CALIFORNIA BAPTIST UNIVERSITY

Cultural Identity in Transference and Countertransference Involving Borderline Personality Disorder

by

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DEDICATION

This dissertation is dedicated to my husband, Eric Estrada, for his endless support and encouragement during the many sleepless nights throughout this process. This dissertation is also dedicated to my mother-in-law Olivia Estrada for her encouragement to complete my doctoral degree in the first place.

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Abstract

Borderline personality disorder (BPD) is a complex disorder characterized by emotional instability, interpersonal and intrapersonal difficulty, and impulsivity. As a result, there are many preconceived notions about those diagnosed with the disorder and what clinical work may entail. One way to conceptualize these preconceived notions is to consider them as a form of countertransference. Clients with BPD are more likely to evoke countertransference reactions from the clinicians that work with them than clients presenting with other disorders. Countertransference reactions in clinical work with the diagnosis may stem from various sources, including transference reactions and cultural identity. The current literature review explores BPD, countertransference, transference, cultural identity, and how these constructs interrelate in clinical work with BPD. Results revealed overall challenges in identifying articles for the present review was the lack of studies jointly focused on the constructs under review. To effectively address the interplay of culture, transference, and countertransference in cases involving BPD it was necessary to draw conclusions by piecing together the findings of studies often not intended to focus on one or more of these variables. Implications for clinical practice and training, and recommended future directions for research will be discussed.

Keywords; *Borderline Personality Disorder, Countertransference, Cultural identity, Transference.*

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CHAPTER 1

INTRODUCTION

One of the best predictors of outcomes within the therapeutic process is the therapeutic working alliance between clinician and client (Hersh, 2008; Gelso, 2011). Furthermore, there are several theoretical orientations and approaches that utilize the therapeutic working alliance as a primary facet of treatment. This is especially the case with treating a disorder such as borderline personality disorder (BPD), found in approximately 1.6% of the general population and 20% of inpatient client psychiatric populations (Cambanis, 2011; Clarkin et al., 2007). Examples of such treatments include dialectical behavioral therapy and transference-focused therapy (Stoffers et al., 2012; Clarkin et al., 2007). Despite the presence of commonly accepted evidence-based treatments for BPD, some myths and stereotypes commonly accompany the diagnosis, which can complicate the treatment provided to these individuals (Hersh, 2008).

A vital facet of the therapeutic relationship is the responses therapist and client have to one another. Collectively these thoughts, impulses, feelings, and behaviors are often called transference (i.e., client responses toward the clinician) and countertransference (i.e., clinician responses to the client). Clinicians who minimize the role that transference and countertransference can play in treating BPD may provide sub-optimal care for these individuals (Hersh, 2008). Moreover, a clinician's unexamined cultural countertransference may negatively impact the therapeutic relationship, especially when these cultural biases are denied and remain unaddressed by the clinician; although the clinician may remain unaware of their countertransference, the biases are frequently perceived by the client (Foster, 1998; Stampley &

Slaght, 2004). Given the role that culture plays in so many elements of daily life, clinicians must maintain awareness of how cultural factors may impact their own biases and countertransference reactions. This particularly applies in therapeutic work with individuals with BPD, as distorted perceptions of the self and others play an important role in the presentation and behaviors associated with the diagnosis (Clarkin et al., 2007). Therefore, clinicians working with BPD may benefit from a summary of how cultural factors have been found to impact the treatment of BPD to increase the likelihood that they provide culturally sensitive care for these clients.

Problem Statement

Healthcare professionals often treat clients with BPD differently than other clients (Warrender, 2015). This may include expectations of relational and clinical difficulties in therapy that can negatively impact treatment (Hersh, 2008). Although limited evidence suggests that clients with BPD may present differently in different cultures (Selby & Joiner, 2009: Jan et al., 2016), this author has found minimal previous research specifically focusing on the impact of the therapist's cultural background in the treatment of clients with BPD.

This literature review aims to explore the impact of a therapist's cultural identity on expressions of therapist countertransference and client transference in psychotherapies involving BPD. A review and critique of existing findings will be presented, along with implications for clinical practice and training and recommended future directions for research.

Search Strategy

Given the dearth of literature specifically addressing cultural experiences of countertransference with BPD, the current search strategy will include terms meant to identify peer-reviewed literature that at least indirectly examines the primary elements of interest in the

current review. Many articles addressed in the current literature review only include culture, transference, and countertransference as secondary variables. Thus, the current author attempted to consolidate the findings and extract meaningful conclusions that can be applied more broadly and directly than the seemingly minor attention given in the extant literature would suggest. The search for recent—2011-2022— peer-reviewed articles was conducted primarily via the California Baptist University (CBU) Annie Gabriel Library online databases. These databases and tools included Academic OneFile, Academic Search Complete, ERIC, Gale, JSTOR, Sage Journals, PubMed, PsycInfo, PsycArticles, Scopus, and PsychNet. Google Scholar was also utilized to locate open-access articles and sources not available directly through the CBU library.

The following core search terms were used to find articles specific to this study: *borderline personality disorder, cultural variation, countertransference, culture,* and *transference*. Variations of these terms were used to ensure detailed search results. To be included in the current review, each source had to meet all the following minimum criteria: a) peer-reviewed publication; b) quantitative or qualitative methodology, c) discuss in some capacity the transference and/or countertransference relationship between clinician and client, and d) address cultural diversity in relation to transference and/or countertransference.

This literature review focused on the experiences of diverse clinicians from a variety of training backgrounds. Resources examining the clinical experiences of psychologists, social workers, marriage and family therapists, professional counselors, and others of varying levels of experience were considered for inclusion in this review. A flow chart detailing article selection is included in Appendix A.

Definitions

Countertransference

Since its first conception in psychology by Freud (1910), countertransference has received a great deal of attention in both clinical and research settings. Freud defined countertransference as the clinician's unconscious reaction to a client's transference. Specifically, Freud (1910) viewed countertransference negatively, as it was believed to represent unresolved conflict from the therapist's life that manifests in session in response to the client. Those advocating for this view tend to see no therapeutic benefit to countertransference.

From Freud's time until the 1950s, this negative, or classical, view of countertransference created some stagnation for research into the topic. However, empirical studies of the construct of countertransference began to emerge, which led to a more totalistic view of countertransference (Cutler, 1958). Countertransference began to be understood as including all of a clinician's reactions toward a client (Little, 1951). Importantly, this totalistic view considers all clinician reactions pertinent for research and deeper understanding. One major limitation of this view is that if all clinician responses to the client are considered countertransference, then none of the clinician's responses are not considered countertransference. This creates difficulty for researchers in identifying and defining specific countertransference behaviors for further study. These early views led to the further development of various viewpoints and interpretations of countertransference. Another perspective emerging from this is complementary countertransference, which views countertransference as the clinician's reactions that complement the clients' way of relating. In this view, clinicians may experience a sense of feeling "pulled" toward behavioral responses by their clients' in-session behavior and reported external experiences (Racker, 1957). Finally, the relational perspective views

countertransference as a mutually constructed experience involving behavior from both the client and clinician throughout therapy (Mitchell, 1993).

These four views of countertransference, including combinations and variations of each, can be found throughout the literature. A more detailed summary of these four views on countertransference and ways that clinicians can manage countertransference can be found in Hayes et al. (2011). For the current literature review, countertransference will be considered from an integrative perspective, combining aspects of all four variations of countertransference noted above. Special emphasis will be placed on countertransference that stems from sources of internal conflict resulting from clinicians' ethnic and racial attitudes, gender attitudes, and worldviews (Stampley & Slaght, 2004). Thus, sources referencing therapists' internal experiences, including conflicts and unresolved personal issues manifesting in sessions, responses to which the therapist feels "pulled" by the client, and interactions co-created by the client and therapist will all be eligible for inclusion if they meet all other inclusion criteria noted in the "Search Strategy" section above.

Transference

Transference has been a topic of exploration for psychology since Freud (1910) coined the term. Although initially thought of as a form of resistance, particularly as used within psychoanalytic theory, transference emerged as an essential agent of healing and change in therapy (Sohtorik İlkmen & Halfon, 2019). A more recent example of this can be found in Transference-Focused Therapy (Clarkin et al., 2007). This theory poses that individuals diagnosed with BPD will display unhealthy interpersonal behaviors with their therapists, like their behaviors in interpersonal relationships outside of therapy (Clarkin et al., 2007). In this

way, transference is an element that can be utilized to gain a deeper understanding of a client's unconscious mind. For the current literature review, transference will be defined as a client's feelings or reactions intended for an important figure or event in their life, but which are instead directed at the clinician (Sohtorik İlkmen & Halfon, 2019).

Borderline Personality Disorder

Adolf Stern first described borderline personality disorder with a group of clients who resisted analytic therapy in 1938 (Paris, 2005). In particular, he suggested that the pathology presented in this type of client is on the border between psychosis and neurosis. Prior to its acceptance in the DSM, the diagnosis was included as a subcategory of personality disorders, labeled as an emotionally unstable personality disorder. Despite recognizing this personality type, it did not gain full recognition in the American Psychiatric Association’s diagnostic classification until the DSM-III (Paris, 2005; APA, 1980). This acceptance of a definition and diagnosis was partly due to Gunderson, whose research operationalized BPD into something measurable through a semi-structured interview (Gunderson, 2009).

Although subtle changes have occurred in the diagnostic criteria for BPD from the DSM-III to the DSM-5-TR, the critical aspects have remained the same (Gunderson, 2009; Paris, 2005). Borderline personality disorder is a complex and multidimensional disorder; therefore, its definition is complex. There are variations in criteria for BPD diagnosis across cultures in the International Classification of Diseases, 10th Revision (ICD-10), the Chinese Classification of Mental Disorders (CCMD), and the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) (Jani et al., 2016). It is important to note that individuals diagnosed with BPD can present with a wide range of symptoms, in addition to the varying presentation of

symptomology across race and ethnicity (Jani et al., 2016). These symptoms can include some overlap with other diagnoses, which has been a leading factor in the controversy in the field regarding the treatment of these individuals and the diagnosis itself. Despite this challenge, there are key elements found in BPD across diagnostic classification systems.

Borderline personality disorder is a chronic condition and is typically first observed in adolescence. It has its highest occurrence in individuals who have endured childhood trauma. Borderline personality disorder is best defined as a disorder characterized by instability (NICE, 2009). This instability is present in the individuals' relationships, mood, behavior, and self-image. There are rapid fluctuations between emotional states, including impulsive and self-harming behaviors (Warrender, 2015). Sources considered for the current review must include participants with formally diagnosed BPD, using any DSM editions from DSM-III through the current version at the time of this review, DSM-5-TR, as these manuals share the common diagnostic features noted above.

Cultural Identity

An essential component in conceptualizing a client's presenting problem is a basic understanding of their cultural background and identity. A clear cultural identity is essential for self-esteem and well-being (Umaña-Taylor et al., 2014). This identity includes understanding group values, norms, and characteristics that impact the individual (Usborne & Taylor, 2010). The cultural identity of the clinician can also affect the therapeutic alliance between client and clinician, which can often be strained when working with clients diagnosed with BPD (Shonfeld-Ringel, 2001; Cambanis, 2012). In addition to cultural identity, sources of countertransference that include race, ethnic attitudes, and gender attitudes that stem from cultural identity or

worldview can impact the working alliance (Stampley & Slaght, 2004). Thus, examining how cultural identity impacts the therapeutic alliance in work with clients diagnosed with BPD is essential.

The most helpful conceptualization of cultural identity is not static, decontextualized, or essentialist; it is dynamic, shifting, and historically embedded (Meca et al., 2017). An individual's cultural identity constantly evolves, as identity involves understanding oneself in relation to others (Meca et al., 2017). Thus, for the purpose of this literature review, cultural identity will be defined as the individual's self-identification as a member of a specified cultural group (or groups), including the behaviors, communication styles, psychology, and sociology of said culture (Hudelson, 2004). Cultural groups will be considered to encompass a wide range of demographic categories self-reported by participants, including but not limited to ethnicity, race, and gender.

Results of the literature review will be grouped according to culture, such that clinicians working with clients who identify with a particular culture may easily find consolidated information regarding the impacts of transference and countertransference within that group. When there is insufficient evidence to draw any meaningful or generalizable conclusions regarding a cultural group, that will be made clear.

A flow chart detailing the article selection process is included as a figure following the completion of the literature review.

CHAPTER 2

LITERATURE REVIEW

Despite the extensive mental health resources utilized in the treatment of and research into BPD, there continues to be considerable suffering for those with the diagnosis. This suffering includes increased mortality and morbidity when compared to the general population. Thus, it becomes crucial to examine how the field understands BPD today, including any misconceptions held about the diagnosis, and how this may be impacting how clinicians approach treatment. These misconceptions include those related to the clinician's cultural experience and the clients' cultural experience.

Borderline Personality Disorder

In order to explore current training related to transference and countertransference associated with BPD, it is important to first describe the diagnosis, including its prevalence, symptomology, and etiology.

