The relationship between formulation, self-observation and the alliance process in psychotherapy for borderline personality disorder: A dialogical sequence analysis

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Abstract: In psychotherapy for borderline personality disorder (BPD), there is evidence supporting the importance of the therapeutic alliance, having a theoretical model for formulating the client's problems, and development of self-observation as mechanisms of change. This case study involved a 22 year-old female with BPD who received five sessions of Cognitive Analytic Therapy. Quantitative measures demonstrated improvements in symptoms and stability in functioning across time. Therapist and client alliance ratings indicated a deterioration in the alliance across time in therapy. Qualitative analysis was performed using Dialogical Sequence Analysis (DSA). DSA is a theory driven method of psychotherapy research that analyses utterances according to their author, addressee and referential object. Results highlight the relationship between the technical and the relational in

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psychotherapy. Specifically, there was evidence that case formulation may be used to try to pre-empt ruptures in the alliance. Additionally, in this case, the open sharing of the formulation was used as a framework for resolving alliance ruptures where they did occur in a manner that promoted improved self-observation. This study suggests that therapists should aim to tentatively hold a case formulation in their minds, checking it with the client and consistently attending to fluctuations in the therapeutic alliance, so as to maximize their flexibility and effectiveness in working with individuals with BPD to improve the client's self-observation.

Keywords: Alliance, borderline personality disorder, dialogical sequence analysis, case study, process research

THE FIRST description of 'borderline personality' emphasized the difficulty in treating clients with this disorder due to their tendency towards projective defences and deficits in interpersonal functioning (Stern, 1938). Ensuing research has underlined the difficulties in treating such clients, as BPD involves prominent deficits in interpersonal functioning (Jeung & Herpertz, 2014; Lazarus, Cheavens, Festa, & Rosenthal, 2014; Skodol et al., 2002), high levels of suicidality and self harm (Black, Blum, Pfohl, & Hale, 2004; Pompili, Girardi, Ruberto, & Tatarelli, 2005; Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994), as well as high levels of affective instability (Carpenter & Trull, 2013; Nica & Links, 2009). These features make treating BPD a significant clinical challenge for mental health professionals (Bender, 2005; Paris, 2005; Vaillant, 1992).

Despite these challenges, a number of novel and effective treatments have been developed to treat BPD, without clear evidence of superiority of one treatment (Stoffers et al., 2012; Zanarini, 2009). Given that these treatments differ in theory and practical implementation (De Groot, Verheul, & Trijsburg, 2008), one parsimonious approach to developing a deeper understanding of their effectiveness is to focus on describing the mechanisms of change that might be common across approaches. These have been described as 'principles of therapeutic change' and importantly, account for the inter-related nature of techniques, client characteristics and the therapeutic relationship (Castonguay & Beutler, 2006; Castonguay, 2011; Goldfried, 1980). By clarifying the elements of treatment that might be responsible for therapeutic change in different disorders, this approach might help focus research and improve clinical practice.

In terms of BPD, a number of key elements of effective treatments have been identified. The first of these is that treatments are structured and clearly defined (Bateman, 2012; Clarkin, 2012; Livesley, 2012; Weinberg, Ronningstam, Goldblatt, Schechter, & Maltsberger, 2011). This is likely to be helpful in assisting therapists to make sense of complex presentations and also to manage potentially difficult countransferential responses, which are demonstrably more negative with BPD clients when compared with depressed clients (Bourke & Grenyer, 2010; Brody & Farber, 1996). Additionally, a treatment structure offers the theoretical framework through which to develop a formulation of the client's difficulties. Formulation provides a working model of the different factors that might contribute to a client's problematic recurring patterns and is fundamental to all therapies (Johnstone & Dallos, 2006). It can assist in providing a basis for effective collaborative work (Macneil, Hasty, Conus, & Berk, 2012; Ryle & Kerr, 2002).

The second important mechanism of change appears to be developing the capacity of the client to reflect on their own thoughts and feelings, as well as those of others (Livesley, 2012). Terms used in the psychotherapy research field include metacognition (Semerari et al., 2005), mentalization (Bateman & Fonagy, 2004), reflective functioning (Clarkin, Yeomans, & Kernberg, 2006), mindfulness (Linehan, 1993) and an observing position (Ryle, 1997). This is perceived as particularly important, due to the impaired and fluctuating capacity for self-reflection that is evident in BPD (Fonagy & Bateman, 2006; Jennings, Hulbert, Jackson, & Chanen, 2012; Semerari et al., 2005). While improved reflection is the explicit focus in treatments such as CAT (Ryle, 1997) and MBT (Bateman & Fonagy, 2006), it appears that all treatments assist the client in improving the quality of their self-observation (Livesley, 2012).

The primary vehicle through which this is achieved is through the therapeutic relationship (Norcross, 2011; Wampold, 2001), which is widely accepted as a fundamental cornerstone of BPD treatment (Gunderson, 2008). One element of the relationship is the therapeutic alliance, or the degree to which therapist and client can work collaboratively and purposively (Bordin, 1979). Ruptures in the therapeutic alliance can occur frequently when treating BPD (Bender, 2005; Cash, Hardy, Kellett, & Parry, 2013; Daly, Llewelyn, McDougall, & Chanen, 2010) and there is preliminary evidence that the extent of resolution of ruptures is predictive of positive outcome in therapy (Daly et al., 2010; Safran, Muran, & Eubanks-Carter, 2011). It is also clear that both therapist's characteristics and technical skills can contribute to fostering a strong alliance (Ackerman & Hilsenroth, 2003).

