borderline personality disorder, including dialectical behaviour therapy, transference-focused therapy and a dynamic supportive treatment.	90 participants diagnosed with borderline personality disorder. Mean age: 31 83 females and 7 males	Group 1: 1 year of transference focused therapy Group 2: 1 year of dialectical behaviour therapy Group 3: 1 year of dynamic supportive treatment	All three treatment groups improved on measurements of depression, anxiety, global functioning and social adjustment. Transference focused therapy and dialectical behaviour therapy improved in suicidality and transference focused therapy and dynamic supportive therapy improved in anger and impulsivity. Only transference-focused therapy demonstrated improvements in irritability and verbal and direct assault.	84% 10/10 fundamental criteria fulfilled	<i>Strengths:</i> Measurements taken at four month intervals Both clinical and statistical significant improvements  <i>Weaknesses:</i> No follow up period Participants took medication as well as therapy Researcher bias to transference focused therapy Unsure numbers in each condition
Vinnars, Barber, Noren, Thormahlen, Gallo, Lindgren & Weinryb	RCT	They examined whether measures of Personality Disorder from the Diagnostic and Statistical Manual of Mental Disorder IV, psychodynamic	156 participants with a personality disorder diagnosis. 76 participants in group 1 and 80 participants in	Group 1 Time-limited, manualised supportive-expressive psychotherapy for 40 weekly	Participants with higher rates of dominance had higher rates of improvement with the open-ended, community delivered psychodynamic	76% 10/10 fundamental criteria fulfilled.	<i>Strengths:</i> 2 year follow up period  <i>Weaknesses:</i> Use of stratified randomisation

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
(2007) Sweden		character, psychological mindedness, interpersonal patterns and personality traits predict treatment outcome for personality disorder patients.	group 2. Average age: 35 Unknown sex 35% avoidant personality, 37% depressive personality and 25% borderline personality	sessions Group 2 Non-manualised, open-ended community delivered psychodynamic treatment.	treatment. Participants with higher rates of interpersonal vindictiveness had higher rates of improvement with the time-limited, manualised supportive-expressive psychotherapy.		No placebo/ control group
Jorgenson & Kjolbye (2007). Denmark	Naturalistic/ non-controlled	This study examines the outcome of up to 15 months of psychoanalytically oriented psychotherapy for patients with borderline personality disorder.	19 participants with borderline personality disorder completed 15 months of psychoanalytically orientated psychotherapy. Mean age: 28 years	Not applicable	11 participants who completed the course of psychotherapy showed significant positive changes in anxiety and depression measures and with general functioning. This was maintained within 32 month follow up period.	71% 6/8 fundamental criteria were met	<i>Strengths:</i> Long follow up period Treatment integrity checks  <i>Weaknesses:</i> No comparison group No intention to treat analysis Very small sample High drop out rates
Bateman & Fonagy (2008) UK	RCT	This study evaluated the effect of mentalisation-based treatment by partial hospitalisation compared to treatment as usual for borderline personality disorder 8 years after entry into the randomised controlled trial and 5 years after the	41 participants with borderline personality disorder. 22 participants in group 1 and 19 participants in group 2. Unknown sex or age range	Group 1: 18 months of partial hospitalisation and mentalisation-based therapy Group 2: Treatment as usual	Mentalisation based therapy was clinically and statistically superior to the treatment as usual group on suicidality, diagnostic status, service use, medication use, global functioning and vocational status.	81% 10/10 fundamental criteria fulfilled	<i>Strengths:</i> 5 year follow up period Intention to treat analysis Exploring clinical and statistical significant change Range of assessments

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
		mentalisation based treatment was complete.			This was maintained 5 years after completing the mentalisation based therapy. However, general social functioning remained impaired in both groups. At the end of the follow up period, 13% of the mentalisation based group met the diagnostic criteria for borderline personality disorder compared with 87% of the treatment as usual group.		<i>Weaknesses</i> Researcher bias to mentalisation-based therapy Little information on randomisation
Gude & Hoffart (2008) Norway	Cohort	Patients with panic disorder/ agoraphobia and cluster C personality disorders receiving schema focused therapy will obtain more reduction in interpersonal problems from pre-treatment to follow up compared to those completing psychodynamic treatment.	42 participants with cluster C personality disorder and agoraphobia. 18 participants in group 1 and 24 participants in group 2. Mean age: 40 years 71% female in group 1 and 61% female in group 2.	Group 1: Non-manualised based psychodynamic treatment Group 2: Manual-based schema-focused therapy	Participants completing schema focused therapy reduced their level of interpersonal problems during the course of the treatment compared to psychodynamic treatment. Schema focused group also improved more in the follow up period than the psychodynamic group in terms of interpersonal difficulties.	76% 7/8 of the fundamental criteria were met	<i>Strengths:</i> One year follow up  <i>Weaknesses:</i> Therapists had preference for schema focused therapy Therapist competence also biased schema focused therapy Small sample No intention to treat analysis Substituted missing

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
							values in group 2 with group mean at follow up.
Abbass, Sheldon, Gyra & Kalpin (2008) Canada	RCT	This study aimed to evaluate the efficacy and long term effectiveness of intensive short term dynamic psychotherapy in the treatment of patients with DSM-IV personality disorders.	27 participants with personality disorders. 14 participants in group 1 and 13 participants in group 2. Mean age: 40 years 42% females in group 1 and 77% females in group 2.	Group 1: Intensive, short term dynamic psychotherapy Group 2: Minimal contact, delayed treatment control condition	The participants in group 1 improved significantly on all primary outcome measures compared to group 2. They reached the normal ranges on both brief symptom inventory and the inventory of interpersonal problems. In the two year follow up, group 1 had an 83.3% reduction of personality diagnosis diagnoses.	76% 10/10 fundamental criteria were met	<i>Strengths:</i> Long term 2 year follow up Treatment integrity checks  <i>Weaknesses:</i> Small sample

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
Gregory, Chlebowski, Kang, Remen, Soderberg, Stepkovitch & Virk (2008) North America	RCT	To describe the results of a 12 month controlled study assessing the feasibility, tolerability and efficacy of a manual-based psychodynamic psychotherapy for persons with co-occurring BPD and alcohol use disorder.	30 participants with 15 in group 1 and 15 in group 2.	Group 1: Dynamic Deconstructive Psychotherapy (including individual weekly sessions over 12 to 18 months and were encouraged to attend group therapy based on the 12 step drugs programme). Group 2: Treatment as usual (including a combination of individual psychotherapy, medication management, alcohol counselling, professional and self-help groups and/ or case management for 12 to 18 months).	The Dynamic Deconstructive Psychotherapy group showed statistically significant improvement in parasuicide behaviour, alcohol misuse, institutional care, depression, dissociation and core symptoms of BPD and treatment retention was 67% to 73%. TAU participants received higher treatment intensity, but only limited change in the same time period.	65% Low quality 8/10 fundamental criteria. Not used	<i>Strengths:</i> Use of minimisation randomisation-allowing for rolling allocation of participants into groups while ensuring comparability of groups on key factors. <i>Weaknesses:</i> Low power with very small sample (n=15 in each group) Researcher allegiance to the model No long term follow up post treatment
Chiesa, Fonagy & Gordon (2009) UK	Cohort	To present preliminary findings of 2 year prospective naturalistic outcome study monitoring psychiatric morbidity and clinical	106 participants with severe personality disorders. 38 in group 1 and 68 in group 2.	Group 1: Psychosocial therapeutic community (including twice weekly	The community based sample improved to a significantly greater degree on all three clinical outcome dimensions compared	78% 8/8 fundamental criteria were met	<i>Strengths:</i> Uses a range of assessment measures, including service utilisation