Prevalence

Estimates of the prevalence of borderline personality disorder have varied over the years. Some surveys put the prevalence of borderline personality in the United States at 1.6% in the general population (Winsper et l., 2020). The lifetime prevalence is estimated at 5.9% (Winsper et al., 2020). There have been no significant differences between males and females in the general population (Nasiri et al., 2013). However, these numbers change when examining clinical settings. In clinical settings, specifically outpatient and psychiatric settings, there is an 11% prevalence, while in inpatient settings, this number increased to 44% (Winsper et al., 2020).

Other estimates of the prevalence of BPD examine the variables that impact these surveys' results. In the general population, with board community samples, rates of BPD varied from 0.4% to 1.8% (Meaney et al., 2016). In outpatient clinical settings, the prevalence of BPD ranges from 8% to 27%, with BPD being the most common personality disorder. Before 1989, clinical interviews of BPD resulted in a 15% prevalence. However, more current studies, which utilized semi-structured interviews, have reported prevalence rates of 40% to 44% in clinical samples (Meaney et al., 2016; Korzekwa et al., 2008).

Studies examining prevalence rates of BPD across ethnicities and cultures have significantly varied (Newhill et al., 2009). One of the first studies to examine rates of endorsement of BPD across cultures found that there were significantly higher rates of BPD in Hispanic participants compared to White and African American participants. A review of 14 studies examining differences of BPD among racial groups found evidence that BPD was less prevalent among African American participants when compared to White participants (Selby & Joiner, 2008). However, these results differ when examined in the broader populations. Specifically, African Americans were more likely to be diagnosed with BPD than white Americans (Newhill et al., 2009).

Symptoms

The DSM-5 conceptualizes BPD as a diagnosis characterized by marked impulsivity and instability within interpersonal relationships, emotion regulation, affect, and self-image (American Psychiatric Association, 2013). A prominent feature of the disorder is an extreme fear of abandonment, with frantic efforts to avoid it. This results in pervasive patterns of instability in relationships due to the cycles of extreme hate and extreme admiration for others in their lives.

Self-harm and suicidal ideation are common experiences for many individuals with BPD due to intense feelings of emptiness. Although these persistent threats of self-harm and suicide may sometimes represent authentic intentions, they often represent frantic and impulsive efforts to avoid abandonment.

The impulsivity associated with BPD can manifest in various ways, including substance abuse, reckless driving, gambling, unsafe sex, impulsive spending, and binge eating. Those diagnosed with BPD tend to have a distorted sense of self, evidenced in their lives by dramatic changes in goals, values, and interests. The DSM-5 further explains that those with BPD have challenges with managing emotions, specifically difficult emotions (APA, 2013). They will often express inappropriate or disproportionate emotions, such as anger. Those with BPD may have dissociative experiences and paranoia when under extreme stress. One of the cardinal features of BPD, and any personality disorder, is the enduring nature of the diagnosis. According to the DSM-5 criteria, these behavior patterns must have been persistent, pervasive, and present in early adulthood and in various settings (APA, 2013).

Although the DSM-5 offers a broadly accepted set of criteria by which an individual is diagnosed with BPD, the symptomology of the disorder can vary across age, gender, and ethnicity. Beginning with age considerations of those diagnosed with BPD, the diagnosis may not be as pervasive and long-standing as originally understood (Frías et al., 2017). Current ongoing longitudinal and cross-sectional research has resulted in the discovery that self-harm, anger, and impulsiveness diminish over time, especially within geriatric populations. This suggests that an individual's maturation may affect the lifelong prevalence of symptoms present in those diagnosed with BPD (Frías et al., 2017).

Few researchers have examined variations in the symptomology of BPD. One way researchers have chosen to examine these differences is through factor analysis (Selby et al., 2008). In one such study, four significant factors emerged across ethnic groups of Caucasians, African Americans, and Hispanics: distributed relatedness, as well as affect, behavioral, and cognitive dysregulation. The cohesive results of these four factors across ethnic groups demonstrate a consistency in diagnosis despite psychological and social-cultural influences in each group (Selby et al., 2008).

However, there were some differences among groups. There were higher rates of affective and behavioral dysregulation among Caucasian participants compared to Hispanic and African American participants (Selby et al., 2008). Another variation among groups was the symptom of impulsivity, which loaded on different factors for each ethnic group. Impulsivity loaded onto cognitive disturbance factors for Caucasians, while it loaded on distributed relatedness for Hispanics and affect dysregulation for African Americans, (Selby et al., 2008). It appears that symptomology and the sources of symptomology associated with BPD may differ among ethnic groups and thus is an important consideration when examining the diagnosis and treatment of BPD.

Etiology

Much like the diagnostic characteristics of BPD have developed over time, so have the etiological understandings of the diagnosis. More specifically, many have extensively explored and reviewed psychological factors of etiology. Early pioneers in the research of BPD utilized developmental theories, including object relations, to explain the occurrence of the disorder (Kernberg, 1967). This approach utilized the psychodynamic theory of object relations and

focused on the separation-individuation state in which a child develops autonomy from their mother. It was theorized that children who did not achieve successful separation and individualization would develop characteristics associated with BPD.

These attempts at understanding the etiology of BPD fell short and were often vague. Later clarification came from examinations of the possible relationship between the diagnosis, sexual abuse, and childhood trauma (Herman & van der Kolk 1987, 1989: Herman et al., 1989). The theory was that individuals who suffer from BPD were more likely to have been traumatized in childhood. This was later confirmed in several studies, that concluded there was a high incidence of child abuse in these individuals, which included physical, sexual, and emotional abuse, witnessing domestic violence, and neglect. These findings led to the theorization that BPD is more than a personality disorder; instead, it is a multifaceted disorder that stems from severe trauma (Herman, 1992). Furthermore, current data examining traumatic experiences in children indicate that these early experiences may alter the development of the brain, resulting in chronic neurotransmitter abnormalities, and structural changes, resulting in affect regulation problems. These theories coalesced over time to create a conceptual framework that BPD is primarily a disorder of emotional dysregulation that stems from a combination of genetic predispositions and the childhood environment. Other scholars, such as Peter Fonagy and Anthony Bateman, theorize that the disorder develops due to a lack of resilience against psychological stressors (Fonagy et al., 2017), while Marsha Linehan theorizes that BPD results from interactions between genetic vulnerabilities and a consistently invalidating environment (Crowell et al., 2009).

Although most theories of BPD's etiology focus on psychological and environmental factors, there are some speculative biological theories exploring the possible role of various

genetic and constitutional factors to make sense of the development of various psychological conditions. Specifically, biological theories began to speculate that certain genetic factors that influence the central nervous system may lead to deficits in a child's ability to grasp early interpersonal experiences (Skoglund et al., 2021). It is theorized that even children raised in healthier homes may not adequately develop emotional intelligence from their interpersonal interactions due to these factors. Twin studies demonstrate a higher concordance of BPD for monozygotic twins compared to dizygotic twins. Additional twin studies have shown over 50% heritability compared to major depressive disorder, which has a 40% heritability (Skoglund et al., 2021).

Other biological theories examine how genetic factors, temperament styles, and parent interpersonal interactions influence the development of BPD (Bozzatello et al., 2021). In relation to BPD, children who cry excessively may be more sensitive to mild distress and are difficult to soothe. These children may unknowingly evoke negative interpersonal reactions from caregivers, such as withdrawal of affection or frustration. The interaction of the child's biological temperament predisposition and the parents' reaction to the child may leave the child more prone to have problems with emotional and psychological growth (Bozzatello et al., 2021).

Additionally, neuroimaging studies have shown identifiable differences in the medial temporal lobe, amygdala, and hippocampus of those diagnosed with BPD relative to the general population (Baird et al., 2005). These findings offer a partial explanation as to why individuals with BPD may misattribute negative emotions such as fear, anger, and disgust to neutral faces while simultaneously having appropriate responses to the perception of happy and upset faces. Those with BPD may also have impaired neuropeptide functioning, specifically serotonin (Baird et al., 2005).

Treatment

Prior to 1987, the primary forms of treatment for BPD were pharmacological methods and psychoanalytic and cognitive behavioral approaches (Stoffers et al., 2012). These approaches tended to fall short when addressing treatment issues specific to BPD. Cognitive behavioral approaches focused on changes to thoughts, behaviors, and feelings, while psychodynamic approaches focused on insight and acceptance. This resulted in individuals receiving this treatment either from ignoring the critical need for change or feeling pressured, criticized, and invalidated when forced to change (Stoffers et al., 2012). These shortcomings in treatment led Marsha Linehan to explore a different approach to treating BPD that created a balance between these two concepts. Then emerged one of the most widely used and efficacious treatment modalities specifically for BPD, Dialectical Behavior Therapy (DBT) (Koerner & Linehan, 2000).

The primary mechanisms of change in DBT are reductions in emotion dysregulation and increasing behavioral skills (Lynch et al., 2006). The theoretical basis of DBT is based on the understanding that the disruptions in the individual's behavior, cognitions, and emotions are associated with the dysregulation of emotions and maladaptive methods of attempting to change these dysregulated emotions (Shearin & Linehan, 1994; Robins & Chapman, 2004). So, the focus of DBT becomes how one can modify the individual's emotion "system." DBT utilizes several processes to achieve this modification including mindfulness skills, behavioral targeting, behavioral chain analysis, dialects, opposite action, and validations (Shearin & Linehan, 1994; Robins & Chapman, 2004).

DBT is currently one of the most well-established treatment modalities for BPD, as evidenced by its strong support in the clinical research literature (Kliem et al., 2010). According

to Division 12 of the American Psychological Association, the Society of Clinical Psychology, DBT had strong research support as of 1998. This finding continues to be reviewed, as evidenced by a treatment re-evaluation that began in 2015 (Chambless et al., 1998; Tolin et al., 2015). Previous support for DBT treatments came from seven different randomized clinical control trials conducted by four independent teams of researchers.

Although DBT is the most well-known and widely utilized approach to the treatment of BPD, there are several other treatment approaches, each with varying degrees of research support (Clarkin et al., 2007). One such approach is Transference-Focused Therapy or TFT. A primary task for the TFT therapist involves focusing on the client's perceptions of interpersonal interactions (Giesen-Bloo et al., 2006). In particular, the treatment focuses on the concept of transference and the extreme experiences of another person (object) as either good or bad that manifest within the transference.

Transference for the TFP therapist is best understood as the client's perception of their interpersonal interactions with their therapist. Modifying the client's transference is viewed as the primary change mechanism. It is believed that the individual diagnosed with BPD will display similar patterns of behavior with their therapist as they would with others in their lives. Thus, therapists will conduct sessions in ways that create opportunities to experience the therapist in new, accurate, and consistent ways. (Giesen-Bloo et al., 2006). This type of change is often referred to as a corrective experience; it focuses on using these interpersonal interactions to modify views of the self that are increasingly stable and reflective of how others likely view the client and create new self-control methods.

The current research support for TFT is unusual in that it has strong, yet controversial, support. This is due to somewhat conflicting findings within various meta-analyses from

multiple teams of researchers (Giesen-Bloo et al., 2006; Clarkin et al., 2007; Doering et al., 2010). TFP was found to be efficacious in randomized control trials and just as efficacious as DBT and other approaches (Clarkin et al., 2007). However, it was found to not perform as well as other approaches to treatment for BPD in another study (Doering et al., 2010). More research is needed to clarify the approach's efficacy further.

Two additional treatment modalities for BPD include Schema-Focused Therapy (SFT) and Mentalization-Based Treatment (Giesen-Bloo et al., 2006). SFT is a cognitive behavioral approach that integrates techniques from other theoretical models (Young et al., 2003). Therapists who utilize this theoretical model aim to change a person’s schemas, or life patterns, utilizing emotion-, behavior-, and cognition-focused techniques. As with TFP, this model utilizes the therapeutic relationship. However, it also utilizes individual traumatic childhood experiences and daily life interactions as the mechanisms of therapeutic change (Young et al., 2003).

Mentalization Based Treatment, or MBT, is a time-limited approach to treatment, utilizing the process of mentalization (Bateman & Fonagy, 2001). Mentalization is the process by which individuals form beliefs about the mental processes of other individuals they interact with and how that influences their own mental states, which then leads to difficulties with emotion regulation, self-image, and impulsivity. The approach utilizes structured mentalization interventions to address these difficulties. Both SFT and MBT show modest efficacy in the current literature and therefore are not as empirically supported as DBT and TFT (Bateman & Fonagay, 2009; Bateman, Psych, & Fonagy, 2008).

Transference

The definition and understanding of transference have varied over time, with the definition often varying by theoretical approach. For this literature review, transference will be defined as an unconscious process of ascribing representational aspects of foundational relationships to another person in conscious and unconscious ways (Levy, 2009). Transference often occurs in the context of a therapeutic relationship but can also be present in everyday relationships. Although some aspects of this transference stem from actual events in the interpersonal relationship, distorted interpretations or cognitive biases can influence its presentation (Prasko et al., 2022).

Evolution of Transference

The first mention of transference appeared in the revolutionary writings of Freud in 1888. At the beginning of his research and exploration of what would later become the psychoanalytic theoretical approach, he referred to transference as a transfer of feelings that an individual had with one person onto an entirely different person (Almond, 2011). Transference was further identified in studies that explored the phenomenon of hysteria in which Freud identified transference as an unconscious and false connection. The false connection is based on a person in the individual's past that produced unconscious ideas and feelings about the clinician. Furthermore, and applicable to more than just the physician, Freud explained that transference is a prototype based on the interpersonal interactions throughout one's life that are carried onto and into other interpersonal relationships (Almond, 2011).