In summary, three fundamental mechanisms of change have been identified in psychotherapy for BPD. Namely, a model that clearly formulates the client's problems, an improved capacity for self-reflection and the use of the therapeutic alliance. These three elements can be combined to postulate that therapeutic change in BPD is partly contingent on the quality of the therapeutic model in developing a formulation of the client's problems and in using this model to assist the client to develop improved self-reflection within the context of a therapeutic relationship. This suggests that there is an interactive effect of case formulation, improved reflection and the therapeutic alliance in bringing about therapeutic change (Bateman, 2012; Clarkin, 2012; Livesley, 2012).

While this account is not original (Bateman, 2012; Clarkin, 2012; Livesley, 2012), there is only limited evidence to support it. The complexity of the therapeutic encounter suggests that simple linear models might not sufficiently account for the responsive (Stiles, Honos-Webb, & Surko, 1998) and transformative nature of psychotherapy (Leiman, 2012). As such, a case study approach offers the first step towards an explication of the inter-relationship between numerous variables and can offer findings that might be clinically relevant and theoretically meaningful (McLeod, 2001; Stiles, 2007). This study aims to examine the relationships between case formulation, self-observation and the therapeutic relationship in the treatment of BPD. More specifically, it will use a case study design to explore how case formulation and therapist technique are used to improve self-reflection in BPD and repair ruptures in the therapeutic alliance.

Method

Case description

'Jenny' is a 22 year old female, living in a rental property with her partner 'Tim', 'Bec' her infant daughter and 'Luke' her toddler-aged son. She provided written, informed consent to take part in an RCT examining treatment for young people with BPD. On assessment the Structured Clinical Interview for DSM-IV (SCID-I & SCID-II; First, Gibbon, Spitzer, & Williams, 1996; First, Gibbon, Spitzer, Williams, & Benjamin, 1997) was administered by an independent research assistant and Jenny was assessed to have Major Depressive Disorder, Panic Disorder without agoraphobia, BPD and Antisocial Personality disorder.

Jenny consented to take part in a randomized controlled trial (Chanen et al., 2015) and was randomized to receive 16 sessions of CAT as well as access to all the services of the Helping Young People Early (HYPE) specialist early intervention programme for BPD in Melbourne, Australia (Chanen et al., 2009). This included case management integrated with individual psychotherapy, general psychiatric management, access to a psychosocial recovery programme and family support. She attended five sessions of CAT before treatment was discontinued after she moved houses and was unable to attend sessions. It is important to note that this should be considered an incomplete treatment due to its short duration, and the outcomes should be interpreted within this context.

Measures

The *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989) is a 36-item questionnaire that is widely used, with parallel therapist and client versions and reported high internal consistency (Horvath & Greenberg, 1989; Tyron & Kane, 1993). Responses are made on a 7-point likert scale and can be divided into 3 subscales corresponding with Bordin's (1979) tripartite view of the tasks, goals and bond. Overall alliance score was used and values can range from 36-252.

The *Borderline Personality Disorder Severity Index IV* (BPDSI-IV; Arntz et al., 2003) is a semi structured interview that yields quantitative ratings that assess BPD severity. The measure demonstrates strong internal consistency as well as discriminant, concurrent and construct validity (Giesen-Bloo, Wachters, Schouten, & Arntz, 2010). Overall scores range from 0-90 with higher scores indicating greater severity of BPD symptoms.

The *Social and Occupational Functioning Assessment Scale* (SOFAS; Goldman, Skodol, & Lave, 1992) is a widely used measure of global functioning, that is a single rating made by the interviewer. It integrates a rating of symptoms as well as a focus on level of adaptive functioning in social and occupational domains. Higher scores correspond with better social and occupational functioning.

The *Montgomery-Asberg Depression Rating Scale* (MADRS; Montgomery & Asberg, 1979) is an interviewer rated 10-item questionnaire that is scored on a 7-point likert scale and measures depressive symptom severity. It was designed to be sensitive to change and demonstrates high inter-rater reliability (Kørner et al., 1990). This study used the *Structured Interview Guide for the Montgomery-Asberg Depression Rating Scale* (SIGMA; Williams & Kobak, 2008), which offers clear anchor

points and a structured interview guide that was designed to maximize inter-rater reliability. In a study of 81 rater pairs, the intra-class correlation for total score was r=.93 indicating excellent inter-rater reliability (Williams & Kobak, 2008).

Dialogical Sequence Analysis (DSA)

DSA (Leiman, 2004, 2012) is a theory driven psychotherapy research approach that is rooted in Vygotsky's (1978) theory of sign mediated activity, object relations theory (Leiman, 1992; Ryle, 1991), and Bakhtin's (1984) dialogical theory. Rather than offering a narrowly prescribed set of steps, DSA provides a set of theoretical concepts that can be used to analyse relational and dialogical components of therapeutic discourse. The methodology assumes that there are meaningful relationships between psychic processes, external actions and verbal expressions. DSA examines utterances in therapy in terms of three elements. The first is the *author* of the statement who is always positioned. Against this there is a counter-positioned *addressee,* to whom the speech is addressed, which might include the therapist, a part of the client or another person who is not present. The third element, is the *referential object*, which is the content or topic of the speech. These relationships are illustrated in Figure 1.