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
		outcome in patients with personality disorders.	Mean age: 33 years 72% of sample were female 59% had borderline personality, 47% avoidant personality and 41% dependent personality disorders	psychoanalytically orientated psychotherapy) over 2 year period Group 2: Community psychotherapy model based on the psychodynamic approach over 2 year period	to those who received the long term residential treatment, including reduction in self mutilation, suicide attempts and hospital admissions. The community sample also had significantly lower drop out rates than the residential treatment.		<i>Weaknesses:</i> No placebo control No follow up
Gregory, Remen, Soderberg & Ploutz-Snyder (2009) North America	Uncontrolled/ naturalistic	To describe the preliminary findings of an ongoing pilot thirty month controlled study that assesses a modified form of psychodynamic psychotherapy for persons co-occurring BPD and alcohol use disorders	30 participants with borderline personality disorder.	Not applicable	Dynamic deconstructive psychotherapy was associated with 31-55% relative risk reduction in parasuicidal behaviour, alcohol misuse and institutional care.	34% Low quality and 4/8 of fundamental criteria were fulfilled Not used	<i>Strengths:</i> Manualised approach  <i>Weaknesses:</i> No comparison group No follow up Small sample/ little statistical power Researcher bias Little information on recruitment, procedure and discussion points
Bateman & Fonagy (2009) UK	RCT	To test the effectiveness of an 18-month mentalisation-based treatment approach in an outpatient context against a structured	134 participants diagnosed with borderline personality disorder. 71 in group one and 63	Group 1: Mentalisation based treatment Group 2: Structured clinical management	Substantial improvements were observed in both conditions across all outcome variables. Patients randomly	83% All fundamental criteria fulfilled	<i>Strengths:</i> Measures of service utilisation  <i>Weaknesses:</i> Researcher bias

Authors/ Year/ Country of study	Study Type	Aims/ Hypotheses	Participants/ Sample Size	Comparison Group	Findings	Quality Assessment	Strengths and Weaknesses
		clinical management outpatient approach for treatment of borderline personality disorder.	in group two.		assigned to mentalisation based therapy showed a steeper decline of both self-reported and clinically significant problems, including suicide attempts and hospitalisation. However, both substantially reduced suicidality, self harm and hospitalisation and improved social and interpersonal functioning.		No follow up
Vinnars, Thormahlen, Noren, Gallop & Barber (2009) Sweden	RCT	To explore the extent in which psychodynamic supportive-expressive psychotherapy can improve maladaptive personality functioning in patients with any personality disorder from DSM-IV. They also hypothesised that supportive-expressive psychotherapy will lead to greater improvement in the quality of object relations and ego functions and greater reduction of	156 participants with personality disorder diagnoses. Group 1 includes 78 participants and group 2 includes 74 participants. Mean age: 35 years 31% male and 69% female	Group 1: Manualised supportive-expressive psychotherapy of 25 sessions Group 2: Non-manualised psychodynamic therapy	Both treatments were equally as effective, in terms of object relations, ego functions and psychological mindedness. This was maintained upon follow up. Only participants rating highly on neuroticism improved more with the non-manualised group improve more than the manualised group.	81% 9/10 of the fundamental criteria fulfilled	<i>Strengths:</i> Use of 1 year follow up  <i>Weaknesses:</i> No consistent frequency of sessions Unclear randomisation

Authors/ Year/ Country of study	Study Type	Aims/ Hypotheses	Participants/ Sample Size	Comparison Group	Findings	Quality Assessment	Strengths and Weaknesses
		interpersonal problems, neuroticism, agreeableness and impulsiveness when compared with the non-manualised group.					
McMain, Links, Gnam, Guimond, Cardish, Korman & Streiner (2009) Canada	RCT	To compare DBT and a general psychiatric management (APA practice guidelines), which includes a combination of psychodynamically informed therapy and symptom-targeted medication management. They hypothesised that DBT participants would show greater reductions in frequency and severity of suicidal and non-suicidal self-injurious behaviour.	90 participants with BPD in group 1 and 90 participants with BPD in group 2 Mean age: 30 years 90% women in group 1 and 82% women in group 2	Group 1: Dialectical Behaviour Therapy, Group 2: General Psychiatric Management	Both groups showed improvements on the majority of clinical outcome measures after 1 year of treatment, including significant reductions in the frequency and severity of suicidal and non-suicidal self-injurious episodes. Both groups had a reduction in general health care utilisation, including emergency visits and psychiatric hospital days as well as improvements in BPD symptoms, symptom distress, depression, anger and interpersonal functioning.	87.5% 10/10 of the fundamental criteria fulfilled	<i>Strengths</i> Use of intention to treat analysis Single blind RCT Range of measures Treatment integrity checks  <i>Weaknesses</i> Interventions not rigidly controlled No follow up but in progress
Vermote, Fonagy Vertommen, Verhaest,	Naturalistic/ Uncontrolled	This study aimed to identify different outcome trajectories in a psychoanalytic hospitalisation-based	70 participants with personality disorders	Not applicable	Trajectory analysis identified four groups of patients, including a high initial symptom levels and considerable	68% Low quality and 5/8 of the fundamental criteria were	<i>Strengths:</i> 12 month follow up <i>Weaknesses:</i> No control group Range in length of

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
Stroobants, Vandeneede, Corveleyn, Lowyck, Luyten & Peuskens (2009) Belgium		treatment in a sample of patients with personality disorder using a naturalistic 12 month follow up design.			and consistent improvement late in treatment (High-Low group), medium initial symptom levels and a quick and sustained response (Medium-Low group), medium initial symptom levels but without substantial improvement (Medium-Medium group) and low initial symptom levels without substantial further improvement during and after treatment (Low-Low group). Data suggested that these four trajectories were related to pre-treatment variables. More introjective personality characteristics benefited from this insight orientated treatment.	fulfilled. Not used	exposure/ stay in hospital- ranged from 1.5 to 13 months

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
Leichsenring, Masuhr, Jaeger, Dally & Streek (2010) Germany	Naturalistic/ uncontrolled	To carry out an effectiveness study evaluating the results of psychoanalytic interactional psychotherapy in patients with borderline personality disorder	132 participants diagnosed with borderline personality disorder	Not applicable	Psychoanalytic interactional psychotherapy achieved significant improvements in target symptoms, general symptoms, interpersonal problems and contentedness with life.	46% Low quality and 3/8 of the fundamental criteria were fulfilled. Not used	<i>Strengths:</i> Range of assessment measures  <i>Weaknesses:</i> No control group No statistical analysis used No follow up period
Doering, Horz, Rentrop, Fischer-Kern, Schuster, Benecke, Bucheim, Martius & Bucheim (2010) Austria and Germany	RCT	To compare transference-focused psychotherapy with treatment by experienced community psychotherapists.	104 female participants diagnosed with borderline personality disorder. Group 1 includes 52 participants and group 2 includes 52 participants. Unknown age and sex	Group 1: 1 year of Transference Focused Psychotherapy Group 2: 1 year of psychotherapy with a experienced community psychotherapist	Fewer participants dropped out of transference focused therapy compared to community psychotherapy group. Transference focused psychotherapy was significantly superior in the domains of borderline symptomatology, psychosocial functioning, personality organisation and psychiatric inpatient admissions. Both groups improved significantly in the domains of depression and anxiety without	81% 10/10 of the fundamental criteria fulfilled	<i>Strengths:</i> Range of assessment measures including measures of service utilisation Treatment integrity checks  <i>Weaknesses:</i> No follow up period