Freud further identified that these preconceived prototypes are partly conscious and partially unconscious. In particular, he theorized that the unconscious part of transference was

challenging to change (Almond, 2011). Therefore, he began to identify transference as a form of resistance in the therapeutic relationship, positing that resolving the transference would resolve the client's neurosis. By the end of his life, and in his last explorations of this concept, Freud believed that transference could be utilized as the primary mechanism of therapeutic change (Almond, 2011).

Melanie Klein explored and developed the concept of transference after Freud, focusing on the interactions that transference caused in therapeutic relationships. Freud theorized that the transference distortion between the therapist and the client is based on tangible aspects of the relationship that could relate to the root of the transference (Levy et al., 2012). Klein took a different approach and theorized that the individual might behave so that the therapist may begin to act or react in the same way that the original source of the transference–a primary attachment figure–behaved. Essentially, interpersonal pressure creates countertransference within the therapist. Later analysts and researchers would further clarify the concept of transference and produce research supporting its importance (Levy et al., 2012).

Evidence Supporting the Concept

Significant research areas have explored transference and how it interacts in therapeutic relationships, specifically focusing on cognitive and social psychology, psychotherapy processes, and neuroscience. In each of these areas of research into transference concepts, there are various goals and focuses of the research.

The current trends in social and cognitive research have focused on the work of a few key researchers. These teams have produced and refined a way to address transference in therapy in two basic sessions (Andersen & Berk, 1998; Andersen et al., 1995; Andersen, Glassman, &

Gold, 1998). The first session consists of the individual providing descriptions and their existing understanding of significant relationships. The second session then involves describing strangers, usually provided through photos or narratives about a stranger. The goal of this session is to help individuals recognize their tendency to misattribute characteristics of the significant relationships in their lives to strangers. This research supports the idea that while transference can occur in everyday relationships, it is only sometimes distorted and misattributed.

Social-Cognitive research explores transference as a dynamic concept, as Freud suggested, and explains how it is not simply a cognitive bias (Levy et al., 2012). In particular, attachment theorists have examined how past romantic interpersonal attachment figures have influenced interpretations of new partners. Their research confirmed previous findings that preconceived notions of past partners are projected onto new partners. However, how this transference is represented depends on the attachment style of the individual (Andersen et al., 2006). Those with secure attachment styles were more likely to attribute positive descriptions and traits to new partners. In contrast, those with insecure (anxious and avoidant) attachment styles were more likely to attribute negative traits to new partners. Furthermore, those with these unhealthy attachment styles presented with dismissive, avoidant, or anxious interactions with these new romantic partners (Brumbaugh & Fraley, 2006; 2007). Other research examining transference within the theoretical concept of attachment theory found that those with secure attachment styles were more likely to be unbiased in their interpersonal interactions. In contrast, those with other attachment styles were more likely to exhibit biases. They had the tendency to view others in the same negative ways in which they viewed themselves interpersonally (Andersen & Saribay, 2005)

Psychotherapy research focuses on transference within therapeutic settings, formulating the idea that transference changes over time, specifically more negative transference. A study re-examined the transference of inpatient adolescents with severe diagnoses, including borderline personality disorder, every six months in treatment (Blatt et al., 1996). These examinations of transference included the view of self, the therapist, and significant relationships in their lives. At the onset of therapy, the therapist was generally seen as positive and admired, while self and significant relationships were seen as negative. After six months of treatment, all transference interactions were seen as negative. However, an additional six months later, each interaction was judged as being less biased and was seen in separate, more objective ways. These results confirm what Freud theorized in that psychotherapy can influence transference concepts, and transference can be used as a mechanism of change.

These explorations of transference helped propel the conceptualization of transference, first presented by Freud in 1888, into the current clinical era. The above recent findings validate the interpretations of transference by early researchers and point to the importance of transference in everyday interactions and therapeutic relationships. They reinforce the importance of transference as a construct and how it can be utilized as a mechanism of change, especially within diagnoses that may more likely have more negative interpersonal interactions associated with transference.

It is important to note that there are various ways transference can manifest in the therapeutic relationship, including positive transference, negative transference, and sexualized transference. Some individuals may view their clinician in an overly optimistic light, producing emotions of love and care and an overall view that the therapist is a trusting figure. This overly positive transference may sometimes lead to sexualized transference. This involves fantasies the

client may have regarding the clinician that are romantic, sensual, and sexual in nature (Landonson & Welton, 2007). A more commonly studied manifestation of transference is negative transference. An example of negative transference is a client who experiences thoughts of distrust toward the therapist, which then leads the client to distance themselves and believe that the therapist is an enemy. Occasionally, a client could vacillate between these types of transference in a therapeutic setting, particularly for those diagnosed with BPD (Levy et al., 2012).

Why Transference Matters for BPD

As noted above, individuals with BPD are likely to have inconsistent interpersonal relationships resulting from many factors (Frías et al., 2017). These relationship challenges can often present as transference toward the clinician in therapeutic settings. It is theorized that those with BPD have difficulty accurately perceiving themselves and others while simultaneously dealing with negative emotions such as aggression and para-suicidality (Koerner & Linehan, 2000). This representation of the self and others tends to have misinterpretations, and those with BPD have difficulty integrating interpretations and representations (Koerner & Linehan, 2000). As it is theorized that BPD may stem from trauma, these representations of self and others may have split early in life as a form of defense (Herman & van der Kolk 1987, 1989: Herman et al., 1989). Therefore, strongly negative, overprocessed representations will overwhelm positive emotions and representations of the self later in life. There is a significant division between negative and positive representations of self and others (Young et al., 2003). Thus, negative transference interactions in life and therapeutic settings become an important exploration aspect for those with BPD (Giesen-Bloo et al., 2006).

The theory that best conceptualizes this phenomenon in clients with BPD is TFT. In TFT, it is theorized that early experiences have resulted in a major split in representations of self and others between negative representations and idealized positive representations (Clarkin et al., 2007). This split results in a polarization of these representations and distortions of interactions with self and others. The goal of TFT is to first integrate these polarized splits, then to increase the individual's awareness and develop a more enriched, flexible, and realistic view of self and others. Thus, resulting in improvements in transference interactions (Clarkin et al., 2007).

Countertransference

Countertransference has been defined in various ways as the conceptualization of countertransference has evolved. These unresolved conflicts may be conscious or unconscious, come from outside personal experiences, or may be a reaction to the client's transference (Hayes et al., 2011). These unresolved conflicts do not encompass all therapist interactions and usually refer to those unresolved conflicts that require consultation and personal therapy and help to understand the interpersonal interactions of the client (Hayes et al., 2011). For the purposes of the current literature review, countertransference will be defined broadly as a clinician's interpersonal reactions to a client, often, but not always, originating in unresolved conflicts from the clinician's personal life and/or interactions with the client.

Evolution of Countertransference

As with the concept of transference, the first writings of countertransference come from the writings of Freud. Throughout these writings, it was theorized that countertransference originates in unresolved personal issues within the therapist; as a result, it is necessary to overcome countertransference to best serve the client (Holmes, 2014). This conceptualization

was well accepted within the psychotherapeutic community from the early 1900s until approximately 1950 (Holmes, 2014).

Over time, the meaning of countertransference in the therapeutic setting changed and evolved into something more. Paul Heimann suggested that this reaction toward the client was not only some obstacle related to the clinician's past, but instead it could be utilized as an essential gauge of the client's understanding of their world (Holmes, 2014). Simultaneously, Winnicott (1994) suggested that there was an underlying usefulness to countertransference and further suggested that it has less to do with the clinician and more with the client. He theorized that some individuals could act in such a way that they evoke adverse reactions from everyone with whom they interact, including the clinician. This can result in individuals reacting with strong negative emotions. He further argued that this had little to do with the therapist's unresolved conflict and more with the client's negative pattern of behavior and interpersonal relationships (Winnicott, 1994).

Countertransference is generally accepted today as a source of helpful information about the client for the therapist. In contrast to perspectives described by some of the previously discussed theories, the subjective worldview of the therapist can influence the interpretations of countertransference interactions. Therefore, current countertransference understandings are moving toward that of a phenomenon co-created by both client and clinician (Hayes & Gelso, 2001).

Subsequent to broadening the definition of countertransference came a broadening in understanding of what causes countertransference to occur within the clinician. These include client attributes, therapy content, and the therapy process (Hayes et al., 1998). Client attributes related to countertransference typically involve physical appearance, as far as the research is

concerned. Research into this type of countertransference has found that physical attributes such as clothing, facial features, race, and ethnicity can influence countertransference reactions. It is essential to note, however, that these reactions are not based objectively on these physical attributes but are related to the therapist's conscious or unconscious preconceived association with the physical feature (Hayes et al., 1998).

A countertransference area that has received much focus within research is content-related countertransference reactions. Currently, research indicates that when the content of the therapy is related to content that is unresolved in a clinician's personal life, there is a greater chance of countertransference interactions (Hayes et al., 1998). This is where therapeutic injuries to rapport can most often occur. The clinician may react to the invoked countertransference with unconscious efforts to protect themselves from perceived threats. This can manifest as avoiding further explorations of the content presented by the client or dismissal of feelings and emotions associated with the content.

The therapy process is the final area of countertransference in the therapeutic relationship. This type of countertransference operates outside the conscious awareness of the clinician more so than previously discussed forms of countertransference; it involves how the client and clinician interact, what happens between them, and what happens to them in the therapeutic relationship (Hayes et al., 1998). Countertransference in the therapy process includes the happenings that occur in, between, and across sessions. For example, within a single session, events could include strong displays of emotion from the client, while between-session events could include missed sessions, and overall process events could include individual approaches to insurance issues and progress assessments. All these events could invoke countertransference interactions (Hayes et al., 1998).

Countertransference may manifest in numerous ways in the clinician's life, both professionally and privately. Countertransference could manifest internally through private thoughts and feelings and result in various behaviors. These may be best categorized as affective, cognitive, and behavioral countertransference reactions. Further discussion of these countertransference manifestations is included below.

Affective Countertransference. A majority of research into affective countertransference has focused on clinician anxiety (Hayes & Gelso, 1991, 1993; Hayes et al., 1998). Although a long-held belief is that clinician anxiety is a warning signal of pending danger in the therapeutic setting. However, research suggests that this occurrence is a predictable response when a clinician has unresolved issues leading to countertransference. Evidence has suggested that clinicians more likely to display anxiety are also more likely to have countertransference reactions than a therapist who does not exhibit signs of anxiety (Hayes & Gelso, 1991, 1993; Hayes et al., 1998). These findings highlight the importance of introspection related to the origins of countertransference emotions.

Cognitive Countertransference. Cognitive countertransference reactions are often related to cognitive distortions on the part of the clinician. Similar to transference in clients, clinicians may experience distorted perceptions of clients and clinical material discussed in sessions. These manifestations were some of the first types of countertransference explored by Cutler (Cutler, 1958). His studies found that therapists tended to exaggerate and simultaneously underestimated the amount of time a client spent on content related to any unresolved issues within the clinician. Further studies examined this in relation to unresolved conflicts involving sexuality and provocative material, finding similar results. Comparatively, research exploring feelings clinicians held for their clients found that clinicians had a greater tendency to perceive clients to

be most like the clinician when they liked a client and found the opposite when the clinician disliked the client (Hayes et al., 1998). Other aspects of cognitive countertransference that have been explored are its influence on therapeutic decisions. Some research has pointed to findings indicating that treatment decisions can be changed when clinician-unresolved conflicts arise in the therapeutic relationship. Some clinicians may end therapy altogether when these issues arise (Lecours et al., 1995; Normandin & Bouchard, 1993). The consensus is that countertransference involving cognitive distortions may affect the clinician's ability to be objective.

Behavioral Countertransference. Behavioral manifestations of countertransference may be demonstrated in two opposing ways: avoidant behavior and overinvolvement behaviors. Countertransference research acknowledges that there is a consistent therapeutic question of appropriate emotional distance from the client. However, countertransference can influence how this decision of emotional distance is made.

The clinician can often display countertransference with avoidance and under-involvement with their clients, which are influenced by numerous variables (Hayes et al., 2011). Current research relates this reaction to clinician empathy and the awareness of their feelings related to countertransference (Linn-Walton & Pardasani 2014). On the opposing end of the spectrum, the therapist can often exhibit countertransference by over-involving themselves emotionally with the client. Although the causes of these countertransference interactions are still being explored, current research points to clinician gender as an influential factor. Male clinicians are more likely to distance and under-involve themselves in response to countertransference, while female clinicians are more likely to over-involve themselves (Baumann et al., 2020).

Managing Countertransference

Examining these manifestations of countertransference has helped develop a framework that can guide clinicians to address countertransference. Addressing and managing countertransference can happen in two primary ways: first, reduce the likelihood of countertransference, and second, reduce any adverse effect on the therapeutic relationship once countertransference is identified (Hayes & Gelso, 2001; Hayes et al., 2011).