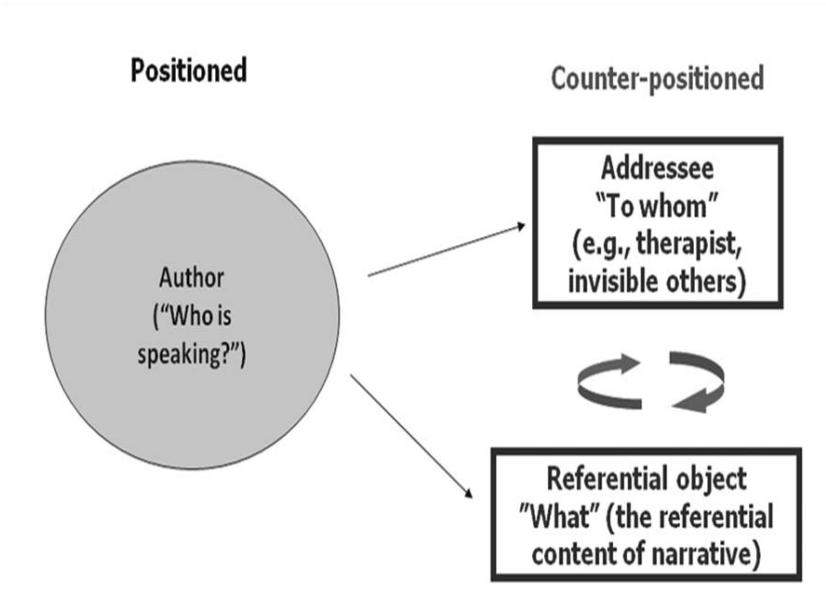

Figure 1 Illustration of DSA conceptualisation of positioned utterances (from Leiman, 2012)

Bakhtin's (1984) theory emphasizes the *double directedness* of utterances, in that they are addressed towards someone and also have a topic or referential object. Depending on the referential object of speech, or the topic, the speaker's position to the addressee can be quite different. For instance, if the addressee is perceived as rejecting, disclosing personal themes to the therapist can become difficult. DSA is a group based approach that is particularly suited to microanalysis of psychotherapy transcripts in that it is able to explore patterns of dialogue in therapy and elucidate the subtle relational dynamics that evolve over time in therapy. It has been used to examine impasses in the context of a network meeting (Tikkanen & Leiman, 2014).

Analytic procedure

The first two sessions of Jenny's CAT were transcribed by the first author, who is a psychologist. The data analysis group included two clinical psychologists and experienced CAT therapists, one of whom was the therapist in the case described. The group also included four experienced psychotherapists. Data analysis sessions occurred through web video conferences and involved large and smaller group discussions and a consensus based approach. The opening exchanges of the first session were utilized to develop a research based DSA formulation of the client's problematic pattern. This formulation (see Figure 3) was then used as a conceptual tool in order to examine the quality of the alliance and self-observation during the first two sessions of therapy.

Ethics approval was provided by the Melbourne Health Research and Ethics committee. Written informed consent was provided by the client for the therapy sessions to be recorded and used for research purposes. Therapy transcripts have been de-identified by using pseudonyms and all identifying details have been altered.

Results

Jenny's psychometric results are presented in Table 1 and demonstrate a decline in the severity of her BPD and depressive symptoms with six month scores remaining in the clinical range (Arntz et al., 2003; Montgomery & Asberg, 1979). Results indicate stability of social and occupational functioning over six months at a level of moderate impairment. The working alliance scores for therapist and client are presented in Figure 2 and demonstrate a reduction in the quality of the

Table1 : Outcome data across 6 months of assessments

Domain	Measure	Baseline	3Month	6 Month	Effect size Cohen's d
Borderline Pathology	BPDSI (total)	44.05	23.35	33.24	d=.91
Depression	MADRS	26	17	17	d=.78
Global Functioning	SOFAS	60	55	59	d=.13

alliance during the course of treatment. In the following section, excerpts will be provided to examine the inter-related nature of reflection, formulation and the alliance.

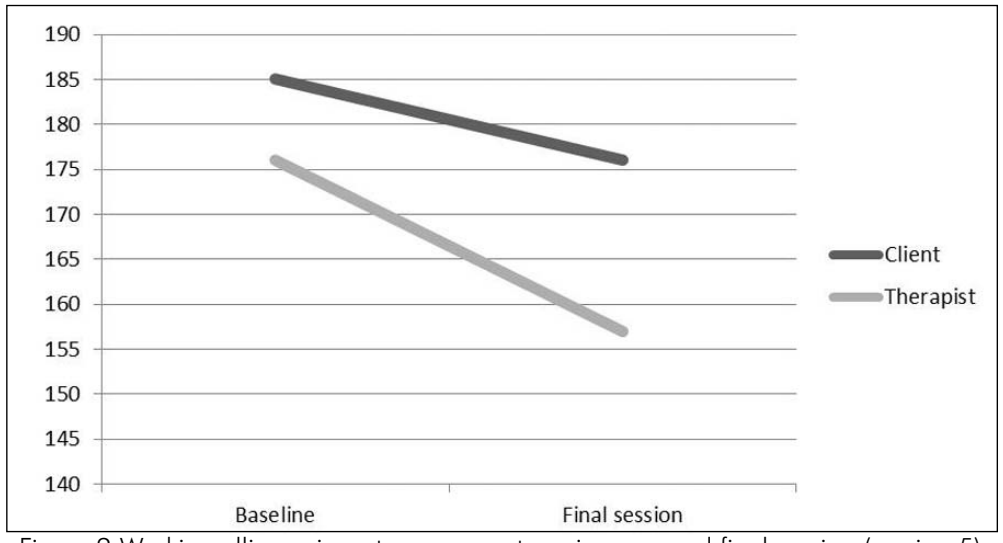

Figure 2 Working alliance inventory scores at session one and final session (session 5)

Session One: Developing the formulation

The following excerpt begins with the fourth speaking turn of the first session of CAT. T signifies therapist speech, C, client speech, square brackets indicate cross talk. Words are emphasized with bold font where they are used for further analysis.