Authors/ Year/ Country of study	Study Type	Aims/ Hypotheses	Participants/ Sample Size	Comparison Group	Findings	Quality Assessment	Strengths and Weaknesses
					significant group differences. Self harming behaviour did not change in either group.		
Gregory, DeLucia-Deranja & Mofle (2010) North America	RCT	This study addresses whether patients who receive dynamic deconstructive psychotherapy are likely to relapse to baseline levels of psychopathology and substance use after termination or whether improvement is sustained	24 participants with borderline personality disorder. Group 1 had 11 participants and group 2 has 23 participants. Unknown sex or age	Group 1: Dynamic deconstructive psychotherapy Group 2: Optimised community care	Dynamic deconstructive psychotherapy had a large, sustained treatment effect with improvements in borderline personality disorder symptoms, depression, parasuicide and recreational drug use compared to community care condition.	78% 10/10 of the fundamental criteria were fulfilled	<i>Strengths:</i> 30 month follow up period  <i>Weaknesses:</i> Small sample Researcher bias Unclear number in each condition Unclear randomisation
Vermote, Lowyck, Luyten, Vertommen, Corveleyn, Verhaest, Stroobants, Vandeneede, Vansteelandt & Peuskens (2010) Belgium	Naturalistic/ uncontrolled	To investigate the association between changes in process variables and changes in outcome variables measured both by symptoms and personality functioning of 4 patients with personality disorder who completed hospitalisation based treatment. The authors expected changes on three dimensions central to psychodynamic	44 participants with personality disorder. Unknown age 70% females and 30% males	Not applicable	Results showed improvements in symptoms, personality functioning, self and object relationships and felt safety, but not reflective functioning after treatment.	85% 8/8 of the fundamental criteria fulfilled	<i>Strengths</i> Assessed every 3 months during treatment and a 3 and 12 month follow up period post treatment Use of psychodynamic measures  <i>Weaknesses</i> No control group

<b>Authors/ Year/ Country of study</b>	<b>Study Type</b>	<b>Aims/ Hypotheses</b>	<b>Participants/ Sample Size</b>	<b>Comparison Group</b>	<b>Findings</b>	<b>Quality Assessment</b>	<b>Strengths and Weaknesses</b>
		understanding of personality disorder, including levels of self and object representation, felt safety and reflective functioning, would be associated with changes in outcome.					
Kallestad, Valen, McCullough, Svartberg, Hoglend & Stiles (2010) Norway	RCT	The authors hypothesised that patients in both short term dynamic psychotherapy and cognitive therapy would develop insight during therapy. Gain of insight during therapy will predict the long term treatment outcome on symptom severity and interpersonal problems during a 2 year follow up period	49 participants with Cluster C personality disorder. Unknown age or sex	Group 1: 40 weekly sessions of short term dynamic psychotherapy using McCullough's affect phobia model Group 2: 40 weekly sessions of cognitive therapy	Group 1 gained insight, which was associated with improved levels of symptom severity and interpersonal functioning. Group 2 did gain insight, but this was not associated with long term outcome.	78% 9/10 of the fundamental criteria were fulfilled	<i>Strengths</i> 2 year follow up period  <i>Weaknesses</i> Unclear number in each condition

## Appendix G: Data extraction form

### General Information

**Date of data extraction**

**Author**

**Identification of the reviewer**

**Notes**

#### Re-verification of study eligibility

Population:	Clients and therapists who have engaged in individual psychodynamic psychotherapy	Y	N	?
	Client with a diagnosis of personality disorder	Y	N	?
	Clients aged 18 and above	Y	N	?
	Study from 2005 onwards	Y	N	?
Exposure:	Psychodynamic psychotherapy	Y	N	?
	Mentalisation based psychotherapy	Y	N	?
	Transference focused psychotherapy	Y	N	?
	Psychoanalysis	Y	N	?
	Dynamic therapy	Y	N	?
Comparator:	Non-psychodynamic psychotherapy	Y	N	?
	No therapy/ waiting list controls	Y	N	?
	Medication	Y	N	?
Outcome:	Effectiveness and efficacy outcomes	Y	N	?
	Quality of life	Y	N	?
	Social functioning	Y	N	?
	Symptomology	Y	N	?

**Study Design**            RCT        Cohort        Case Control        Cross-sectional

**Continue?**                    Yes                    No

**Specific Information**

**Population Characteristics**

1. Target population (describe)
2. Inclusion Criteria
3. Exclusion Criteria
4. Recruitment procedures used
5. Characteristics of participants:

Individuals with  
personality disorder

Comparator

No of participants enrolled:  
No of participants completed:  
Age:  
Ethnicity:  
Gender:  
Type of personality disorder:  
Other information:

**Exposure**

**Additional Notes**

1. Type of treatment
  - a) Long term psychodynamic therapy
  - b) Short term psychodynamic therapy
  - c) Mentalisation based therapy
  - d) Tranference focused therapy
  - e) Psychoanalysis
  - f) Other
2. What was the length of treatment? \_\_\_\_\_
3. What was the treatment intensity? \_\_\_\_\_
4. Medication used \_\_\_\_\_

## Comparator

## Additional Notes

1. Type of treatment
  - a) Treatment as usual
  - b) Non-psychodynamic therapy
  - c) Psychodynamic therapy
  - d) Another comparator
2. What was the length of treatment? \_\_\_\_\_
3. What was the treatment intensity? \_\_\_\_\_
4. Medication used \_\_\_\_\_

## Outcome

- 1) What was measured at baseline?
  - a)
  - b)
  - c)
- 2) What was measured after the exposure (or at the follow up?)
  - a)
  - b)
  - c)
- 3) Type of outcome measurement?
- 4) Who carried out the measurement? Was the assessor blinded?
- 5) How was the outcome measured?
- 6) If a tool was used, was it validated? If so, how?
- 7) How was the validity of self reported behaviour maximised?
- 8) What were the follow up intervals? (where applicable)
- 9) Drop out rates (plus proportion of those who did not agree to participate if stated) and reason for drop out
- 10) Limitations
- 11) Notes

## **Analysis**

- 1) Stats techniques used
- 2) Were confounding variables assessed?
- 3) Attrition rate (overall rates)
- 4) Was attrition (missing data) adequately dealt with?
- 5) Number (or %) followed up from each condition
  - a) Condition A
  - b) Condition B
  
- 6) Overall study quality      good      reasonable      poor
- 7) Number of 'unclear' or unanswered assessment items
- 8) Number of fundamental criteria met
- 9) Notes

**Appendix H: Table of included studies**

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
Vinnars, Barber, Noren, Gallop & Weinryb (2005)	RCT	Stratified randomisation-including 4 stratification variables: DSM-IV cluster, age, sex and marital status	Outpatient	40 individual sessions over a year	Manualised supportive expressive psychotherapy Non-manualised community-delivered psychodynamic therapy	Presence of at least one DSM-IV personality disorder diagnoses or a diagnosis	Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II) Symptom Checklist- 90 (SCL-90) Global Assessment of Functioning (GAF)	Mixed model ANOVA Mann Whitney U Chi square	12 participants in supportive expressive group and 16 participants in community group attended no more than 2 sessions after being randomised	78%
Emmelkamp, Benner, Kuipers, Feiertag, Koster & van Apeldoorn (2006)	RCT	Randomisation	Outpatient	20 weekly individual sessions over 6 months	Brief dynamic therapy	Avoidant personality disorder. High risk of suicide excluded.	SCID-II Personality Disorder Belief Questionnaire (PDBQ) Social Phobia Anxiety Inventory Avoidance Scale. Lehrer Woolfolk Anxiety Symptoms	T-tests Analyses of covariance (ANCOVA)	Intention to treat analysis: 5 participants in CBT, 3 participants in dynamic therapy and 6 participants in waiting list control	78%

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
Giesen-Bloo, van Dyck, Spinhoven, van Tilburg, Dirksen, van Asselt, Kremers, Nadort & Arntz (2006)	RCT	Randomisation	Outpatient	Twice weekly individual sessions for 3 years for both TFP and SFT	Transference Focused Therapy	Borderline personality disorder, BPDSI-IV score greater than 20	SCL-90, BPD Severity Index (BPDSI-IV), Rosenberg Self Esteem Questionnaire, Young Schema Questionnaire (YSQ), Inventory of Personality Organisation (IPO), World Health Organisation Quality of Life (WHOQOL), Defence Style Questionnaire (DSQ), Miskimins Self-Goal Discrepancy Scale	ANCOVA	Intention to treat analysis: 12 participants from schema focused group and 22 participants from transference focused group	84%
Levy, Meehan, Kelly, Reynoso, Weber, Clarkin & Kernberg	RCT	Randomisation	Outpatient	TFP includes individual sessions twice a week for	Transference focused therapy (TFP) and modified supportive psychodynamic	Borderline personality disorder	Adult Attachment Interview (AII), SCID-II, International	Chi-square	Intention to treat analysis: 1 participant from TFP and 1	84%