The first way to manage countertransference is to utilize more preventative measures. Current research suggests that clinicians with fewer unresolved personal conflicts are less likely to have countertransference reactions (Hayes & Gelso, 2001; Hayes et al., 2011). Numerous clinical qualities are associated with fewer countertransference interactions, including self-integration, anxiety management, empathy skills, self-insight, and conceptual skills. Self-awareness and the ability to conceptualize one's work through a theoretical framework have led to reductions in countertransference reactions, while self-awareness appears to be the leading preventative measure of countertransference reactions (Prasko et al., 2022).

Current research has evolved to recognize that even some of the best clinicians will experience countertransference and attempt to break the taboo nature of countertransference reactions. Instead, it points to the necessity of balance in countertransference, in that the clinician is not blunted and overwhelmed by the countertransference reactions (Gabbard, 2020; Prasko et al., 2022). This balance is best achieved through the implementation of self-insight and self-integration through reflection and consultation. However, it is important to note that the implementation of these strategies depends on the specifics of the situation.

Why Countertransference Matters for BPD

As noted in early research into the concept, countertransference can occur due to the negative emotions invoked by the client's actions. As clients diagnosed with BPD tend to experience challenges in their interpersonal relationships, it stands to reason that countertransference may be more likely to occur when working with these clients than with clients presenting with most other diagnoses.

Historically, individuals diagnosed with BPD have been associated with negative countertransference interactions with clinicians (Liebman & Burnette, 2013). Early research into the concept indicated clinicians perceive individuals with BPD as more hostile and dominant (McIntyre & Schwartz, 1998). As more research into the concept of countertransference developed, including countertransference related to BPD, this notion was further confirmed (Bhola & Mehrotra, 2021).

Countertransference in work with individuals with BPD can manifest in a variety of ways in the therapeutic relationship. In clinical training, clinicians are educated on the complexities of working with these individuals, including their strong interpersonal interactions and patterns of behavior (Teyber & Teyber, 2010). This training may assist students in remaining curious about clients and open to the many ways their clients may present in a session. Despite this training, client behavior in session can be overwhelming, and students may struggle to appropriately diagnose and respond to transference and acting out behavior from clients. In particular, individuals with BPD may be more likely than other clients to have emotional outbursts and inconsistencies in therapy attendance due to previous negative patterns of behavior (Bhola & Mehrotra. 2021). Additionally, individuals with BPD may be more likely to bring up content related to trauma and negative experiences that may relate to unresolved conflicts in the

clinicians' personal lives (Bhola & Mehrotra. 2021). The source of countertransference with the individual's BPD can come from multiple directions. As a result, the ways in which countertransference manifests, such as therapeutic withdrawal and distancing from the clinicians, can result in more negative therapeutic outcomes. These adverse outcomes could be as simple as an injury to the rapport, which can be overly exaggerated and misinterpreted by the individual with BPD. These rapport injuries could further trigger feelings of abandonment, resulting in irreversible damage to the therapeutic relationship and even termination of services (Bhola & Mehrotra. 2021).

Although previous research has focused on these overly negative countertransference reactions in working with individuals with BPD, overly positive countertransference interactions have been explored in another research (Cambanis, 2012). Some clinicians have overly positive countertransference reactions to individuals with BPD, including feelings of warmth, nurturance, and even anger at people who have psychologically injured the individual. These overly positive countertransference interactions have also included feeling that the client is their favorite, a sense of therapeutic optimism, and seeing the client as special relative to other clients (Cambanis, 2012).

Although research tends to focus on how negative countertransference can affect therapeutic outcomes, overly positive reactions can negatively impact outcomes. In addition to therapeutic over-involvement, positive countertransference could result in losing objectivity. Examinations of countertransference in work with BPD have produced both overly positive and negative countertransference reactions, including feeling helpless, inadequate, overwhelmed, disorganized, over-involved, and treating the client with favoritism (Cambanis, 2012). It is clear that therapists who lack self-awareness and self-integration and who have unresolved conflicts

within their personal life are especially vulnerable to experiencing a variety of countertransference feelings when working with clients diagnosed with BPD.

A common theme in the research examining countertransference reactions involving BPD is how clinician experience affects the amount of countertransference presented. Findings from several studies support the idea that the more experience a clinician has with BPD, the less negative and overall countertransference interactions are present (Liebman & Burnette, 2013). The more a clinician is exposed to individuals with BPD, the less intense and fewer countertransference reactions are (Liebman & Burnette, 2013). Although this is not limited to clinicians who work with BPD, it is essential to consider why this occurs, as BPD is more likely to evoke negative countertransference interactions.

Cultural Applications

In the therapeutic relationship, the therapist and the client attend to numerous indirect and direct communication cues. This includes not just the content of what each person says but the way in which each communicates as well. For participants in therapy, be they client or clinician, the cues attended to may influence the transference and countertransference of each experience. A clinician, for example, may attend to cues that assist in identifying discrepancies and deviations from what may be considered normal, healthy, or adaptive behavior. When individuals deviate from socially acceptable behavior, their behavior may be considered to represent psychopathology. However, in an intercultural therapeutic relationship, attending to culturally influenced cues that deviate from the clinician's or the dominant culture's expectations may lead to over or under-diagnosis or countertransference that may influence therapeutic outcomes.

Transference

Transference can find its origins in a variety of sources, from early foundations of relationships and cultural influences (Prasko et al., 2022). There are significant dropout rates in intercultural therapeutic relationships with indications that this may be due to unaddressed and ignored transference involving culture and race (de Haan et al., 2018). This cultural transference can present in various ways, including those perceived as negative. It may be best understood as unconscious or conscious distortions related to culture that display as interpersonal behaviors in response to the therapist. These behaviors result from the client's direct and indirect experiences with people who are a part of the therapist's cultural group (Berger et al., 2014).

Cultural transference can occur when the client identifies with a minority or majority group. Transference for the client who identifies as part of a minority group is related to the perception of the therapist's racial group and the authority from this assumed group (Comas-Dıas & Jacobsen, 1991). These assumptions result in positive and negative transference issues related to racial identity. The client may make assumptions based on their perception of the therapist's racial identity, and these can result in distortions related to past traumas (Helms & Cook, 1999). Essentially, the therapist may represent past traumas the client has experienced related to race, which may involve socioeconomic status, attitudes, oppression, and traditions commonly associated with their racial group. Moreover, the client may perceive the therapist as more experienced and expect more from the therapist due to the perceived racial identity. For example, a client may assume that a therapist who is perceived to be White or White-passing has more authority or knowledge in their given specialty.

Transference can also occur when the client is a part of the majority group and the therapist is part of a minority group (Gailly, 2003). In this intercultural therapeutic interaction,

transference can present through experiences of fear, disdain, superiority, and even comfort. For example, an individual from a majority group who is an outcast in their family of origin may feel as if a therapist from a minority group is the only one who can understand their experience. This can result in the client feeling as though the therapist is safe and caring, but this can also result in the client viewing the therapist as someone who is there to "serve" them (Helms & Cook, 1999). These different transference reactions can be influenced by the gender of the clinician as well. For example, a client from a male-dominant culture may attribute more authority to a male clinician than a female clinician.

Countertransference

Some evidence indicates that unresolved conflict may be associated with preconceived notions about cultures and ethnicities (Unger, 2012; Ford et al., 2015). These unresolved conflicts related to culture and race may be further associated with cultural conditioning. The way in which a clinician conceptualizes and understands factors of cultural conditioning, including assumptions, values, attitudes, stereotypes, and worldviews, may greatly influence the client.

As of 2018, the majority of psychologists in the United States identify as White, approximately 79%, while 10% identify as Hispanic or Latino, 4.7% identify as Black or African American, and 4.2% identify as Asian (Linet al., 2018). In comparison, the US Census data from 2020 indicates that 57.8% of Americans identify as White, 18.7% as Hispanic or Latino, and 12.1% as Black or African American (US Census Bureau, 2020). While Lin et al. (2018) focused their research on psychologists, the research highlights the importance of examining these identity differences, even if considering clinicians from different training backgrounds. These

data regarding the racial identity of psychologists highlight the importance of identifying cultural countertransference, especially for White therapists involved in intercultural therapies. Countertransference in intercultural therapies can be the result of lifelong efforts to avoid complex issues related to immigration, race, and cultural differences. This can result in unconscious efforts to avoid uncomfortable and complex emotions which manifest in several ways (Comas-Dıas & Jacobsen, 1991; Gailly, 2003; Gorkin,1996; Holmes, 1992).

The first way in which this countertransference manifests for the White therapist involved in interracial therapy is through viewing the client as exotic (Qureshi & Collazos, 2011). This is best explained as the therapist viewing the client as "other," and this other represents a foreign or exotic culture. This results in a majority of the session focusing on interviewing the client as if the therapist were an anthropologist rather than focusing on therapeutic interventions and mental health.

Intercultural countertransference can manifest as the therapist viewing the client as "the White man's burden" (Qureshi & Collazos, 2011). This results in the therapist feeling as if the disadvantages of another cultural group are their responsibility as the White therapist. The therapist then unconsciously views themselves as part of a more advanced culture, and the client is part of an "inferior" culture.

Intercultural countertransference can also present as variations of colorblindness (Qureshi & Collazos, 2011). Colorblind countertransference denies the importance and relevance of race, racism, and cultural differences. The therapist will assert the idea that racism is an issue of the past or in other countries, and that all clients, regardless of race and ethnicity, are part of the human race. Colorblindness countertransference can also present as refusing to see the client as a cultural being and putting forth the idea that the therapist sees the client as they "really are." This

can minimize the importance of cultural identity and leaves the therapist open to underestimating their own unresolved issues related to cultural differences.

One additional way intercultural countertransference can manifest is overt and less unconscious than the others discussed (Qureshi & Collazos, 2011). In this form of countertransference, the therapist will view the client's racial or cultural group as the "problem." This is best explained within the statement stem, "I am not racist but…." If an individual uses this type of phrasing, it may be because they are trying to excuse away a misconception that they know is rooted in racism. In the case of countertransference, the therapist views some aspect of the client's cultural or racial group as the root of the distress in their lives. It becomes a more overt and direct expression of intercultural countertransference.

BPD Differences Across Cultures

The functioning of an individual's personality can be significantly influenced by the cultural context in which the individual exists (Bhugra & Becker, 2005). Social, family, and religious values, traditions, and practices of varying cultures greatly influence personality features. Additionally, the culture to which an individual belongs can significantly influence whether a behavior is considered acceptable and what is considered a deficit or socially unacceptable (Bhugra & Becker, 2005). There are inconsistencies across cultures when attempting to define what is considered healthy development and well-being (Leighton & Hughes, 2005). There are variations in acceptance, flexibility, openness, and containment of personality differences. While some cultures may pay less attention to personality differences, others may be able to contain them with cultural and subcultural units (Leighton & Hughes, 2005). When personality differences are less accepted, it can easily lead to conflicts and feelings

of rejection, significantly affecting mental health and well-being (Leighton & Hughes, 2005). Some cultures may be more likely to encourage and promote personality traits and patterns, while others may devalue, suppress, or ignore these traits (Leighton & Hughes, 2005).

This is especially true when comparing the development of BPD in individualistic cultures versus collectivistic cultures. Moreover, there are difficulties in identifying global guidelines for identifying and treating personality disorders such as BPD. Although much of the well-established diagnostic understandings and treatments for BPD have been explored in Western countries and worldviews, it is crucial to examine understandings of BPD in other cultures (Ronningstam et al., 2018). These diagnostic understandings are explored in more depth in the following sections.

BPD is a controversial diagnosis in countries with Eastern worldviews, particularly China, partly due to how the diagnosis is classified in the DSM-5 when compared to the Chinese Classification of Mental Disorders. The Chinese psychiatric communities contend that criteria are inappropriate within the context of Chinese culture, such as fear of abandonment and examples of impulsivity (Ronningstam et al., 2018). Ronningstam et al. (2018) suggest that this is likely due to collectivistic cultures' tremendous value on community, collective identity, and relationships. However, there is evidence in the research that suggests a certain level of BPD prevalence in Chinese culture and across Asia (Kim et al., 2001). The prevalence of BPD in China specifically ranges from 1% in college students to 8.4% in high school populations. Ranges of prevalence in clinical settings are from 1.3% to 7.1%. These numbers vary across countries within the continent. For example, the prevalence of BPD in Southeast Asia is 13% in outpatient and inpatient settings (Kim et al., 2001). While in Singapore, prison settings have a 16% prevalence, with 36% in psychiatric settings.

Despite these prevalence rates, emerging research indicates a difference in factor structure in specific Asian cultures, such as Singapore, which is majority ethnically Chinese (Keng et al., 2019). The McLean Screening Instrument for BPD was utilized in Singapore, and a difference was identified when compared to the same instrument's outcomes established in Western studies. The first two factors of affect dysregulation and self-disturbances were consistent across the two cultures. However, the difference lies in the third factor (Keng et al., 2019). In Western countries, behavioral dysregulation and interpersonal dysregulation are loaded as separate factors, while in Singapore, these two factors are loaded together (Keng et al., 2019). This suggests that interpersonal facets of BPD may be interlaced with behavioral dysregulation in the context of Chinese culture.