C4: Me and Tim have been **fighting** a lot the last couple of days.

T4: Mhmm

C5: Like bad fighting.

T5: Ok, is that usual or a bit out of the ordinary [for you]?

C6: [Um, every now] and then we have a really bad fight but I nearly **punched him in the face** again this time.

T6: Ok, that's a fairly significant fight.

C7: Yeh.

T7: What tends to get you into those really big arguments?

C8: Me being **pig-headed** pretty much. Um, I'm a **bit pissed off** because we're still not talking to Tim's family. My girlfriend went away and I've got no one to look after the kids. I couldn't even go and get my hair cut. I couldn't even go to the supermarket.

The excerpt opens with the referential object or topic of conversation being fighting. In C6, when discussing nearly punching Tim in the face, Jenny is very open about her anger and rage. Nonetheless, it seems there is something intolerable about the situation for the client. In T7 the therapist prompts reflection and for more detail about the antecedents to the fights and in C8 Jenny immediately moves to a self-critical position, characterizing herself as 'pig-headed' or stubborn. As if responding to her self-blame, Jenny begins to give external reasons for her uncontrolled anger. She then moves to an angry 'pissed off' position regarding the lack of support that she received. She expresses feeling dismissed and disregarded at having no one to help care for her children, and it appears that her intense anger might arise from feeling as though these needs are not being met.

Another element that helps to contribute to the development of the formulation occurs later in the session where the topic turns to drug use.

T73: Yeh, are you still feeling the cravings for the **ice**?

C73: Yes, I still want, if I think about it.

T74: Right.

C74: Definitely. Like I start to get the sweats and my heart races and I want it but I'm very **quiet** about it because I feel very **judged**. Especially by Tim who's an ex-addict and I tend not to say anything until he does. So.

T75: So **that's interesting** that he, 'cause he used with you, it was never only you but you feel **judged** by him for [the fact that]

C75: [I'm stronger] I'm supposed to be the **strong one**. I don't want him to think that I'm also **weak.**

T76: Right, ok.

C76: (5 second pause) (sigh).

T77: (sigh) **It**'s hard isn't it?

C77: Yeh, I still stand by the fact that out of every substance I've used the one I will never give up is my cigarettes. (laughs) I love my cigarettes. I can't get through my day without those.

The discussion has moved to Jenny's previous problematic use of ice (crystal methamphetamine). In C74 we see the counterpoint to the client's self-critical position, in which she is now feeling criticized and judged by others. In T75, the therapist avoids colluding with this criticism and takes a curious point of view, commenting 'that's interesting'. In C75 Jenny clarifies her underlying appraisal – the fear of being weak if she loses control and her perception of herself as 'strong' and capable. There is a 5 second pause, which is rare in this client's therapy and it appears that at this stage Jenny is reflecting on her vulnerability. In T77 the therapist empathically states that this reflecting process ('it') might be difficult. In C77 Jenny moves the topic to the safer ground of cigarettes. This supports the thesis that self-observation might be contingent on the emotional state of the person with BPD. That is, the client finds it difficult to maintain a coherent sense of self, especially under the emotional activation associated with reflecting on her drug addiction. She rapidly shifts to safer ground. Soon after, the therapist attempts to return to the client's vulnerable feelings.

Session One: Utilizing the alliance and formulation to stimulate reflection

T80: I imagine it's also hard to get your **needs met** when you always have to be the strong one. Because even having needs and letting people know of them might be weak.

C80: That's why I don't ask for help with the kids.

T81: Yeh, it might actually then leave you feeling really shit.

C81: Yeh.

T82: Because, yeh. People either **dismiss** what you want and need or **you kind of do it** in a way by not, by kind of holding on to it because otherwise you'll feel kind of weak and shit.

C82: **Yeh**, the only people that don't make me feel that way are my kids. And even they sometimes make me feel like I'm being **walked all over** but I'm **pretty good** with them these days. Like um, I don't, I used to, I could actually lose my temper and fly off with Luke. Now, I sound angry but I'm not actually feeling the anger that I'm projecting.

T83: So that you can be more controlled.

C83: Yeh it sounds scary, getting what needs to be done, done. But not actually start throwing stuff.

T84: Yeh, so that you won't fly off the handle.

C84: Yeh.

T85: So you'll be able to let him know that you're not happy but without going too far.

C85: If I do feel **that anger**, I take it out on Tim.

T86: Right.

C86: Like why do I have to get to this point? Why can't you step in and do something?