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
(2006)				one year. DBT includes weekly individual and group sessions for a year. SPT includes weekly individual sessions for a year.	therapy (SPT). SPT is a manualised psychoanalytically orientated treatment, but was conceptualised as a control condition.		Personality Disorder Examination (IPDE)		participant from DBT	
Clarkin, Levy, Lenzenweger & Kernberg (2007)	RCT	Randomisation	Outpatient	TFP includes two weekly individual sessions for a year. DBT included weekly individual and group sessions for a year. Supportive treatment included weekly individual	Transference focused therapy	Borderline personality disorder based on DSM-IV criteria	IPDE, SCID-II Overt Aggression Scale-Modified Anger, Irritability and Assault Questionnaire, Barratt Impulsiveness Scale-II, Brief Symptom Inventory (BSI) Beck Depression Inventory (BDI)	Individual growth curve analyses- unconditional growth model	Intention to treat analysis 8 participants dropped out of therapy	84%

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
				sessions for a year.			GAF Social Adjustment Scale (SAS)			
Jorgensen & Kjolbye (2007)	Uncontrolled	Opportunity/ convenience	Outpatient	Weekly individual sessions for 1 year and weekly group sessions for 22 months.	Psychoanalytically orientated psychotherapy based on Object Relations theory and core elements from attachment and mentalisation-based therapy	Borderline personality disorder according to the DSM-IV criteria	SCL-90 Beck Anxiety Inventory (BAI) BDI Inventory of Interpersonal Problems (IIP) Defence Style Questionnaire (DSQ)	Linear regression analysis	15 participants had premature ended therapy	71%
Vinnars, Barber, Noren, Thormahlen, Gallo, Lindgren & Weinryb (2007)	RCT	Stratified randomisation-including 4 stratification variables: DSM-IV cluster, age, sex and marital status	Outpatient	40 weekly individual sessions	Supportive-expressive psychotherapy based on Luborsky's (1984) psychodynamic model and community delivered psychodynamic treatment	DSM-IV personality disorder diagnosis or a depressive or passive-aggressive personality diagnosis from DSM-IV appendix	SCL-90 Karolinska Psychodynamic Profile IIP Psychological Mindfulness Karolinska Scale of Personality	Mixed effects model-random regression model	Not discussed	76%
Bateman & Fonagy (2008)	RCT	Randomisation	Partial hospitalisation	Group and individual sessions twice a week for 36	Mentalisation based therapy	Borderline personality disorder	Zanarini Rating Scale from DSM-IV BPD GAF Emergency	Mann Whitney tests Multivariate analysis of variance	Not reported	81%

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
				months			room visits Hospitalisation Psychiatric outpatients, Community support, Psychotherapy, Medication, Suicidality, Self harm	(MANOVA)		
Gude & Hoffart (2008)	Cohort	Purposive	Inpatient	SFT includes 1 individual and 3 group sessions weekly for 11 weeks. Dynamic treatment includes 1/2 individual and 1 group sessions weekly for 12 weeks.	Non-manualised psychodynamic treatment called 'treatment as usual'	A diagnosis of panic disorder with agrophobia and at least one cluster C personality disorders diagnosis	SCID-II IIP SCL-90 Mobility Inventory for Agrophobia	Repeated measures ANOVA	Not reported	76%
Abbass, Sheldon, Gyra & Kalpin (2008)	RCT	Randomisation	Outpatient	27 weekly individual sessions	Intensive short term dynamic psychotherapy (ISTDP) based on Davanloo's (1990)	A DSM-IV personality disorder. Excluded any participants	SCID-II BSI GAF IIP	Multiple regression T-test Chi-square	1 participant in the ISTDP group	76%

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
					model	with active suicidal or violent behaviour				
Bateman & Fonagy (2009)	RCT	Randomisation using a stochastic minimisation program	Outpatient	MBT includes 18 months of weekly combined individual and group sessions. SCM includes regular individual and group sessions.	Mentalisation based therapy	Borderline personality disorder as assessed by SCID-II for DSM-IV and a suicide attempt or episode of life threatening self harm within the last 6 months	GAF BDI IIP Modified SAS, Suicide attempt Life threatening self harm Hospital admission	Chi square Kruskal-Wallis statistic T-test Mixed effects logistic regression	Intention to treat analysis 19 participants from MBT and 16 from structured clinical management dropped out	83%
Chiesa, Fonagy & Gordon (2009)	Cohort	Convenience	Therapeutic/ residential community v community outpatient setting	Therapeutic / residential group includes 2 weekly individual sessions and 1 weekly group session for 7.2 months. Community	Therapeutic community includes individual and group psychodynamic based therapy	A DSM-IV personality disorder	BSI, Cassell Community Adjustment Questionnaire, Self mutilation, Suicide attempts and Hospital admissions	Mantel-Cox test Cochran's Q Odds ratio analysis Friedman test	27.5% of residential/ therapeutic community sample and 8.8% of the outpatient/ community sample dropped out	78%

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
				outpatient group includes 2 weekly group sessions for 18.3 months.						
Vinnars, Thormahlen, Noren, Gallop & Barber (2009)	RCT	Randomisation	Outpatient	25-28 individual sessions on average over 1 year	Manualised supportive expressive psychotherapy based on Luborsky's psychodynamic treatment manual. Community-delivered psychodynamic group based on non-manualised psychoanalytically orientated therapy	At least one DSM-IV personality disorder diagnosis or a depressive or passive-aggressive personality diagnosis from DSM-IV appendix. Exclude participants with severe suicidal intent	Karolinska Psychodynamic Profile Psychological mindfulness IIP Karolinska Scale of Personality	ANCOVA	Had access to 89 of the 156 participants at follow up. Unclear drop outs from treatment.	81%
Gregory, DeLucia-Deranja & Mogle (2010)	RCT	Randomisation using minimisation method of rolling assignment based on	Outpatient	12- 18 months of weekly individual sessions	Dynamic deconstructive psychotherapy (DCP)- manual based treatment for co-occurring BPD and substance use	Borderline personality disorder based on DSM-IV	SCID-II Lifetime Parasuicide Count, Social Provisions Scale	ANOVA Logistic regression	Used modified intention to treat analysis, in which they included	78%

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
		matched group metrics			and anti-social personality disorder		Addictions Severity Index, Borderline evaluation of severity over time (BEST)		participants who had a minimum 'dose' of treatment of at least 6 months. 3 participants from DCP and 5 participants from the control group dropped out	
McMain, Links, Gnam, Guimond, Cardisj, Korman & Streiner (2009)	RCT	Pre-generated block randomisation scheme developed and held by statistician who prepared sealed envelopes each containing group allocation in random order.	Outpatient	DBT was 1 hour of weekly individuals sessions and 2 hour of weekly group sessions for 1 year. GPM was 1 hour of individual dynamic therapy weekly for	Psychodynamic approach drawn from Gunderson (2001) emphasised the relational aspects and early attachment relationships.	DSM-IV criteria for BPD and have at least 2 episodes of suicidal or non-suicidal self-injurious behaviour in the past 5 years (1 of which was 3 months before enrolling)	Zanarini Rating Scale for BPD, SCL-90, STAXI, BDI, IIP, EQ-ED thermometer measuring health-related quality of life, Treatment History Interview, Reasons for Early	Generalised estimating equation and mixed effects linear growth curve models	35 participants in DBT group and 34 participants in GPM group dropped out of treatment	87.5%