Butler et al. (2007) theorized that this is closely linked with the collectivistic nature of many Eastern countries in the world. Behavioral dysregulations may arise in the context of interpersonal relationships due to the close vicinity in which family and individual may live together, as well as the close ties of the culture (Butler et al., 2007). They theorize that there is an emphasis on social harmony, interdependence, and emotion control. The interpersonal dysregulation that manifests as behavioral problems can further invalidate the culture's social environment. This cycle can be more pronounced, particularly in a culture that values emotion control (Butler et al., 2007).

Early experiences of invalidation and development of BPD have strong associations within Asian cultures, aligning with most biosocial etiology models. Examinations of the development of BPD, specifically in Asian cultures, found that a tendency to view the self most strongly in terms of group identity, along with high levels of conforming to norms, can leave an

individual vulnerable to invalidations (Cheng et al., 2010). It is essential to reiterate that this finding is specific to collectivistic cultures, such as some East Asian cultures.

Overall, there is evidence to suggest similarities and differences in the presentation of BPD in Asian cultures when compared to Western cultures. There was a similar clinical picture in specific comparisons of Japanese BPD clients with US BPD clients. However, there are notable differences overall. Eastern Asians with BPD may be more likely to suppress emotions and reduce behavioral reactivity to emotional stimuli (Zhang et al., 2012). It appears there are significant differences in interpersonal, behavioral, and emotional dysregulation presentation across these two broad cultural groups.

In examining a different collectivistic culture, Italian immigrants in the United States have been found to be more effective and expressive when compared to other White ethnicities. There is an emphasis on family, which plays a dominant role in the culture, and the high affectivity levels. For example, Italian mothers have been found to show higher levels of affective expression, socialization, physical handling, and holding of their children than American mothers (Hsu & Lavelli, 2005). Perhaps relatedly, Italians show less impulsivity and parasuicidal behaviors overall. However, those with BPD will often display higher levels of social anxiety and interpersonal hypersensitivity than Italians without BPD (Paris, 1996). This is especially present when one pursues expressions of assertiveness and individualistic goals. Many clinicians may misdiagnose or miss diagnoses of BPD in Italians, as evidence suggests they often internalize emotions, such as emotional sensitivity, emptiness, and painful interpersonal relationships (Paris, 1996).

Several ethnic groups and sub-cultures are found in Australia, and there exists a significant stigma against mental illness, particularly personality disorders, within many of these

groups. This creates significant challenges in examining the occurrence and presentation of the diagnosis. There is a hesitation to diagnose personality dysfunctions and treat these disorders and dysfunctions (Tyrer et al., 2010). Over the last 200 years, many individuals have experienced trauma in the country, most notably the indigenous peoples, due to colonization. As a result, responses to these ongoing traumas are seen as personality characteristics rather than treatable conditions (Belli et al., 2013). This, in turn, results in the over-pathologizing of an entire culture. There are additional challenges with the undertreatment of men diagnosed with personality disorders. Despite the presence of the diagnosis being similar across genders, prevalence studies suggest that there are slightly higher rates of men with personality disorders in general in Australia (Belli et al., 2013). Yet, fewer men receive treatment. There is, however, a growing trend in recognition of the need for services, treatment, and research of personality disorders within Australian culture.

Just as it is vital to examine worldwide differences in cultural expression of BPD, it is also important to examine differences across cultural groups within the Unities States. Several studies examining the prevalence and symptom endorsement related to BPD have varied when comparing Hispanic, White, and African Americans (Paris, 2010). For example, in an analysis of data from treatment-seeking individuals, there were higher rates of BPD in Hispanic Americans than in African Americans and Whites. Additionally, Hispanic Americans were more likely to endorse unstable relationships, lack of anger control, and affective lability (Grant et al., 2008).

One facet of BPD that has been largely explored across ethnicities in the context of BPD is suicide and parasuicidal behavior among White and African American women (Guertin et al., 2001; Gratz, 2006). Despite the higher levels of adversity that African American women face, there are higher rates of parasuicidal behavior in White women. However, the results differ when

males and females are included in the analysis, as results indicate only lower rates of parasuicidal behavior in African American women, not men, compared to White Americans (Walker et al., 2006). The authors hypothesized that African American women have several protective factors, such as spiritually-based coping, close kinship bonds, and support networks (Rockett et al., 2006). Parasuicidal behaviors are often studied in the context of BPD and used to examine prevalence. The scarcity of these behaviors in African American women may leave them misdiagnosed or underdiagnosed.

Concerning impulsivity and externalizing behaviors, several studies have indicated a difference in violent behaviors, particularly that African Americans are exposed to and commit violence more than White Americans in the context of BPD. However, this difference may be better accounted for by lower socioeconomic status (Sampson et al., 2005). Differences in violence are likely better attributed to African Americans who experience lower socioeconomic status, as they are exposed to more stressors, violence-inducing situations, and poverty in concentrated geographic areas.

Several studies have indicated various differences in the presentation and prevalence of BPD. For example, BPD was found to be more prevalent in Native American men, less prevalent in Hispanic and Asian Americans, and overall higher rates of BPD in nonwhite individuals (McGilloway et al., 2010). However, all of these associations were better explained by lower socioeconomic status. This may be due to the well-documented notion that lower socioeconomic status has been linked to greater development of internalization and externalization in young adults and youth.

Overall, examining cross-cultural and ethnic variations in symptomology and the prevalence of BPD is essential for researchers and clinicians. The cultural context of a diagnosis

is vital. The DSM-5-TR contains the cultural formulation interview to help the clinician focus on how the various aspects of culture can affect their perspective of their conditions (APA, 2022). This includes their background, social context, and developmental experiences. An individual cultural perception can contribute to treatment motivation, self-coping, and help-seeking behaviors. This is especially true of personality functioning, which includes identity, self-directions, and in the context of cultural agency, acceptance, authorship, and autonomy. These tools can provide context for the development of BPD for the individual within their culture and background when otherwise overlooked when not fitting into Western understandings of the diagnosis.

CHAPTER 3

DISCUSSION

Summary of Findings

BPD is a complex diagnosis with varying origins, presentations, and treatment approaches. It is well known to be conceptualized by marked impulsivity and instability in interpersonal relationships, affect, self-image, and emotion regulation (APA, 2013). Despite this well-known and accepted conceptualization, the symptomology of the disorder can vary across gender, age, and ethnicity (Selby et al., 2008). The development of the diagnosis has numerous theories by which it may occur, including childhood traumatic experiences, alterations in brain development, neurotransmitter abnormalities, genetic factors, and temperament styles combined with parenting styles (Kernberg, 1967; Herman & van der Kolk, 1987, 1989: Herman et al., 1989; Fonagy et al., 2017; Skoglund et al., 2021; Bozzatello et al., 2021; Baird et al., 2005). The

prevalence of the diagnosis varies depending on the setting and population examined. Broad community samples estimate a 0.04% to 1.8% prevalence, while outpatient client samples estimated prevalence is 8% to 27%, and clinical samples range from 40% to 44% (Meaney et al., 2016; Korzekwa et al., 2008; Newhill et al., 2009). Historical treatment for BPD has included pharmacological methods and psychoanalytic and behavioral approaches. However, the most widely utilized and efficacious treatment is DBT. Other approaches for treatment include TFP, SFT, and MBT (Kliem et al., 2010; Clarkin et al., 2007; Giesen-Bloo et al., 2006; Doering et al., 2010).

The concepts of transference and countertransference have evolved over time. Both concepts first appeared in the revolutionary writings of Freud in 1888 (Almond, 2011). However, over the years, theorists and researchers explored transference and countertransference to expand upon their importance within the therapeutic relationship (Levy et al., 2012; Holmes, 2014; Hayes & Gelso, 2001). Transference is the unconscious process of ascribing representational aspects of foundational relationships to another person in conscious and unconscious ways (Levy, 2009). In contrast, countertransference is a clinician's interpersonal reactions to a client, typically from unresolved conflicts (Hayes et al., 2011).

These concepts are essential in working with BPD because they will likely be present during the therapeutic relationship. The misinterpretations of self and others that tend to be present in the client with BPD lead to difficulties in integration interpretations and representations (Young et al., 2003; Giesen-Bloo et al., 2006). These tend to be overly positive and negative and often present in transference towards the clinician in therapeutic settings (Hayes & Gelso, 1991, 1993; Hayes et al., 1998; Hayes et al., 2011; Bhola & Mehrotra, 2021; Cambanis, 2012). Countertransference in therapeutic work with a client with BPD can come

from various sources, including the transference the client displays. This can create a vicious cycle of countertransference and transference, and when left unchecked, it can lead to negative therapeutic outcomes (Blatt et al., 1996). It is important to note that both overly positive and negative countertransference and transference can occur in therapeutic relationships working with those diagnosed with BPD (Landonson & Welton, 2007; Liebman & Burnette, 2013). This transference and countertransference can be addressed in various ways, including therapeutic approaches such as TFT and clinical consultation with more experienced clinicians (Clarkin et al., 2007).

Culture, cultural identity, and preconceived perceptions of culture can influence the presentations of countertransference and transference in the therapeutic relationship (Prasko et al., 2022). Cultural transference includes conscious and unconscious distortions that display as interpersonal behaviors and interactions with the therapist and are specifically related to culture (de Haan et al., 2018; Berger et al., 2014). This transference can occur when a client is from a minority or majority group. Cultural transference can be present in the therapeutic relationship through perceptions of authority and privilege (Comas-Dıas & Jacobsen, 1991; Gailly, 2003).

Cultural countertransference in intercultural therapy can stem from lifelong efforts of avoidance of complex issues related to race, which can be unconscious and manifest in several ways (Comas-Dıas & Jacobsen, 1991; Gailly, 2003; Gorkin, 1996; Holmes, 1992). For white clinicians these manifestations of cultural countertransference may include viewing the client as exotic, viewing the client as “the White man’s burden,” variations of colorblindness, and viewing the client as “the problem” of their racial or cultural group (Qureshi & Collazos, 2011).

The diagnostic presentation of BPD can vary when comparing individualistic and collectivistic cultures (Ronningstam et al., 2018). There are well-established treatment and

diagnostic understandings of BPD in countries with predominant western worldviews. However, these diagnostic understandings can differ in predominantly Asian countries, Italy, and Australia. In particular, BPD is a controversial diagnosis in East Asian countries, specifically China (Ronningstam et al., 2018). Despite the Chinese psychiatric communities' disputes about the appropriateness of BPD diagnostic criteria to the Chinese culture, there continues to be a level of prevalence of the diagnosis. The prevalence of BPD in China specifically ranges from 1% in college students to 8.4% in high school populations. Ranges of prevalence in clinical settings are from 1.3% to 7.1% (Kim et al., 2001). These numbers vary across countries within the continent. For example, the prevalence of BPD in Southeast Asia is 13% in outpatient and inpatient settings. While in Singapore, prison settings have a 16% prevalence, with 36% in psychiatric settings. Eastern Asians with BPD may be more likely to suppress emotions and reduce behavioral reactivity to emotional stimuli (Kim et al., 2001; Keng et al., 2019). It appears there are significant differences in interpersonal, behavioral, and emotional dysregulation presentation across these two cultures (Keng et al., 2019; Ronningstam et al., 2018).

Examinations of other collectivistic cultures revealed essential differences in the presentation of BPD. Italians and Italian Americans display less impulsivity and parasuicidal behaviors while endorsing higher anxiety levels and interpersonal hypersensitivity (Hsu & Lavelli, 2005; Paris, 1996). This has led to many clinicians misdiagnosing or missing the BPD diagnosis altogether (Paris, 1996). In Australia, the significant stigma against mental illness has led to significant challenges in examining the occurrence and presentation of BPD (Tyrer et al., 2010). There are additional challenges with the undertreatment of men diagnosed with personality disorders (Belli et al., 2013). Despite the presence of the diagnosis being similar in

each gender, prevalence studies suggest that there are slightly higher rates of men with personality disorders in general in Australia (Belli et al., 2013).

In examinations of BPD in Western countries and individual differences in Americans, several studies examining prevalence and symptoms endorsement of BPD have varied when comparing Hispanic, White, and African Americans (Paris, 2010). An analysis of data from treatment-seeking individuals showed higher rates of BPD in Hispanic Americans than in African Americans and Whites (Grant et al., 2008). Additionally, Hispanic Americans were more likely to endorse unstable relationships, lack of anger control, and affective lability (Grant et al., 2008).

Despite the higher levels of adversity that African American women face, there are higher rates of parasuicidal behavior in White women (Guertin et al., 2001; Gratz, 2006). One proposed hypothesis to explain this is that African American women often have several protective factors, such as spiritually-based coping, close kinship bonds, and support networks. Parasuicidal behaviors are often studied in the context of BPD and used to examine prevalence. Concerning impulsivity and externalizing behaviors, several studies have indicated a difference in violent behaviors, particularly that African Americans are exposed to and commit violence more than white Americans in the context of BPD (Walker et al., 2006; Sampson et al., 2005). Differences in violence are better attributed to African Americans who experience lower socioeconomic status, as they are exposed to more stressors, violence-inducing situations, and poverty in concentrated geographic areas (Walker et al., 2006; Rockett et al., 2006).