In T80, the therapist suggests that Jenny's experience of vulnerability as being a weak and dismissed position might lead to her having difficulties getting her 'needs met'. The client amplifies this understanding in C80. In T82 the therapist further develops this understanding by emphasizing that the dismissing can be experienced from others and can also take place at an intrapsychic level. This invites further reflection on this pattern and in C82 Jenny offers minimal agreement saying 'yeh' and then denies that this dynamic is in place with her children. However, she then notes that she can feel 'walked all over' or exploited by them. She then appears to move again into a somewhat defensive mode, explaining that she is 'pretty good' with her children and has reduced her angry feelings towards them. This might be accurate but might also reflect the client's sensitivity towards criticism in the therapeutic relationship and desire to appear competent. In T84 the therapist responds empathically and non-judgmentally, emphasizing that she understands that the client might need to sound 'scary' in order to avoid overwhelming anger. In C85 Jenny concedes that she does at times experience 'that anger' but that she takes it out on her partner, and in C86 she moves to the angry and blaming position towards Tim.

From the therapy transcripts, the DSA group developed a tentative formulation of the client's key dialogical sequences, which is presented in Figure 3. A key relational dynamic for Jenny, called a *reciprocal role* in CAT, involves a critical, blaming position in relation to a guilty and judged counter-position. Importantly, the client is able to take both positions, for example, being critical towards her partner or herself, as well as feeling very judged in terms of drug use. In the above excerpts we see how this leads to anger towards others, as well as a perceived anger in others that leads to a justifying position. This formulation can be revised through further analysis of transcripts however it can be especially useful both to make sense of complex interactions that are difficult to comprehend and in order to determine whether change is occurring in terms of positions taken or reflective capacity.

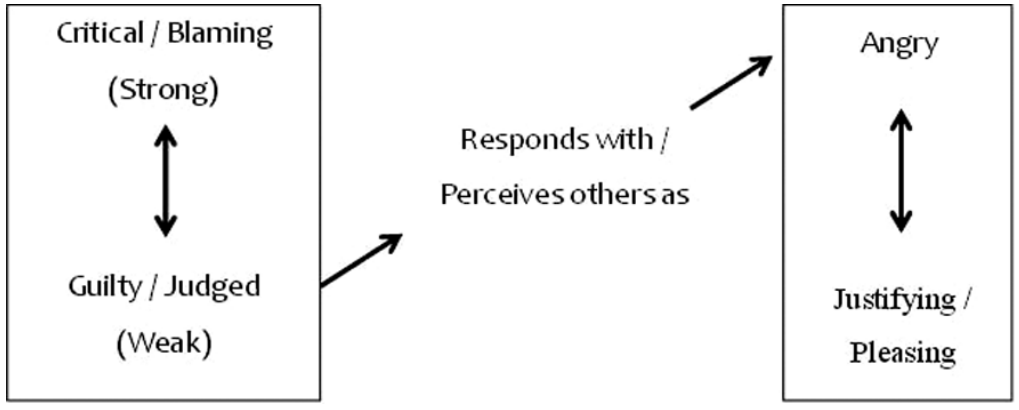

Figure 3 Case formulation of key dialogical sequences established from session one

Session Two: Using the formulation to assist in reflection and to maintain the alliance

This session presents examples of how formulation can be used in session to assist in fostering self-reflection and managing the therapeutic alliance. It is important to note that the DSA formulation was developed by the research team independently, yet it is clear that the therapist's formulation utilizes some similar concepts. This excerpt begins in the context of an exploration of the client's need to please others.

C115: Yeh I mean, you're here to help me and I want help. Like, this is where I want to be. Um, and I've got no reason to **lie** to you.

T116: Mhmm

C116: I don't really see a lot of point in lying. And I've got. . .

T117: I'm not talking about lying, I'm talking about maybe **not saying something** because you think I'll get angry at you, because you don't like people being **angry at you**. Or if I say that, that person, me included, might get angry at me so I won't say it.

C117: I suppose I could possibly be like that if I ever got on the drugs again. I don't think I'd want you to know about that. Um, otherwise, no. Not unless I did something **seriously stupid**. And I'm not real prone to doing seriously stupid stuff. Self-reckless, sure a little bit. But not seriously stupid stuff. (*pause 6 secs*). I just like to have fun like other people sometimes.

T118: **Why** do you think I'd get angry at you if you started using ice again?

C118: Because you've put a lot of hard work and time into helping me get better and I would just be **back-pedalling** on you. Or, again it'd be a show of **weakness** um, I don't know. It's just something that my **brain assumes**. It's a good question, why do you think that person would be angry at you?

T119: Mmm

C119: 'Cause **I just think they will**.

T120: Because you've gotten to a point where you make an automatic assumption [that people]. . .

C120: [yeh and] I get angry at people doing that to me (laughs). Yeh.

T121: Yeh, so when people make automatic assumptions about you, you get angry.

In C115 Jenny denies a need to 'lie' and in T117 the therapist reframes lying in a less critical voice as 'not saying something' thereby avoiding reciprocating with judgement, as Jenny might anticipate. The therapist also alludes to the other being 'angry' at Jenny, which according to the formulation is an intolerable position. The client denies doing 'seriously stupid' things, pauses to reflect and states that she just likes to have fun. This is a potential example of *multiple addressees,* in that this statement appears to be justifying the client's behaviour and drug use both to the therapist and the critical aspect of herself.