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
				1 year			Termination From Treatment Questionnaire.			
Vermote, Lowyck, Luyten, Verommen, Corveleyn, Verhaest, Stroobants, Vandeneede, Vansteelandt & Peuskens (2010)	Uncontrolled	Opportunity/ convenience	Inpatient	Dynamic treatment includes weekly individual sessions and group therapy three times a week for 12 months	Psychodynamic hospitalisation based treatment program, which combines open-ended residential and day-hospital treatment for patients with personality disorder. This includes both group and individual work	Primary diagnosis of personality disorder based on DSM-III-R	SCL-90 Spielberger State-Trait Anxiety Inventory (STAI) State-Trait Anger Inventory (STAXI) BDI Object Relations Inventory (ORI) Differentiation Relatedness Scale Felt Safety Scale Reflective Functioning Scale	Multi-level growth curving model Chi square	Not reported	85%
Doering, Horz, Rentrop, Fischer-Kern, Schuster,	RCT	Randomisation	Outpatient	TFP includes individual sessions	Transference focused therapy	Borderline personality disorder based on	Suicide attempts Cornell Interview for	Chi square McNemar test Mann	Intention to treat analysis. 13 participants	81%

<b>Authors/Years</b>	<b>Study Type</b>	<b>Sample Methods</b>	<b>Inpatient or outpatient setting</b>	<b>Therapy duration</b>	<b>Definition of psychodynamic therapy</b>	<b>Definition of personality disorder</b>	<b>Assessment/ outcome measure</b>	<b>Statistical Analysis</b>	<b>Attrition Rate</b>	<b>Quality Score %</b>
Benecke, Bucheim, Martius & Bucheim (2010)				twice a week for 1 year. Community therapists includes sessions for 1 year and were free to choose frequency		DSM-IV	Suicidal and Self Harming behaviour SCID-II GAF BDI STAI BSI Self harming behaviours Psychiatric inpatient admissions Cornell Revised Treatment History Inventory (CRTHI) Structured Interview of Personality Organisation (STIPO)	Whitney T-test ANCOVA	dropped out of the transference focused group and 22 participants dropped out of the community control group	
Kallestad, Valen, McCullough, Svartberg, Hoglend & Stiles (2010)	RCT	Randomisation	Outpatients	Both therapies 40 individual sessions weekly.	McCullough's Short Term Dynamic Psychotherapy (STDP) model based on Malan's triangle of conflict	Cluster C personality disorder based on DSM-IV criteria	SCL-90 IIP Achievement of Therapeutic Objectives Scale (ATOS) for insight.	T-test ANCOVA	No participants dropped out of either condition during therapy.	78%

**Appendix I: Extract from coded transcript (Ashley)**

Initial coding	Transcript	Emergent Themes
<p>Almost stopped-missed session</p> <p>Worse than better</p> <p>Put in a cupboard-shut the door</p> <p>Cupboard was full</p> <p>Smothered me</p> <p>Therapy- getting everything out of the cupboard</p> <p>I was a mess- after therapy</p> <p>Improved as I got used to it</p> <p>Banging my head against a brick wall</p> <p>Making myself really upset</p> <p>Wanted something more immediate Difficult to keep going- more depressed</p> <p>It's a process</p>	<p>Yeah, there was period at about [pause] a year in maybe were I kinda almost stopped going. I missed a few sessions and it was largely because, it sounds ridiculous but if anything it was making me feel worse rather than better because I have got this wonderful habit of if something happens, I don't deal with it and I put it in a cupboard and shut the door and try and forget about it, erm. Unfortunately, it got to the point that the cupboard was full and anytime I tried to put anything into it, it came down and it smothered me. Erm, and part of therapy was getting everything out of the cupboard, and that meant that, I mean I had therapy on a Thursday afternoon and Thursday night I wouldn't sleep properly and Friday I was a mess and just you know work was, I mean there were days I would just go into the toilets and cry. I...I wasn't very good on Friday, erm, I mean it was something that kinda improved as I got used to it but, it was, I mean, I felt a bit like I was banging my head against a brick wall, because it was kinda like, yeah ok I am doing this and making myself really upset and it doesn't seem to be getting anywhere. I kinda wanted something a bit more immediate and I found it quite difficult to keep going despite the fact, you know, I really wasn't feeling that great and it was sort of like what is the point of doing this when it's actually making me feel more depressed. But it is one of those things, it is a process I think....</p>	<p>Cupboard as coping-shut door on feelings and forget- barrier to feelings Emotions as dangerous- need to hide away</p> <p>Smothering-dangerous/ suffocating</p> <p>Therapy as hard work-got better</p> <p>Painful- banging head against brick wall</p> <p>Frustration/ - taking a long time- no answers</p> <p>Process- takes time, gradual process</p>

## **Appendix J: Participation information sheets**

### **Client Participant Information Sheet**

#### **1. Study Title**

What are the accounts of therapists and clients with difficulties, strains and repairs in their relationship during long-term therapy?

#### **2. Invitation Paragraph**

My name is Donna Haskayne and I am Trainee Clinical Psychologist. I am currently completing a research project on both client and therapist accounts of their relationship during therapy. You are being invited to take part in this research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask the researcher if there is anything that is not clear or if you want more information.

- Part 1 tells you the purpose of this study and what will happen to you if you take part
- Part 2 gives you more detailed information about the conduct of the study

#### **Part 1: Information about the study**

#### **3. What is the purpose of the study?**

The purpose of the study is to understand more about client and therapist accounts of their relationship when involved in long term therapy. Therefore both clients and therapists are being asked to participate in an interview discussing their experiences of therapy, including their relationship, any difficulties in their relationship and how this was resolved.

#### **4. Why have I been chosen?**

You have been selected after expressing interest about engaging in research related to your therapy at the Psychotherapy Service. You will have also been selected as you were involved in long term therapy at the Psychotherapy Service and are now discharged from the service. Both you and your therapist will be asked to be interviewed separately to understand the different perspectives of your relationship in therapy, including difficulties and how these were resolved.

#### **5. Do I have to take part?**

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign two consent forms. The consent forms will be sent to you, please sign both consent forms and return to the researcher in the pre-paid self addressed envelope. If we do not hear from you two weeks after sending this information sheet and consent form, we plan to telephone you to find out your decision about participating in this study. If you decide to take part, you are still free to withdraw up to 48 hours after completing the interview without giving a reason.

#### **6. What will happen to me if I take part?**

You will be asked to sign two consent forms (a copy for you and a copy for the researcher). A one hour semi-structured interview will take place with the researcher asking questions about your relationship with your therapist during therapy. These interviews will take place at the University of Birmingham in Edgbaston, Birmingham. The researcher will finish the interview with some debriefing questions about your well-being and contact numbers to use if you feel you need to talk further on the issues raised during the interview. 48 hours after the interview, the researcher will contact you to check you still want your interview to be used in the research.

**7. What do I have to do?**

You will be asked to return two signed consent forms to the researcher in the pre-paid self addressed envelope. Following this, the researcher will call you to invite you to attend an interview for approximately one hour with the researcher. The interview will be digitally audio recorded by the researcher. If you do consent to take part, your doctor will be informed of your participation in this study, but will not be told any details about the interview itself.

**8. What are the possible disadvantages and risks of taking part?**

Sometimes people may find some questions difficult within the interview or too personal to answer. If you feel like this you do not have to answer those questions. In the event of any distress, the audio recorder will be switched off. If distress is caused, you have the option to talk to a therapist (not your previous therapist) at the Psychotherapy Service and encouraged to speak to your doctor.

The researchers will reimburse any travel expenses, child-care arrangements and loss of earnings that have been incurred as a consequence of participating in the research interview. This will be calculated and arranged after the interview.