Overall, examining cross-cultural and ethnic variations in symptomology and the prevalence of BPD is vital for researchers and clinicians. These diagnostic understandings of the diagnosis help clinicians avoid and address the countertransference and transference issues that

will come up in the therapeutic relationship. This is especially true when working with clients with BPD, as these transference and countertransference issues are much more likely to present themselves.

Strengths and Limitations of Existing Literature

The literature examining BPD, countertransference, transference, and cultural identity as separate concepts is well-established and extensive. One major challenge in identifying articles for the present review was the lack of studies jointly focused on the constructs under review. To effectively address the interplay of culture, transference, and countertransference in cases involving BPD, it was necessary to draw conclusions by piecing together the findings of studies often not intended to focus on one or more of these variables. Relevant information was often embedded as a minor narrative within a manuscript focused on other primary variables. Ultimately, however, though the existing literature seldom explored interrelations between culture and the other constructs of current interest, some meaningful conclusions could be drawn for the present review. The strengths and limitations of the extant body of literature involving these constructs are included below.

Strengths of Existing Literature

A common strength that arose from examining the literature involving each of the constructs included in this review is the breadth and depth of each body of literature. There was extensive independent literature on culture, BPD, transference, and countertransference.

Studies examining transference and culture had strengths in the diversity of participants included in the surveys, psychometric assessments, and theoretical understandings. Multiple

cultural perspectives were examined and included in the literature as a whole. There were examinations of transference between a white therapist and a client of color, between a therapist of color and White clients, and lastly, culturally similar therapist and client pairings. This allowed for greater generalizability in the concepts of culture, transference, and even BPD due to the depth of topical focus on transference and BPD.

The topical focus of BPD and cultural variations in the existing literature was vast in the number of studies examining differences and the cultures examined. Studies exploring the jointed constructs included different cultures within the U.S., as well as different cultures across the world, including China, Singapore, Italy, and Australia. These inclusions allow for greater generalizability to cultural differences that may be present in those diagnosed with BPD. Additionally, studies examining the diagnosis criteria across cultures were longitudinal and cross-sectional in nature, which allows for continued generalizability as the understanding of BPD across cultures grows.

Limitations of Existing Literature

Although the breadth and depth of the existing literature in the constructs included in this review provided strengths, there were limitations present in the collective and separative bodies of literature. These limitations went beyond the lack of literature jointly exploring the constructs of the present review.

A theme that arose throughout the collective literature is Western conceptualizations of transference, countertransference, and BPD. Although there was some acknowledgment that clinician diagnostic understandings might be different for BPD across the globe, there was a lack of mention of this in the literature examining countertransference and transference. This led to

limitations in the overall generalizability in some of these concepts across cultures, as the prevalence rates examined may have limited accuracy.

Studies that did examine the prevalence of BPD were limited to online surveys and self-report and may not have accounted for misunderstandings of the diagnostic criteria for BPD. Additionally, studies acknowledged that understandings of BPD across cultures might lead to over or underdiagnosis, which again may have an effect on the accuracy of the prevalence rates. Lastly, studies that did examine cultural differences left out examinations in South American cultures altogether.

One area that contained some of the greatest limitations, despite the depth and breadth of the concept in general, is countertransference as it relates to culture. Studies that examined countertransference in clinicians working with a client with a different cultural background than their own had a lack of diversity in their samples and participants. These studies focused on the countertransference experience of the White therapist, the White client, and the client of color. However, therapists of color were largely unrepresented in the literature. This led to a lack of generalizability of concepts of countertransference management and a large gap within the literature itself. This also leads to gaps in the current review to come to conclusions regarding clinicians of color working with clients diagnosed with BPD.

Clinical Training Implications

In outpatient client samples, the estimated prevalence of BPD is 8% to 27%, and clinical samples range from 40% to 44% (Meaney et al., 2016; Korzekwa et al., 2008; Newhill et al., 2009). These prevalence rates are comparable to that of depression and anxiety. However, clinicians' training in clinical and counseling psychology doctoral programs is not comparable to

training in addressing depression and anxiety (Levy, 2021). Although there are numerous approaches to the treatment of personality disorders, specifically BPD, such as DBT and TFT. These approaches are often not examined as closely as approaches to depression and anxiety in doctoral training programs, which typically have more time-limited approaches (Levy, 2021). This can lead to new clinicians feeling unprepared to work with the complexities of therapeutic interventions often utilized when treating BPD (Levy, 2021).

This leads to more significant issues, such as only 16% of doctoral programs having faculty that specialize or are interested in personality disorders in general, let alone BPD specifically (Levy, 2010). If few student clinicians are being trained specifically in clinical approaches intended for use with BPD, those entering the workforce with only minimal training in working with BPD may avoid continued work with the disorder. As they represent the next generation of training faculty, this may perpetuate the cycle of programs lacking faculty with experience with the diagnosis (Levy, 2010). Meanwhile, the prevalence of the diagnosis in outpatient and clinical settings does not change and continues to grow as diagnostic understandings and representations are fine-tuned. It is important to note that there are numerous opportunities for student clinicians to seek out their training in DBT and TFT if they desire to work with the diagnosis in their post-doctoral placements. However, these opportunities should also be available within their programs.

An important aspect of therapeutic work with any client, and BPD in particular, is countertransference. There are often preconceived notions about clients with BPD regarding their interpersonal interactions with a therapist. However, there is also the strain that working with these individuals can cause on the therapist. Thus, examinations of countertransference issues with new and seasoned clinicians become essential. The negative consequences of

countertransference are endorsed less often by more experienced clinicians than the training or student clinicians (Liebman & Burnette, 2013). This is not to say that countertransference does not happen; instead, the negative consequences or issues are less likely to impact the therapeutic relationship. This is a significant indicator that something is missing within the training for countertransference-related issues in the therapeutic relationship. Although it is essential to recognize that there will be a natural decrease in these issues as clinicians gain more experience, it is also essential to acknowledge and bridge the gap as much as possible. Somewhere along the way, the more seasoned clinician is learning ways to more effectively manage their countertransference. However, these ways of addressing countertransference should be taught to newer psychologists and student clinicians with more intentionality. This is a fundamental way student clinicians could be better prepared to deal with interpersonal conflicts in their clinical work in general, particularly with their clients diagnosed with BPD.

There are several ways in which clinical training for borderline personality disorder could improve during doctoral training. For training during doctoral programs, Ph.D. and PsyD programs may need to go beyond hiring professors and researchers with a focus or interest in personality disorders. Programs should examine their current curriculum for gaps in training related to personality disorders. Classes such as those that focus on diagnostic competence (e.g., utilizing the DSM-5-TR) should increasingly emphasize personality disorders and, specifically, differential and comorbid diagnoses related to disorders such as BPD. One example of this could include case studies and vignettes engaging the class in diagnostic differentiation between BPD and bipolar disorder or multiple presentations of BPD in clients from diverse backgrounds. These tasks would afford students the opportunity to think critically about the various manifestations of

BPD in different cultures rather than simply checking off symptoms from a list in the latest edition of the DSM.

Classes that focus on treatment approaches and modalities, whether psychodynamic, cognitive behavioral, group, or otherwise, should emphasize treatment modalities that are efficacious for BPD. These would include time spent learning how to apply DBT or TFT approaches to BPD case examples, as well as how to adapt these modalities to appropriately treat clients with BPD from diverse cultural backgrounds.

Lastly, courses focusing on professional development, such as clinical practicum courses, should address countertransference and transference that may be more likely to occur with BPD. Clinical practicum courses introducing and exploring countertransference concepts may focus on general approaches to managing countertransference but may not adequately prepare students for some of the more intense countertransference that is often experienced with BPD. One way to bridge this gap in competency in work with BPD is to introduce the countertransference challenges that may arise with case studies, role plays, and class discussions early on in training and to continue the discussions throughout training.

Just as there is a gap in competency training for BPD and countertransference during doctoral training programs, there are similar gaps in post-doctoral training. Overcoming these shortcomings could occur in several ways, such as increasing the use of role-play exercises, discussion of case studies, and placing an emphasis on training in therapeutic approaches such as DBT and TFT. Additionally, initial licensure applications could begin to include a requirement that a certain number of training hours be completed that involve the identification and treatment of personality disorders, managing related countertransference, and treatment modalities that have demonstrated effectiveness with personality disorders, such as DBT and TFT.

Future Research Directions

In examining the research on countertransference related to the therapist and client's cultural identities in therapeutic work with BPD, some gaps link these key concepts. Three major areas of future research came from this review of current literature examining these concepts. First, key concepts must be included in examining cultural countertransference and transference and precisely how this may impact BPD. The diagnostic underpinnings of BPD in countries dominated by a Western worldview appear to be more solidified than in countries with Eastern worldviews. The existing literature demonstrates that worldview–sometimes understood as cultural values that drive behavior–can influence the presentation of a diagnosis and, relatedly, the clinician's assumptions in working with these individuals. Future research should focus on how the client's cultural identity can impact diagnostic presentations and, therefore, understandings of how to effectively work with such a complex personality disorder.

The second area stems from the lack of research on countertransference for minority-identifying clinicians. Most of the research into countertransference related to cultural and ethnic identity focused on White clinicians. Although this research is vital as it comprises most psychology communities, it leaves the work of entire groups of clinicians unexamined. There may be separate cultural countertransference for minority-identifying clinicians in the therapeutic relationship. Suppose these issues remain unexamined in the clinical literature. In that case, the result is an entire group of clinicians left without guidance on dealing with the specific countertransference presentations that may differ from those of Western and/or White therapists. This would be especially harmful in working with BPD, a diagnosis more likely to bring about countertransference issues.

A third area that could guide future research of BPD is based on the understanding of BPD in the psychiatric and psychopharmacology field of research. In psychopharmacology, BPD is categorized into three different presentations. These presentations include hysteroid-dysphoric, schizotypal, and angry impulsive (Preston et al., 2008). The individual with a hysteroid-dysphoric presentation has a higher degree of emotional lability and is more sensitive to perceived interpersonal loss, rejection, and abandonment, resulting in desperate attempts to avoid this rejection and abandonment (Preston et al., 2008). The schizotypal presentation tends to display odd thinking, specifically ideas of reference, vagueness, idiosyncratic beliefs, magical thinking, and periods of depersonalization. The angry-impulsive presentation or subtype presents with hostile and aggressive interpersonal interactions, with low levels of frustration tolerance, and often can be volatile (Preston et al., 2008).

These presentations or subtypes of BPD guide psychiatry in the type of psychotropic medication that can be prescribed. This is partly due to the idea that there is no specific medication for BPD, but there are ways to treat the symptoms (Preston et al., 2008). Existing clinical psychology research has not tended to examine BPD in this same way. Instead, the diagnosis is considered one whole rather than as a single diagnosis with a diverse set of subtypes. If future researchers were to examine the reliability and validity of these subtypes, it could potentially guide how the diagnosis is differentially treated in psychotherapy. Additionally, these different symptom clusters could have varying impacts on the countertransference and transference experienced by participants in the therapy process. Consequently, this could guide the development of more effective training regarding the management of countertransference and transference. These symptom clusters and subtypes may also offer explanations for the varying diagnostic presentations of the diagnosis and its underpinnings across cultures and worldviews.

In summary, BPD continues to be a complex diagnosis that evokes strong feelings from participants on all sides of the clinical encounter. To serve most effectively those suffering the consequences of the instability involved with the diagnosis, clinicians much continue to expand their understanding of the many iterations of the BPD symptom spectrum that can differ based upon a number of factors, including cultural identity.