In T118, the therapist offers an important intervention, asking the client to reflect on why the therapist might be angry at her drug use. This can be seen from a CAT perspective as improving the client's capacity for reflection. From the perspective of the formulation, it is acknowledging the central role that anger can play in causing strain in relationships and the therapist is seeking to prepare the ground for potential ruptures in the future. From a DSA perspective, the referential object or topic of conversation moves from drug use to the emotion itself, namely anger. The therapist takes a neutral, curious position.

In C118, Jenny has difficulty clarifying her reasons, suggesting that her drug use might be perceived by the therapist as being 'back-pedalling' or worthy of judgement or a sign of 'weakness'. She goes on to externalize the reasoning as something her 'brain assumes'. Finally, in C119, she loses all reflective capacity stating 'I just think they will'. It is evident that, in the context of the emotionally laden 'hot topic' of drug use, the client's self-observation capacities are diminished. Yet, her fundamentally self-critical positioning remains. The next excerpt follows immediately from the previous one.

Session Two: Using the formulation to improve the alliance

C121: Yeh well it's like you say that I look like a pretty straight up and down person and I generally tell it how it is. Whether it's about you or about someone else. I just say it **straight up**. Nobody else is like that. Nobody else is like that. So all I can do is make an assumption about what someone is feeling or thinking because you know they're **never saying** what they actually think.

T122: Yep.

C122: So even you in your job where you're supposed to be not judgemental, you're supposed to be, and just you've heard it all before anyway. But there's got to be something going on in your mind that makes some sort of judgement at some point, because you're human.

T123: Sure.

C123: And, so when people say things to me, whether they be really nice or really nasty there's always a **hidden motive** behind it or there's always something else going on in their head. They just don't want to upset ya.

T124: Yeh, and I completely agree. I don't think this is a **judgement free zone**. And I don't think this is necessarily an **anger free [zone].**

C124: [No.]

T125: Or a disappointment free zone or whatever. I'm just wondering, what I'm hoping though, is that if something like that happens, like if you find yourself **not saying something** because you're worried I'll get angry or maybe if you do feel judged by me or I'm actually hoping that we can **find a way to talk about it**.

C125: [Yeh well.]

T126: [because I] don't think this is, like I agree with you, I don't think it is going to be free of all of that stuff.

C126: No.

T127: Because yes, this is separate from your life, but I think some of the stuff that happens in your life will also play itself out.

C127: Yeh probably.

T128: In a different way I think.

C128: If I felt **judged** or anything like that I would quite easily approach you about it. But if I thought you were **angry** at me I'd probably sus you out about it first and then make a [decision].

T129: [Ok yeh.]

C129: 'Cause I reckon I'd find it pretty quick. Whether I'd figure out whether you were angry at me or not.

T130: And I don't think there is actually a problem with us getting angry.

C130: No.

T131: I think there's a problem obviously if we start yelling and I think we both need to feel safe here. But anger is, see that is what was interesting to me about when you said I'm kind of **afraid** of, in a way you're afraid of other people being angry at you. It's kind of like, that's really interesting because anger's gonna happen. You know because anger is one of the whole gamut of emotions that is going to happen. You are going to get angry and other people are going to get angry at you.

C132: Yeh.

T133: There's no way of avoiding it.

C133: I think it's the outcome of how that person handles the anger. I can't handle it when people shut off from me and don't tell me what the problem is.

C121 offers a picture of Jenny's view, where she is the only 'straight up' honest person and others 'never say' what they are thinking. In C122 she extends this, directly challenging whether the therapist is unbiased or also engages in judgement. In C123 she elaborates her suspicion that others have a 'hidden motive'. Throughout this early exchange, the therapist agrees with Jenny's assertions, culminating in T124 where she acknowledges that therapy does not necessarily exist without 'judgement' or 'anger' implying that these might be inevitable in therapy. This utilizes key themes in the formulation of Jenny's issues in a manner that seeks to foster the alliance and avoid ruptures. In T125, the therapist once again softens Jenny's idea of a 'hidden motive', similar to the earlier discussion of lying and reframes it as 'not saying something'. She argues that rather than avoiding these difficult states, the dyad need to 'find a way to talk about' these difficult areas.

Jenny's speaking turn in C128 is instructive in demonstrating that although judgement is difficult, she can communicate about this issue. By contrast, anger in others is intolerable and too difficult to discuss openly, unless she feels in control. In T131 the therapist uses this insight to explore the fear that is underlying the anger. In this way she seeks to assist the client to access these vulnerable feelings in the context of a strong alliance. In C132, the client does not access these feelings but does take a more nuanced and accepting position towards the anger, suggesting some limited therapeutic progress.

The next excerpt occurs soon after and the topic has returned to Jenny's drug use.