**9. What are the benefits of taking part?**

There are no direct benefits. However, this study will hopefully help to understand more about difficulties and repairs within therapeutic situations from both a client and therapist perspective.

**10. What happens when the research stops?**

After your part in the research, your information will be entered into a computer database (accessible only by the researcher or supervisors at the University of Birmingham) and your information will be assigned a different name. Any information with your name on it will be kept in a locked cabinet with limited access to members of the research team and supervisors. The list matching your name to your changed name will also be kept in a locked cabinet. The digital audio recording of the interview will be destroyed as soon as it is typed up and transcribed. The transcriptions do not include any information such as your name, address, date of birth, contact information, etc, that could identify you- only a code to link them to you. The transcriptions will be destroyed after 10 years.

**11. What if something goes wrong?**

It is not anticipated that anything will go wrong, but you are free to withdraw up to 48 hours after completing the interview if you feel something has gone wrong. Any complaint about the way you have been dealt with during this study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2 of the information sheet.

**12. Will my taking part in this study be kept confidential?**

All information collected about you during the course of the research will be kept strictly confidential. The details are included in Part 2.

**13. Contact for further information?**

Please contact the primary researcher  
Ms. Donna Haskayne  
Trainee Clinical Psychologist  
School of Psychology  
The University of Birmingham  
Edgbaston, Birmingham  
B15 2TT

**This completes Part 1 of the Information Sheet. If the information in Part 1 has interested you and you are considering participation, please continue to read additional information in Part 2 before making a decision.**

## **Part 2: Additional information**

### **14. What if relevant new information becomes available?**

As the research is based on your experiences of therapy, it is highly unlikely that new information will become available. If the study is stopped for any other reason, you will be told why and your information will be destroyed.

### **15. What will happen if I don't want to carry on with the study?**

After the interviews, you will have 48 hours to decide if you wish to continue to use your information in the study. If you decide that you want to withdraw your data, all your information provided to the researcher will be destroyed. If you decide you want to continue, you will not be able to withdraw after this point and your information will be used in the study.

### **16. What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak with the researcher who will do their best to answer your questions (please telephone 0121 414 3665). You can also contact the Patient Advocacy and Liaison Service (PALS) on 0800 953 0045 or email [PALS@bsmhft.nhs.uk](mailto:PALS@bsmhft.nhs.uk). If you remain unhappy and wish to complain formally, you can contact the Independent Complaints Advocacy Service (ICAS) for NHS complaints (please telephone 0845 120 3748)

In the event that something does go wrong and you feel distressed or harmed during the research study, there are no special compensation arrangements. If you are distressed and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Birmingham (the researcher's sponsoring organisation), but you may have to pay legal costs. The normal NHS complaints mechanisms will still be available to you (if appropriate).

### **17. Will my taking part in this study be kept confidential?**

Yes, this means your data and interview information is entered into a word document, you will be assigned a different name and your name will not appear in the database. Your changed name will be used to identify you from that point forward. The list that connects your name to your changed name will be kept in a locked cabinet or a password-protected word document accessed only by the researchers and a supervisor at the University of Birmingham. Non-identifying information about your age, gender, ethnicity and presenting difficulties will also be recorded. The digital audio recording of the interview will be destroyed as soon as it is typed up and transcribed. The transcriptions do not include any information such as your name, address, date of birth, contact information, etc, that could identify you- only a code to link them to you. The transcriptions will be destroyed after 10 years.

### **18. Will I receive a copy of my transcript of the interview and give permission to what is quoted from the interview?**

It is also important to note that some of the interview may be quoted within the research. Therefore, you will be sent a transcript of your interview a number of weeks after the interview. You will have an opportunity to read the transcript and highlight any part of the interview you do not want to be quoted in the main report. If you participate in the project and read the results of our work, you will obviously be able to identify your quotes from your interview. It may also be possible that you identify a very small number of quotes from your therapist too. We will present the information in such a way that the risk is minimised, and when we do use quotes, we will be careful not to use quotes that may cause distress or seriously breach confidentiality.

**19. What will happen to the results of the research study?**

The results of this study will be part of a thesis for the Doctorate in Clinical Psychology. These results also may be published in an academic paper. No identifiable information will be used in this report. Quotes will only be used with your permission. It is possible that this study could be published in an academic journal.

**20. Who is organising and funding the research?**

The University of Birmingham is organising and sponsoring this research.

**21. Who has reviewed the study?**

This study was given favourable ethical opinion for conduct in the NHS by a local Research Ethics Committee.

You may keep this information sheet and will be given a copy of the signed consent form should you choose to participate. If you would like to contact me to ask any further questions before signing the consent form, please contact me on the above number or email address. Thank you for taking the time to read this information sheet.

## **Therapist Participant Information Sheet**

### **1. Study Title**

What are the accounts of therapists and clients with difficulties, strains and repairs in their relationship during long-term therapy?

### **2. Invitation Paragraph**

My name is Donna Haskayne and I am Trainee Clinical Psychologist. I am currently completing a research project on both client and therapist accounts of their relationship during therapy. You are being invited to take part in this research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask the researcher if there is anything that is not clear or if you want more information.

- Part 1 tells you the purpose of this study and what will happen to you if you take part
- Part 2 gives you more detailed information about the conduct of the study

### **Part 1: Information about the study**

#### **3. What is the purpose of the study?**

The purpose of the study is to understand more about client and therapist accounts of their relationship when involved in long term therapy. Therefore both clients and therapists are being asked to participate in an interview discussing their experiences of therapy, including their relationship, any difficulties in their relationship and how this was resolved.

#### **4. Why have I been chosen?**

You have been invited to take part in this research, as you have worked as a therapist at the Psychotherapy Service for over one year. Both you and one of your clients will be asked to be interviewed separately to understand the different perspectives of your relationship in therapy, including difficulties and how these were resolved.

#### **5. Do I have to take part?**

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign two consent forms. If you decide to take part you are still free to withdraw up to 48 hours after completing the interview without giving a reason.

#### **6. What will happen to me if I take part?**

You will be asked to sign two consent forms (a copy for you and a copy for the researcher). A one hour semi-structured interview will take place with the researcher asking questions about your relationship with your client during therapy. These interviews will take place at the University of Birmingham in Edgbaston, Birmingham. The researcher will finish the interview with some debriefing questions and contact numbers to use if you feel you need to talk further on the issues raised during the interview. 48 hours after the interview, the researcher will contact you to check you still want your interview to be used in the research.

#### **7. What do I have to do?**

You be asked to return the signed consent forms to the researcher. Following this, the researcher will call you to invite you to attend an interview for approximately one hour with the researcher. The interview will be digitally audio recorded by the researcher.

**8. What are the possible disadvantages and risks of taking part?**

Sometimes people may find some questions difficult within the interview or too personal to answer. If you feel like this you do not have to answer those questions. In the event of any distress, the audio recorder will be switched off. If distress is caused, you are encouraged to speak to your supervisor and given further contact details of NHS counselling services.

The researchers will reimburse any travel expenses, child-care arrangements and loss of earnings that have been incurred as a consequence of participating in the research interview. This will be calculated and arranged after the interview.

**9. What are the benefits of taking part?**

There are no direct benefits. However, this study will hopefully help to understand more about difficulties and repairs within therapeutic situations from both a client and therapist perspective.

**10. What happens when the research stops?**

After your part in the research, your information will be entered into a computer database (accessible only by the researcher or supervisors at the University of Birmingham) and your information will be assigned a different name. Any information with your name on it will be kept in a locked cabinet with limited access to members of the research team and supervisors. The list matching your name to your changed name will also be kept in a locked cabinet. The digital audio recording of the interview will be destroyed as soon as it is typed up and transcribed. The transcriptions do not include any information such as your name, address, date of birth, contact information, etc, that could identify you- only a code to link them to you. The transcriptions will be destroyed after 10 years.