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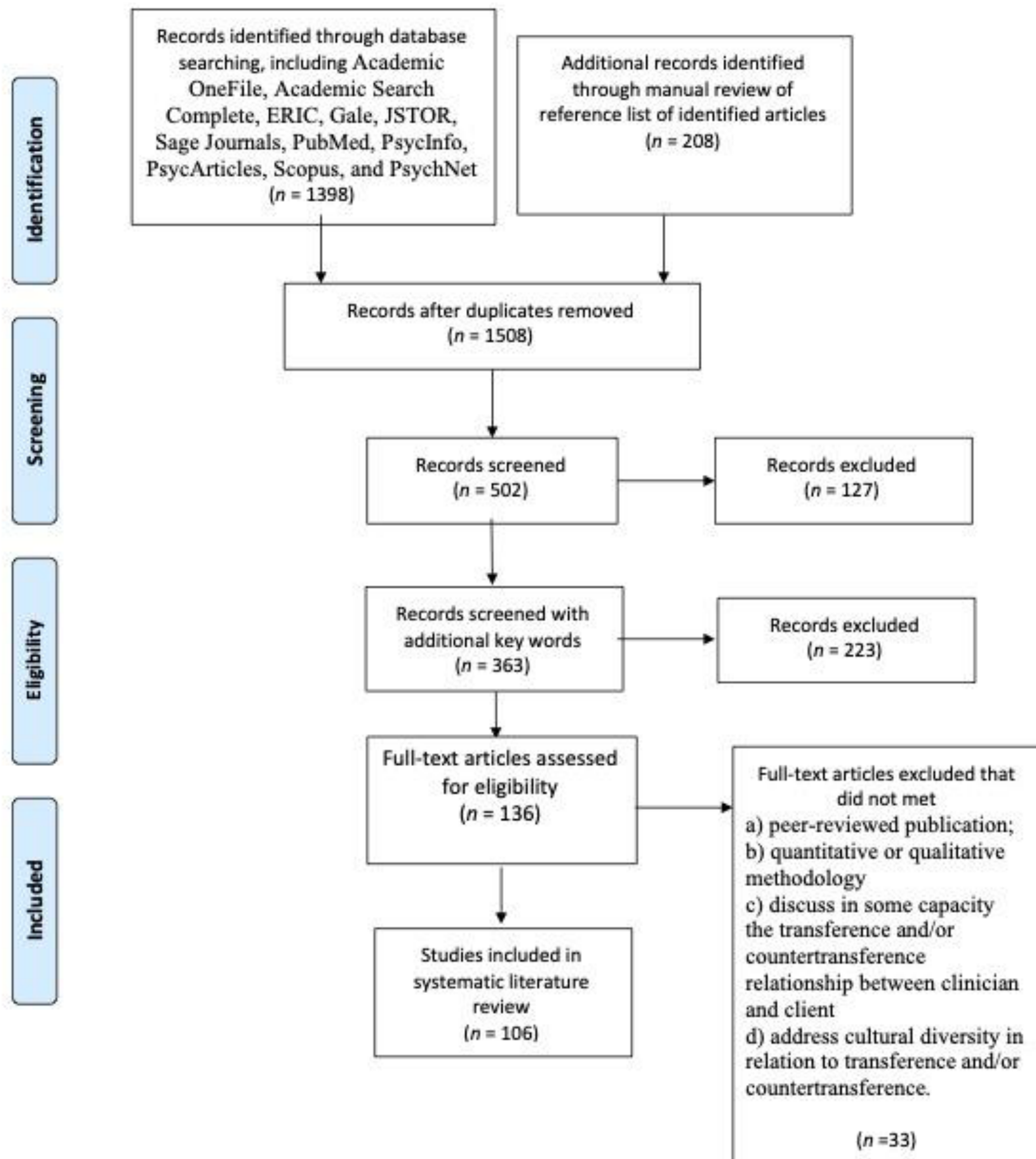
APPENDIXES

APPENDIX A

FIGURES

Figure 1

Flow Diagram



APPENDIX B

MANUSCRIPT

Cultural Identity in Transference and Countertransference Involving Borderline Personality Disorder

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ABSTRACT

Borderline personality disorder (BPD) is a complex disorder characterized by emotional instability, interpersonal and intrapersonal difficulty, and impulsivity. As a result, there are many preconceived notions about those diagnosed with the disorder and what clinical work may entail. One way to conceptualize these preconceived notions is to consider them as a form of countertransference. Clients with BPD are more likely to evoke countertransference reactions from the clinicians that work with them than clients presenting with other disorders. Countertransference reactions in clinical work with the diagnosis may stem from various sources, including transference reactions and cultural identity. The current literature review explores BPD, countertransference, transference, cultural identity, and how these constructs interrelate in clinical work with BPD. Results revealed overall challenges in identifying articles for the present review was the lack of studies jointly focused on the constructs under review. To effectively address the interplay of culture, transference, and countertransference in cases involving BPD, it was necessary to draw conclusions by piecing together the findings of studies often not intended to focus on one or more of these variables. Implications for clinical practice and training and recommended future directions for research will be discussed.

Cultural Identity in Transference and Countertransference Involving Borderline Personality Disorder

One of the best predictors of outcomes within the therapeutic process is the therapeutic working alliance between clinician and client (Hersh, 2008; Gelso, 2011). Furthermore, there are several theoretical orientations and approaches that utilize the therapeutic working alliance as a primary facet of treatment. This is especially the case with treating a disorder such as borderline personality disorder (BPD), found in approximately 1.6% of the general population and 20% of inpatient client psychiatric populations (Cambanis, 2011; Clarkin et al., 2007). Examples of such treatments include dialectical behavioral therapy and transference-focused therapy (Stoffers et al., 2012; Clarkin et al., 2007). Despite the presence of commonly accepted evidence-based treatments for BPD, some myths and stereotypes commonly accompany the diagnosis, which can complicate the treatment provided to these individuals (Hersh, 2008).

Healthcare professionals often treat clients with BPD differently than other clients (Warrender, 2015). This may include expectations of relational and clinical difficulties in therapy that can negatively impact treatment (Hersh, 2008). Although limited evidence suggests that clients with BPD may present differently in different cultures (Selby & Joiner, 2009: Jan et al., 2016), this author has found minimal previous research specifically focusing on the impact of the therapist's cultural background in the treatment of clients with BPD.

This literature review aims to explore the impact of a therapist's cultural identity on expressions of therapist countertransference and client transference in psychotherapies involving BPD. A review and critique of existing findings will be presented, along with implications for clinical practice and training and recommended future directions for research.

Search Strategy

Given the dearth of literature specifically addressing cultural experiences of countertransference with BPD, the current search strategy will include terms meant to identify peer-reviewed literature that at least indirectly examines the primary elements of interest in the current review. Many articles addressed in the current literature review only include culture, transference, and countertransference as secondary variables. Thus, the current author attempted to consolidate the findings and extract meaningful conclusions that can be applied more broadly and directly than the seemingly minor attention given in the extant literature would suggest. The search for recent—2011-2022— peer-reviewed articles was conducted primarily via the California Baptist University (CBU) Annie Gabriel Library online databases. These databases and tools included Academic OneFile, Academic Search Complete, ERIC, Gale, JSTOR, Sage Journals, PubMed, PsycInfo, PsycArticles, Scopus, and PsychNet. Google Scholar was also utilized to locate open-access articles and sources not available directly through the CBU library.

The following core search terms were used to find articles specific to this study: *borderline personality disorder, cultural variation, countertransference, culture,* and *transference*. Variations of these terms were used to ensure detailed search results. To be included in the current review, each source had to meet all the following minimum criteria: a) peer-reviewed publication; b) quantitative or qualitative methodology, c) discuss in some capacity the transference and/or countertransference relationship between clinician and client, and d) address cultural diversity in relation to transference and/or countertransference.

This literature review focused on the experiences of diverse clinicians from a variety of training backgrounds. Resources examining the clinical experiences of psychologists, social workers, marriage and family therapists, professional counselors, and others of varying levels of experience were considered for inclusion in this review.

Countertransference

These four views of countertransference, including combinations and variations of each, can be found throughout the literature. A more detailed summary of these four views on countertransference and ways that clinicians can manage countertransference can be found in Hayes et al. (2011). For the current literature review, countertransference will be considered from an integrative perspective, combining aspects of all four variations of countertransference noted above. Special emphasis will be placed on countertransference that stems from sources of internal conflict resulting from clinicians' ethnic and racial attitudes, gender attitudes, and worldviews (Stampley & Slaght, 2004). Thus, sources referencing therapists' internal conflicts and unresolved personal issues manifesting in sessions, responses to which the therapist feels "pulled" by the client, and interactions co-created by the client and therapist will all be eligible for inclusion if they meet all other inclusion criteria noted in the "Search Strategy" section above.

Transference

Transference has been a topic of exploration for psychology since Freud (1910) coined the term. Although initially thought of as a form of resistance, particularly as used within psychoanalytic theory, transference emerged as an essential agent of healing and change in therapy (Sohtorik, İlkmen & Halfon, 2019). A more recent example of this can be found in Transference-Focused Therapy (Clarkin et al., 2007). This theory poses that individuals diagnosed with BPD will display unhealthy interpersonal behaviors with their therapists, like their behaviors in interpersonal relationships outside of therapy (Clarkin et al., 2007). In this way, transference is an element that can be utilized to gain a deeper understanding of a client's

unconscious mind. For the current literature review, transference will be defined as a client's feelings or reactions intended for an important figure or event in their life, but which are instead directed at the clinician (Sohtorik, İlkmen & Halfon, 2019).

Borderline Personality Disorder

Borderline personality disorder is a chronic condition and is typically first observed in adolescence. It has its highest occurrence in individuals who have endured childhood trauma. Borderline personality disorder is best defined as a disorder characterized by instability (NICE, 2009). This instability is present in the individuals' relationships, mood, behavior, and self-image. There are rapid fluctuations between emotional states, including impulsive and self-harming behaviors (Warrender, 2015). Sources considered for the current review must include participants with formally diagnosed BPD, using any DSM editions from DSM-III through the current version at the time of this review, DSM-5-TR, as these manuals share the common diagnostic features noted above.

Cultural Identity

The most helpful conceptualization of cultural identity is not static, decontextualized, or essentialist; it is dynamic, shifting, and historically embedded (Meca et al., 2017). An individual's cultural identity constantly evolves, as identity involves understanding oneself in relation to others (Meca et al., 2017). Thus, for the purpose of this literature review, cultural identity will be defined as the individual's self-identification as a member of a specified cultural group (or groups), including the behaviors, communication styles, psychology, and sociology of said culture (Hudelson, 2004). Cultural groups will be considered to encompass a wide range of

demographic categories self-reported by participants, including but not limited to ethnicity, race, and gender.

Results of the literature review will be grouped according to culture, such that clinicians working with clients who identify with a particular culture may easily find consolidated information regarding the impacts of transference and countertransference within that group. When there is insufficient evidence to draw any meaningful or generalizable conclusions regarding a cultural group, that will be made clear.

A flow diagram (Figure 1) detailing the article selection process will be included following the completion of the literature review.

Literature Review

Despite the extensive mental health resources utilized in the treatment of and research into BPD, there continues to be considerable suffering for those with the diagnosis. This suffering includes increased mortality and morbidity when compared to the general population. Thus, it becomes crucial to examine how the field understands BPD today, including any misconceptions held about the diagnosis, and how this may be impacting how clinicians approach treatment. These misconceptions include those related to the clinician's cultural experience and the clients' cultural experience.

Borderline Personality Disorder

Prevalence

Estimates of the prevalence of borderline personality disorder have varied over the years. Some surveys put the prevalence of borderline personality in the United States at 1.6% in the

general population (Winsper et al., 2020). The lifetime prevalence is estimated at 5.9% (Winsper et al., 2020). There have been no significant differences between males and females in the general population (Nasiri et al., 2013). However, these numbers change when examining clinical settings. In clinical settings, specifically outpatient and psychiatric settings, there is an 11% prevalence, while in inpatient settings, this number increased to 44% (Winsper et al., 2020). A review of 14 studies examining differences of BPD among racial groups found evidence that BPD was less prevalent among African American participants when compared to White participants (Selby & Joiner, 2008). However, these results differ when examined in the broader populations. Specifically, African Americans were more likely to be diagnosed with BPD than White Americans (Newhill et al., 2009).

Symptoms

The DSM-5 conceptualizes BPD as a diagnosis characterized by marked impulsivity and instability within interpersonal relationships, emotion regulation, affect, and self-image (American Psychiatric Association, 2013). A prominent feature of the disorder is an extreme fear of abandonment, with frantic efforts to avoid it. This results in pervasive patterns of instability in relationships due to the cycles of extreme hate and extreme admiration for others in their lives. Self-harm and suicidal ideation are common experiences for many individuals with BPD due to intense feelings of emptiness. Although these persistent threats of self-harm and suicide may sometimes represent authentic intentions, they often represent frantic and impulsive efforts to avoid abandonment.

Few researchers have examined variations in the symptomology of BPD. One way researchers have chosen to examine these differences is through factor analysis (Selby et al.,

2008). In one such study, four significant factors emerged across ethnic groups of Caucasians, African Americans, and Hispanics: affect dysregulation, distributed relatedness, behavioral dysregulation, and cognitive dysregulation. The cohesive results of these four factors across ethnic groups demonstrate a consistency in diagnosis despite psychological and social-cultural influences in each group (Selby et al, 2008).

However, there were some differences among groups. There were higher rates of affective and behavioral dysregulation among Caucasian participants compared to Hispanic and African American participants (Selby et al., 2008). Another variation among groups was the symptom of impulsivity, which loaded on different factors for each ethnic group. Impulsivity loaded onto cognitive disturbance factors for Caucasians, while it loaded on distributed relatedness for Hispanics and affect dysregulation for African Americans (Selby et al., 2008). It appears that symptomology and the sources of symptomology associated with BPD may differ among ethnic groups and thus is an important consideration when examining the diagnosis and treatment of BPD.

Etiology

Early attempts at understanding the etiology of BPD fell short and were often vague. Later clarification came from examinations of the possible relationship between the diagnosis, sexual abuse, and childhood trauma (Herman & van der Kolk 1987, 1989: Herman et al., 1989). The theory was that individuals who suffer from BPD were more likely to have been traumatized in childhood. This was later confirmed in several studies that concluded there was a high incidence of child abuse in these individuals, which included physical, sexual, and emotional abuse, witnessing domestic violence, and neglect. These findings lead to the theorization that

BPD is more than a personality disorder; it is a multifaceted disorder that stems from severe trauma (Herman, 1992). Furthermore, current data examining traumatic experiences in children indicate that these early experiences may alter the development of the brain, resulting in chronic neurotransmitter abnormalities and structural changes, resulting in affect regulation problems. These theories coalesced over time to create a conceptual framework that BPD is primarily a disorder of emotional dysregulation that stems from a combination of genetic predispositions and the childhood environment. Other scholars, such as Peter Fonagy and Anthony Bateman, theorize that the disorder develops due to a lack of resilience against psychological stressors (Fonagy et al., 2017), while Marsha Linehan theorizes that BPD results from interactions between genetic vulnerabilities and a consistently invalidating environment (Crowell et al., 2009).