Session Two: Utilizing the formulation to repairing an alliance rupture and improve reflection

> C146: It's almost hurtful, you know the first time that **you** try a **drug** like that, you're taking a leap, you're taking a big chance. But then when you realize what it actually does to you, it's **not that big a deal**. It's not like I'm **incapable of looking after my kids** and then **when someone else judges you** on that, that **hasn't done it before** and then tells you that you're being **irresponsible** and that you're putting your kids' lives in danger and all that, it's quite **insulting**. Because I would never do that on purpose, I would never do it deliberately and I did a fair bit of research on the ice before I ever even took it.
>
> T147: Oh, and that would, and I think that, you know, I think that that's a **really good place** to kind of start from. I think if we ever, if **we** did **fall into** some of those **unhelpful patterns**, I don't think either of us have done it deliberately or **intentionally**.
>
> C147: [No.]
>
> T148: and therefore I think we can take the blame out of it and go 'Oh hang on a minute, we fell into something here'.
>
> C148: [Yeh.]
>
> T149: We both did it. And, you know, not feel that either one of us is to blame to for it but actually just talk about it and go 'well **what happened**?'
>
> C149: Yeh.
>
> T150: Because ultimately, and I don't say this to be dismissive, but ultimately at the end of this **you have a right** to do everything exactly the same as you already, as you always have.
>
> C150: Yeh.
>
> T151: Because it's **your life**.
>
> C151: Yeh exactly. And that's where I can sort of detach myself from you is the fact that yes you're involved in my life at the moment and you're trying to help me but you're not part of my life as such. If that makes sense. So the **emotional attachment** isn't as strong as it would be with Leigh or my mum.

This excerpt begins by discussing the 'drug' ice, from the depersonalized position of 'you'. Jenny describes feeling 'judge[d]' and 'insult[ed]' regarding a perceived other who views something that is 'not that big a deal' as her being 'irresponsible' as a mother. The addressee might be an abstract other person or potentially the therapist herself, whom the client assumes 'hasn't done it [ice] before'. If the latter is the case, this might be viewed as a rupture in the alliance and a breakdown in the bond. There might be some element of the client projecting her judgemental perspective on to the therapist. Jenny then moves from the judged position to the justifying one, stating that she would never endanger her children 'deliberately' and that she researched ice before using it.

The phrase 'when someone else judges you' is an example of what Bakhtin calls a 'word with a sideward glance' (Bakhtin, 1984, p. 195), which is a 'hidden polemic' (p. 163), where the statement obliquely takes a swipe at and anticipates the addressee's objection. In this case it appears that Jenny is warning the therapist against any judgement about her drug use.

In T147, the therapist seems to intuit the challenge, struggle for the right words and then allies with Jenny's defences, characterizing her position as 'a really good place' to start. She then moves to strengthen the alliance with the client using the word 'we' and reframing the critical terms of judgements and irresponsibility as the more benign 'unhelpful patterns', that both parties can 'fall into' unintentionally. In this way the therapist seeks to offer the option for feelings of guilt and vulnerability to be explored within the therapeutic relationship without the need for a corresponding intentionally critical or judgemental counter-position. In T148 and 149, the therapist continues to expand on the same theme. In T149 the therapist seeks to encourage greater reflection, and in T150-T151 the therapist emphasizes the client's autonomy.

In C151 Jenny states the she does have some capacity to 'detach' and observe her own states within the context of the therapeutic relationship, which she might not have in family relationships. She states that this is due to the weaker 'emotional attachment' and this is consistent with her difficulties maintaining accurate self-observation when she is in a highly aroused emotional state. Nevertheless, the strength of the alliance remains somewhat precarious at this stage.

Discussion

This case study demonstrates the inextricably intertwined nature of therapeutic technique and the therapeutic relationship (Hill, 2005). It is evident that all technical interventions occur in an interpersonal context

and have relational meaning (Butler & Strupp, 1986). This is not to say that efforts to compare the relative importance of technique and the alliance are uninformative, but rather, that a comprehensive account of change processes in therapy necessitates a consideration of both.

The formulation, known as the *reformulation* in CAT (Ryle, 1997), is the basic shared understanding that guides the direction of the therapy. In Jenny's case, elements of her formulation, including the pivotal roles of anger and judgment, are evident from the earliest exchanges in therapy. This corroborates earlier findings regarding the considerable information that can be gleaned from a micro-analysis of the opening utterances of the first sessions of therapy (Stiles et al., 2006).

Importantly, and consistent with the CAT model, it is evident in this case that the formulation was actively addressed by the therapist in an open and collaborative manner. This case demonstrates that the formulation serves multiple functions in that it assists therapists to focus on the relevant referential objects (themes) that are involved in maintaining the client's problematic patterns. This helps to foster self-observation, known as the 'observing eye' in CAT (Ryle & Kerr, 2002). The formulation also assists in negotiating alliance ruptures, when they appear in the context of referential objects, such as Jenny's drug use.

The unstable sense of self, that is characteristic of BPD, is particularly evident in Jenny's case in excerpts where anger and judgment are the topic of conversation or where Jenny perceives judgment in the context of the therapeutic relationship. In these cases, Jenny experiences ***state shifts*** and reduced reflective capacity. This presentation is well accounted for by Ryle's (1997) Multiple Self-States Model of BPD. At the lowest level, this model posits a restricted and extreme repertoire of reciprocal roles, which are presented in the formulation and evident throughout Jenny's therapy. The second level suggests rapid switches in self-states that occur as a result of dissociative processes in response to early adverse experiences. In Jenny's case these switches are evident when topics shift to and from her problematic drug use. Finally, the third level of the model describes impaired self-reflection, which occurs for Jenny particularly under high emotional activation. It is important to note that the diagnostic label BPD covers a heterogenous set of personality traits and there is considerable debate about the appropriate nosology to capture this complexity (Skodol, Morey, Bender, & Oldham, 2013; Tyrer, 2009).