**11. What if something goes wrong?**

It is not anticipated that anything will go wrong, but you are free to withdraw up to 48 hours after completing the interview if you feel something has gone wrong. Any complaint about the way you have been dealt with during this study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2 of the information sheet.

**12. Will my taking part in this study be kept confidential?**

All information collected about you during the course of the research will be kept strictly confidential. The details are included in Part 2.

**13. Contact for further information?**

Please contact the primary researcher

Ms. Donna Haskayne  
Trainee Clinical Psychologist  
School of Psychology  
The University of Birmingham  
Edgbaston, Birmingham  
B15 2TT

**This completes Part 1 of the Information Sheet. If the information in Part 1 has interested you and you are considering participation, please continue to read additional information in Part 2 before making a decision.**

## **Part 2: Additional information**

### **14. What if relevant new information becomes available?**

As the research is based on your experiences, it is highly unlikely that new information will become available. If the study is stopped for any other reason, you will be told why and your information will be destroyed.

### **15. What will happen if I don't want to carry on with the study?**

After the interviews, you will have two weeks to decide if you wish to continue to use your information in the study. If you decide that you want to withdraw your data, all your information provided to the researcher will be destroyed. If you decide you want to continue, you will not be able to withdraw after this point and your information will be used in the study.

### **16. What is there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak with the researcher who will do their best to answer your questions (please telephone 0121 414 3665). If you remain unhappy and wish to complain formally, you can contact the Independent Complaints Advocacy Service (ICAS) for NHS complaints (please telephone 0845 120 3748). In the event that something does go wrong and you feel distressed or harmed during the research study, there are no special compensation arrangements. If you are distressed and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Birmingham (the researcher's sponsoring organisation), but you may have to pay legal costs.

### **17. Will my taking part in this study be kept confidential?**

Yes, this means your data is entered into a word document, you will be assigned a different name and your name will not appear in the database. Your changed name will be used to identify you from that point forward. The list that connects your name to your changed name will be kept in a locked cabinet or a password-protected word document accessed only by the researchers and a supervisor at the University of Birmingham. Non-identifying information about your age, gender, ethnicity and presenting difficulties will also be recorded. The digital audio recording of the interview will be destroyed as soon as it is typed up and transcribed. The transcriptions do not include any information such as your name, address, date of birth, contact information, etc, that could identify you- only a code to link them to you. The transcriptions will be destroyed after 10 years.

### **18. Will I receive a copy of my transcript of the interview and give permission to what is quoted from the interview?**

It is also important to note that some of the interview may be quoted within the research. Therefore, you will be sent a transcript of your interview a number of weeks after the interview. You will have an opportunity to read the transcript and highlight any part of the interview you do not want to be quoted in the main report. If you participate in the project and read the results of our work, you will obviously be able to identify your quotes from your interview. It may also be possible that you identify a very small number of quotes from your client too. We will present the information in such a way that the risk is minimised, and when we do use quotes, we will be careful not to use quotes that may cause distress or seriously breach confidentiality.

### **19. What will happen to the results of the research study?**

The results of this study will be part of a thesis for the Doctorate in Clinical Psychology. These results also may be published in an academic paper. No identifiable information will be used in this

report. Quotes will only be used with your permission. It is possible that this study could be published in an academic journal.

**20. Who is organising and funding the research?**

The University of Birmingham is organising and sponsoring this research.

**21. Who has reviewed the study?**

This study was given favourable ethical opinion for conduct in the NHS by a local Research Ethics Committee.

You may keep this information sheet and will be given a copy of the signed consent form should you choose to participate. If you would like to contact me to ask any further questions before signing the consent form, please contact me on the above number or email address. Thank you for taking the time to read this information sheet.

**Appendix K: Consent forms**

**CLIENT PARTICIPANT CONSENT FORM**

*Title of Project:* What are the accounts of therapists and clients with difficulties, strains and repairs in their relationship during long-term therapy?

*Researcher:* Donna Haskayne

Please initial box

1. I confirm that I have understood the information sheet dated ..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason, without my medical/social care or legal rights being affected.
3. I understand that the research interview will be audio-recorded
4. I understand that following the research interview I will have a 48 hour period for reflection. The researcher will then contact me at which point I may withdraw my interview entirely or in part, without giving any reason, without my medical/social care or legal rights being affected.
5. I understand that the data collected during this study will be looked at by the researcher and supervisors at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.
6. I understand that I will be given a copy of my transcript of the interview to give permission on what can and cannot be quoted in the final report. I understand my name will not be attributed to any such quotes.
7. I agree to my doctor being informed of my participation in this study.
8. I understand that data collected during the study (and medical notes where applicable) may be looked at by individuals from regulatory authorities or from the NHS trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
9. I agree to take part in the above study.

..... Name of participant	..... Date	..... Signature
..... Name of researcher	.....	.....

**THERAPIST PARTICIPANT CONSENT FORM**

*Title of Project:* What are the accounts of therapists and clients with difficulties, strains and repairs in their relationship during long-term therapy?

*Researcher:* Donna Haskayne

Please initial box

1. I confirm that I have understood the information sheet dated ..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason.
3. I understand that the research interview will be audio-recorded
4. I understand that following the research interview I will have a 48 hour period for reflection. The researcher will then contact me at which point I may withdraw my interview entirely or in part, without giving any reason.
5. I understand that the data collected during this study will be looked at by the researcher and supervisors at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.
6. I understand that I will be given a copy of my transcript of the interview to give permission on what can and cannot be quoted in the final report. I understand my name will not be attributed to any such quotes.
7. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
8. I agree to take part in the above study.

.....  
Name of participant

.....  
Date

.....  
Signature

.....  
Name of researcher

**Appendix L: Research participation letter**

Psychotherapy Service  
[Address]  
Direct Line Telephone Number  
Fax Number  
Reception Telephone Number

[Date]

Dear [Psychotherapy client],

**Re: Participation in research on therapy at the Psychotherapy Service**

As you are coming to the end of your therapy I am writing to inform you about some forthcoming research that is taking place on client perspectives of therapy after being discharged. It is very important to get an understanding of how clients experience therapy and their relationship with their therapists. It is hoped that this will help to understand more about therapeutic processes and improve future therapy. To gain this understanding, I am hoping to speak to clients who have been discharged from the Psychotherapy Service. I wish to contact you after you have been discharged, to discuss this research in more detail and decide if you want to take part. By showing interest in the research, it in no way commits you to participate in any research. Please return the slip below in the envelope provided or to reception.

Kind regards

Donna Haskayne  
Clinical Psychology Doctorate Trainee

---

I **do** want to be contacted about participating in research relating to my therapy at the Psychotherapy Service.

Please print your name \_\_\_\_\_

Sign \_\_\_\_\_ Date \_\_\_\_\_

## **Appendix M: Interview schedule**

### Therapist Interview Questions:

Give therapist participants a brief outline of the research and the definition of rupture and repair for the purposes of this research

#### *Occupational background*

- 1) How long have you been working as a psychologist?
- 2) How long have you been working at the Psychotherapy Service?
- 3) How long have you been working analytically?

#### *Definitional issues*

- 1) How does our definition of alliance rupture and repair differ from yours?

#### *Therapeutic relationship*

- 1) Can you remember what your first impressions of the client were?

Prompts:

- a. How did this relationship develop?
- b. On reflection, how would you describe your relationship with your client?
- c. How did you feel about the client and how the client feel about you initially and over the course of therapy?

#### *Rupture*

- 1) Talk about a difficult/ challenging time in the relationship with your client.

Prompts:

- a. How did you make sense of this?
- b. How did it make you feel?
- c. What was your role in this?
- d. How did the client make sense of this?
- e. How did this differ to your view?
- f. What part do you think you played in this? How?
- g. Did you agree/ disagree in part or completely with you client? How? (unconscious)
- h. How did this impact on your supervision?
- i. How did you experience difficulties at the time? Sensations?
- j. When you think about these difficulties, is there a visual element/ image that comes to mind?