The therapist repeatedly prompts reflection in the client in a manner consistent with CAT. It appears that Jenny is capable of reflection, but

only under certain circumstances, and that more therapy was likely needed for her to continue to develop this capacity. This case suggests that an account of BPD that primarily focuses on emotional dysregulation (Linehan, 1993) might fail to account for the diffuse sense of self that has been emphasized in other models (Kernberg, 2012; Ryle, 1997). It appears that this understanding of sense of self in BPD can assist the therapist to negotiate the relationship successfully. It would be helpful for future research to also consider a more fine-grained analysis of the different facets that make up reflection and metacognition and how they manifest in therapy interactions (Semerari et al., 2005).

In terms of addressing ruptures in the therapeutic alliance, this case illustrates two points that might help to elaborate alliance theory. The first is that the therapist appears to be attempting to pre-empt and prevent ruptures by explicitly raising the potential that themes like anger and judgement will enter the therapeutic domain. This appears to be a productive strategy, but it is not one that has been specifically examined in previous research. Studies have found different rates of ruptures in different treatments (Muran et al., 2009), and that focusing on the alliance can improve treatment (Constantino et al., 2008). Yet, it remains to be seen whether attempting to pre-empt ruptures actually prevents their occurrence, reduce their impact or whether other pathways might be more important. In this case, despite active efforts to sustain the alliance, quantitative data suggest that the alliance weakened over the brief course of therapy.

The second element pertaining to addressing ruptures illustrated by this case is that the formulation offers a shared language that can be used as a means through which to negotiate ruptures in the alliance (Shine & Westacott, 2010). In Jenny's case the ruptures appear to be closely linked with her key dialogical patterns in terms of feeling dismissed or judged by a critical or angry other. When these manifest in the relationship, it appears that the therapist and client are able to work through them. However, it is also evident that the productive therapeutic work is only done when the client's level of emotional arousal is contained to a sufficient extent to allow some level of self-reflection. This is consistent with Fonagy and Bateman's (2007) account of the mentalization system being inhibited by arousal of attachment.

The quantitative alliance data suggest that both the therapist and client perceived a reduction in the quality of the alliance across time in therapy. One study of interpersonal microprocesses suggested that the early phase of therapy should be characterized by consensual engagement

and that successful therapists disconfirm clients expectations of negative complementarity or hostility (Altenstein, Krieger, & Grosse Holtforth, 2013). The active, non-judgemental and collaborative stance of the therapist in this case appears to be consistent with this finding. Another potential explanation is provided by Valkonen and Leiman (in submission), who examine 'active barriers' that might be present in people with BPD that might inhibit self-observation. From the perspective of Transference Focused Psychotherapy, primitive defences, such as splitting and projective identification, are seen to impair reflective capacities (Clarkin et al., 2006). These defences appear to be present in Jenny's perceptions of critical judgment from the therapist and it appears that the therapy did not continue for long enough to overcome these barriers, and any related damage to the alliance. It is also possible that Jenny felt judgement in her broader social context, and that this might have contributed to her moving houses.

This study has a number of limitations. The therapy for the case selected was terminated early by the client who moved too far away from the mental health service to be able to attend further sessions. Hence, it was not possible to follow up how these findings might have developed across time in therapy and it is possible that further sessions of therapy might have affected the alliance and outcome ratings that have been provided. The psychometric data point to a reduction in Jenny's BPD symptoms and also her depressive symptoms, yet both remain in the clinical range and as such the result could be considered 'improved but not recovered' (Jacobson, Roberts, Berns, & McGlinchey, 1999, p. 300). At six month follow up her level of global functioning appears to have remained stable and impaired across treatment. This is broadly consistent with the common trajectory for BPD, which involves symptomatic improvement concomitant with functional stagnation (Gunderson et al., 2011; Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010). It is unknown how further sessions might have influenced this trajectory for this individual client.

Another shortcoming is that DSA is a qualitative analytic tool and as such does not conform to traditional definitions of reliability (Leiman, 2012). These shortcomings are addressed to some extent by consensual group-based analysis. However the extent to which the analysis provided is justified in light of the case material presented is left open to challenge. The approach is vulnerable to criticisms of disproportionate influence of individuals in the data analysis team, or that prior conceptions might influence the data analysis process. Additionally, in a single case study design, it is unclear whether results will generalize to the broader population.

This study has several implications for clinical practice and research. The first applies to the therapist's inner processes and stance during therapy. Classical conceptions argued for the therapist to offer an 'evenly hovering attention' in therapy (Freud, 1912, p. 111) as a 'participant observer' (Sullivan, 1953). More recent integrations have emphasized cultivating mindfulness in order to be able to engage in and reflect on the therapeutic process simultaneously (Harris, 2009; Safran & Muran, 2000; Siegel, 2010). The present study suggests that therapists should aim to tentatively hold a case formulation in their minds, checking it with the client and consistently attending to fluctuations in the therapeutic alliance, so as to maximize their flexibility and effectiveness in working with individuals with BPD to improve the client's self-observation.

Given the robust link between alliance and outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011), fostering a positive alliance might be seen as an evidence-based practice (Muran & Barber, 2010). This study extends beyond this, to suggest that it might be fruitful to use case formulation to assist in pre-empting ruptures in the alliance, as suggested by Ryle (1997). Therapists should also be aware of the effect of the context or topic of the session in mediating BPD clients' reflective capacities and use their formulation to inform their understanding of fluctuations in self-reflective capacity. Further studies are needed to examine how to effectively achieve this and to further clarify the relationships between reflection, formulation and the alliance and how they might best be utilized by therapists to enhance outcomes. □

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