2) How would you explain these difficulties to a person who wasn't a psychologist or therapist?

3) Was there a time when you wanted to avoid a session with your client? Why was this?

4) What was your experience of breaks in therapy?

Prompts:

- a. What did that feel like for you?

### *Repair*

1) How did you progress?

Prompts:

- a. What happened with that difficulty?
- b. What was the result?

If repaired:

1) How did you make sense of this?

Prompts:

- a. How was it worked through?
- b. Did it involve other people? (i.e. complaints)
- c. If so how did that feel for you? How did you make sense of it?
- d. How did you deal with this?
- e. How did your client deal with this?
- f. What role did you play in this change?
- g. How did this impact upon you and your life outside of therapy?
- h. How do you make sense of this now?

If un-repaired:

1) What stopped the situation being resolved? How did you interpret this?

Prompts:

- a. Did you discuss this with your client?
- b. How was this dealt with?
- c. What role did you play in this?
- d. What role did your client play in this?
- e. If not, why stopped you?
- f. How did you cope with this?
- g. How did this impact upon you and your life outside of therapy?
- h. How do you make sense of this now?

*Ending:*

1) Do you remember your last session?

2) How did you deal with the ending?

- a. How did you feel towards you client?

*Reflections*

1) How were these difficulties similar to other challenges you have had?

2) How were these difficulties different to other challenges you have had?

3) On reflection, what did you think of/ feel about the relationship with your client?

4) Now how do you feel about your relationship with your client?

### Client Interview Questions:

The interview will start by discussing the nature of the research. To help avoid a social desirability effect, there will be a brief discussion with the participant prior to the interview to normalise the experience of ruptures during therapy and give some background on the research.

#### *A narrative about the precursors to therapy*

- 1) How long ago were you discharged from therapy?
- 2) When were you initially referred to the therapy?
- 3) Why were you initially referred to therapy?
- 4) Did you work with the same therapist throughout therapy?
- 5) How long were you in therapy for?
- 6) How often did you go to therapy?
- 7) How did that change over the course of therapy?
- 8) Were there any breaks in therapy?
- 9) Why did you finish therapy?

#### *Therapeutic relationship*

- 1) Can you remember what you first thought of your therapist?

Prompts:

- b. How did this relationship develop?
- c. How did it compare to other relationships in your life? (transference)
- d. On reflection, how would you describe your relationship with your therapist?

#### *Rupture*

- 1) All relationships have ups and downs, did this happen with your relationship with your therapist?
- 2) Talk about a difficult/ challenging time in the relationship with your therapist.

Prompts:

- b. How did it make you feel? How intense was this?
  - c. Have you felt like this before?
  - d. How did you make sense of this?
  - e. How did it impact on how you see your therapist?
  - f. How did your therapist make sense of/ see this?
  - g. What did you think/ feel about this?
  - h. What part do you think you played in this? How?
  - i. Did you agree/ disagree in part or completely with you therapist? How? (unconscious)
- 3) Was there a time when you wanted to avoid a session with your therapist? Why was this?
  - 4) What was your experience of breaks in therapy?

Prompts:

- a. What did that feel like for you?

*Repair*

1) How did you progress?

Prompts:

- a. What happened with that difficulty?
- b. What was the result?

If repaired:

1) How was it worked through?

Prompts:

- a. What role did you play in this change?
- b. How did this impact upon you and your life outside of therapy?
- c. How do you make sense of this now?

2) Did it involve other people? (i.e. complaints)

Prompts:

- a. How did you deal with this?
- b. How did your therapist deal with this?
- c. What did your therapist suggest?

3) Did you feel therapy dealt with the nub of the problem/ issue?

Prompts:

- a. How? If not, why not?
- b. Did it deal with some issues but not others?
- c. How did the therapy do this?

If un-repaired:

1) What stopped the situation being resolved?

2) Did you discuss this with your therapist?

Prompts:

- a. How was this dealt with?
- b. What role did you play in this?
- c. What role did your therapist play in this?
- d. If not, why stopped you?
- e. How did you cope with this?
- f. How did this impact upon you and your life outside of therapy?
- g. How do you make sense of this now?

*Ending:*

1) How did you deal with the ending?

- a. How did you feel towards your therapist?

2) On reflection, what did you think of/ feel about the relationship with your therapist?

3) Now how do you feel about your relationship with your therapist?

## Appendix N: Breakdown of emergent themes into superordinate themes

<b>Superordinate theme</b>	<b>Emergent Theme</b>	<b>Discussed by participants</b>
Emotions as dangerous	Bomb Smothering Cold Armour Cupboard	Ashley, Sam, Alex and Morgan [clients' theme]
The therapeutic discovery: Hard work and gradual	Therapy as hard work Therapy as painful Therapy as crossword/ puzzle Game playing	Sam, Jessie, Ashley, Fran, Alex, Charlie, Morgan, Pat
The therapeutic discovery: To and fro	Going flat Repetitive Back and forth	Sam, Jessie, Ashley, Fran, Morgan, Alex
The struggle: Not knowing	2 gold stars Where are you? Silence Sounding board Unfinished business	Ashley, Fran, Morgan, Pat, Jessie, Alex
The struggle: Control and power	Self doubt Shades of grey Power Different viewpoints Elephant in the room Over-analysis	Charlie, Morgan, Alex, Ashley, Pat
The positive connection: Emotional sensitivity	Not just a job Click Safety net Making mark/ caring Read me/ picking up on signs	Sam, Jessie, Ashley, Fran, Alex, Charlie, Morgan, Pat
The positive connection: Shining a light	Shining a light/ noticing and commenting Acknowledge and hare feelings Insight into yourself Parallel with other relationships	Alex, Charlie, Pat, Sam, Jessie, Ashley, Fran, Morgan
Leaving and being left	Growth Loss Anger/ retaliation Sentimental relationship Missing and longing Not washed hands of them Released as a sane person	Pat, Morgan, Sam, Jessie, Ashley, Fran, Alex, Charlie,

## **Appendix O: Dyad summary**

### *Dyad one (Client Sam and Therapist Jessie)*

Dyad one both described a positive therapeutic relationship, which did fluctuate at some points in therapy. The main difficulty described by both Sam and Jessie was the difficulty emotionally connecting in their therapeutic relationship. Sam used the image of the Tinman from the Wizard of Oz to describe the difficulty in identifying and expressing emotions with another person. Through therapy, Sam talked about being able to connect and share emotions with Jessie more openly.

### *Dyad two (Client Ashley and Therapist Fran)*

Dyad two both commented on difficulties gaining and maintaining contact with each other throughout therapy. Ashley used the metaphor of a cupboard in which unexpressed emotions were stored and Fran helped to process feelings in the cupboard. Ashley described this as a painful process, like a root canal, in which Ashley craved for reassurance from Fran. The lack of reassurance created tensions, which fluctuated throughout therapy. Increased trust and a sense of togetherness between the dyad helped to maintain contact in their relationship.

### *Dyad three (Client Alex and Therapist Charlie)*

Dyad three talked about the struggle of remaining in emotional contact with each other, because Alex tended to forget material from the session and avoid emotional reaction. Alex described this as an “etch-a-sketch moment” in which Alex would wipe away and remove feelings from the session. There was a stalemate in their relationship that was resolved by increasing the frequency of sessions each week. Through this, Charlie talked about the tempo increasing and emotional contact being more available between the dyad.

### *Dyad four (Client Morgan and Therapist Pat)*

Both Morgan and Pat talked about peaks in the strength of their relationship when Morgan was more emotionally involved in therapy. When less emotionally involved, there seemed to be more distance in their relationship in which Morgan perceived Pat more negatively. During these times, Morgan described finding it difficult to fully open up in therapy and referred to this as “the elephant in the room.” Over the course of therapy, both Morgan and Pat were able to make emotional contact and Morgan talked about a “sentimental attachment” to Pat.