Although most theories of BPD's etiology focus on psychological and environmental factors, some speculative biological theories explore the possible role of various genetic and constitutional factors to make sense of the development of various psychological conditions. Specifically, biological theories began to speculate that certain genetic factors that influence the central nervous system may lead to deficits in a child's ability to grasp early interpersonal experiences (Skoglund et al., 2021). It is theorized that even children raised in healthier homes may not adequately develop emotional intelligence from their interpersonal interactions due to these factors. Twin studies demonstrate a higher concordance of BPD for monozygotic twins compared to dizygotic twins. Additional twin studies have shown over 50% heritability compared to major depressive disorder, which has a 40% heritability (Skoglund et al., 2021).

Other biological theories examine how genetic factors, temperament styles, and parent interpersonal interactions influence the development of BPD (Bozzatello et al., 2021). In relation

to BPD, children who cry excessively may be more sensitive to mild distress and are difficult to soothe. These children may unknowingly evoke negative interpersonal reactions from caregivers, such as withdrawal of affection or frustration. The interaction of the child's biological temperament predisposition and the parents' reaction to the child may leave the child more prone to have problems with emotional and psychological growth (Bozzatello et al., 2021).

Additionally, neuroimaging studies have shown identifiable differences in the medial temporal lobe, amygdala, and hippocampus of those diagnosed with BPD relative to the general population (Baird et al., 2005). These findings offer a partial explanation as to why individuals with BPD may misattribute negative emotions such as fear, anger, and disgust to neutral faces while simultaneously having appropriate responses to the perception of happy and upset faces. Those with BPD may also have impaired neuropeptide functioning, specifically serotonin (Baird et al., 2005).

Treatment

DBT is currently one of the most well-established treatment modalities for BPD, as evidenced by its strong support in the clinical research literature (Kliem et al., 2010). According to Division 12 of the American Psychological Association, the Society of Clinical Psychology, DBT had strong research support as of 1998. This finding continues to be reviewed, as evidenced by a treatment re-evaluation that began in 2015 (Chambless et al., 1998; Tolin et al., 2015). Previous support for DBT treatments came from seven different randomized clinical control trials conducted by four independent teams of researchers.

Although DBT is the most well-known and widely utilized approach to treatment of BPD, there are several other treatment approaches, each with varying degrees of research support

(Clarkin et al., 2007). One such approach is Transference-Focused Therapy or TFT. A primary task for the TFP therapist involves focusing on the client's perceptions of interpersonal interactions (Giesen-Bloo et al., 2006). In particular, the treatment focuses on the concept of transference and the extreme experiences of another person (object) as either good or bad that manifest within the transference.

The current research support for TFT is unusual in that it has strong, yet controversial, support. This is due to somewhat conflicting findings within various meta-analyses from multiple teams of researchers (Giesen-Bloo et al., 2006; Clarkin et al., 2007; Doering et al., 2010). TFT was found to be efficacious in randomized control trials and was just as efficacious as DBT and other approaches (Clarkin et al., 2007). However, it was found to not perform as well as other = approaches to treatment for BPD in another study (Doering et al., 2010). More research is needed to clarify the approach's efficacy further.

Two additional treatment modalities for BPD include Schema-Focused Therapy (SFT) and Mentalization-Based Treatment (Giesen-Bloo et al., 2006). SFT is a cognitive behavioral approach that integrates techniques from other theoretical models (Young et al., 2003). Therapists who utilize this theoretical model aim to change a person's schemas, or life patterns, utilizing emotion-, behavior-, and cognition-focused techniques. Mentalization Based Treatment, or MBT, is a time-limited approach to treatment, utilizing the process of mentalization (Bateman & Fonagy, 2001). Mentalization is the process by which individuals form beliefs about the mental processes of other individuals they interact with and how that influences their own mental states, which then leads to difficulties with emotion regulation, self-image, and impulsivity. Both SFT and MBT show modest efficacy in the current literature, and therefore are not as empirically supported as DBT and TFT (Bateman & Fonagay, 2009; Bateman, Psych, & Fonagy, 2008).

Transference

The definition and understanding of transference have varied over time, with the definition often varying by theoretical approach. For this literature review, transference will be defined as an unconscious process of ascribing representational aspects of foundational relationships to another person in conscious and unconscious ways (Levy, 2009). Transference often occurs in the context of a therapeutic relationship but can also be present in everyday relationships. Although some aspects of this transference stem from actual events in the interpersonal relationship, distorted interpretations or cognitive biases can influence its presentation (Prasko et al., 2022).

Why Transference Matters for BPD

As noted above, individuals with BPD are likely to have inconsistent interpersonal relationships resulting from many factors (Frías et al., 2017). These relationship challenges can often present as transference toward the clinician in therapeutic settings. It is theorized that those with BPD have difficulty accurately perceiving themselves and others while simultaneously dealing with negative emotions such as aggression and para-suicidality (Koerner & Linehan, 2000). This representation of the self and others tends to have misinterpretations, and those with BPD have difficulty integrating interpretations and representations (Koerner & Linehan, 2000). As it is theorized that BPD may stem from trauma, these representations of self and others may have split early in life as a form of defense (Herman & van der Kolk 1987, 1989: Herman et al., 1989). Therefore, strongly negative, overprocessed representations will overwhelm positive emotions and representations of the self later in life. There is a significant division between negative and positive representations of self and others (Young et al., 2003). Thus, negative

transference interactions in life and therapeutic settings become an important exploration aspect for those with BPD (Giesen-Bloo et al., 2006).

The theory that best conceptualizes this phenomenon in clients with BPD is TFT. In TFT, it is theorized that early experiences have resulted in a major split in representations of self and other between negative representations and idealized positive representations (Clarkin et al., 2007). This split results in a polarization of these representations and distortions of interactions with self and others. The goal of TFT is to first integrate these polarized splits, then to increase the individual's awareness and develop a more enriched, flexible, and realistic view of self and others, thus resulting in improvements in transference interactions (Clarkin et al., 2007).

Countertransference

Countertransference has been defined in various ways as the conceptualization of countertransference has evolved. These unresolved conflicts may be conscious or unconscious, come from outside personal experiences, or may be a reaction to the client's transference (Hayes et al., 2011). These unresolved conflicts do not encompass all therapist interactions and usually refer to those unresolved conflicts that require consultation and personal therapy and help to understand the interpersonal interactions of the client (Hayes et al., 2011). For the purposes of the current literature review, countertransference will be defined broadly as a clinician's interpersonal reactions to a client, often, but not always, originating in unresolved conflicts from the clinician's personal life and/or interactions with the client.

Why Countertransference Matters for BPD

As noted in early research into the concept, countertransference can occur due to the negative emotions invoked by the client's actions. As clients diagnosed with BPD tend to

experience challenges in their interpersonal relationships, it stands to reason that countertransference may be more likely to occur when working with these clients than with clients presenting with most other diagnoses.

Historically, individuals diagnosed with BPD have been associated with negative countertransference interactions with clinicians (Liebman & Burnette, 2013). Early research into the concept indicated clinicians perceive individuals with BPD as more hostile and dominant (McIntyre & Schwartz, 1998). As more research into the concept of countertransference developed, including countertransference related to BPD, this notion was further confirmed (Bhola & Mehrotra, 2021).

Countertransference in work with individuals with BPD can manifest in a variety of ways in the therapeutic relationship. In clinical training, clinicians are educated on the complexities of working with these individuals, including their strong interpersonal interactions and patterns of behavior (Teyber & Teyber, 2110). This training may assist students in remaining curious about clients and open to the many ways their clients may present in a session. Despite this training, client behavior in session can be overwhelming, and students may struggle to appropriately diagnose and respond to transference and acting out behavior from clients. In particular, individuals with BPD may be more likely than other clients to have emotional outbursts and inconsistencies in therapy attendance due to previous negative patterns of behavior (Bhola & Mehrotra. 2021). Additionally, individuals with BPD may be more likely to bring up content related to trauma and negative experiences that may relate to unresolved conflicts in the clinicians' personal lives (Bhola & Mehrotra. 2021). The source of countertransference with the individual's BPD can come from multiple directions. As a result, the ways in which countertransference manifests, such as therapeutic withdrawal and distancing from the clinicians,

can result in more negative therapeutic outcomes. These adverse outcomes could be as simple as an injury to the rapport, which can be overly exaggerated and misinterpreted by the individual with BPD. These rapport injuries could further trigger feelings of abandonment, resulting in irreversible damage to the therapeutic relationship and even termination of services (Bhola & Mehrotra. 2021).

Although previous research has focused on these overly negative countertransference reactions in working with individuals with BPD, overly positive countertransference interactions have been explored in another research (Cambanis, 2012). Some clinicians have overly positive countertransference reactions to individuals with BPD, including feelings of warmth, nurturance, and even anger at people who have psychologically injured the individual. These overly positive countertransference interactions have also included feeling that the client is their favorite, a sense of therapeutic optimism, and seeing the client as special relative to other clients (Cambanis, 2012).

Although research tends to focus on how negative countertransference can affect therapeutic outcomes, overly positive reactions can negatively impact outcomes. In addition to therapeutic over-involvement, positive countertransference could result in losing objectivity. Examinations of countertransference in work with BPD have produced both overly positive and negative countertransference reactions, including feeling helpless, inadequate, overwhelmed, disorganized, over-involved, and treating the client with favoritism (Cambanis, 2012). It is clear that therapists who lack self-awareness and self-integration and who have unresolved conflicts within their personal life are especially vulnerable to experiencing a variety of countertransference feelings when working with clients diagnosed with BPD.

A common theme in the research examining countertransference reactions involving BPD is how clinician experience affects the amount of countertransference presented. Findings from several studies support the idea that the more experience a clinician has with BPD, the less negative and overall countertransference interactions are present (Liebman & Burnette, 2013). The more a clinician is exposed to individuals with BPD, the less intense and fewer countertransference reactions are (Liebman & Burnette, 2013). Although this is not limited to clinicians who work with BPD, it is essential to consider why this occurs, as BPD is more likely to evoke negative countertransference interactions.

Cultural Applications

In the therapeutic relationship, the therapist and the client attend to numerous indirect and direct communication cues. This includes not just the content of what each person says but the way in which each communicates as well. For participants in therapy, be they client or clinician, the cues attended to may influence the transference and countertransference that each experience. A clinician, for example, may attend to cues that assist in identifying discrepancies and deviations from what may be considered normal, healthy, or adaptive behavior. When individuals deviate from socially acceptable behavior, their behavior may be considered to represent psychopathology. However, in an intercultural therapeutic relationship, attending to culturally influenced cues that deviate from the clinician's or the dominant culture's expectations may lead to over or under-diagnosis or countertransference that may influence therapeutic outcomes.

Transference

Transference can find its origins in a variety of sources, from early foundations of relationships and cultural influences (Prasko et al., 2022). There are significant dropout rates in intercultural therapeutic relationships, with indications that this may be due to unaddressed and ignored transference involving culture and race (de Haan et al., 2018). This cultural transference can present in various ways, including those perceived as negative. It may be best understood as unconscious or conscious distortions related to culture that display as interpersonal behaviors in response to the therapist. These behaviors result from the client's direct and indirect experiences with people who are a part of the therapist's cultural group (Berger et al., 2014).

Cultural transference can occur when the client identifies with a minority or majority group. Transference for the client who identifies as part of a minority group is related to the perception of the therapist's racial group and the authority from this assumed group (Comas-Dıas & Jacobsen, 1991). These assumptions result in positive and negative transference issues related to racial identity. The client may make assumptions based on their perception of the therapist's racial identity, and these can result in distortions related to past traumas (Helms & Cook, 1999). Essentially, the therapist may represent past traumas the client has experienced related to race, which may involve socioeconomic status, attitudes, oppression, and traditions commonly associated with their racial group. Moreover, the client may perceive the therapist as more experienced and expect more from the therapist due to the perceived racial identity. For example, a client may assume that a therapist who is perceived to be White or White-passing has more authority or knowledge in their given specialty.

Transference can also occur when the client is a part of the majority group and the therapist is part of a minority group (Gailly, 2003). In this intercultural therapeutic interaction, transference can present through experiences of fear, disdain, superiority, and even comfort. For

example, an individual from a majority group who is an outcast in their family of origin may feel as if a therapist from a minority group is the only one who can understand their experience. This can result in the client feeling as though the therapist is safe and caring, but this can also result in the client viewing the therapist as someone who is there to "serve" them (Helms & Cook, 1999). These different transference reactions can be influenced by the gender of the clinician as well. For example, a client from a male-dominant culture may attribute more authority to a male clinician than a female clinician.

Countertransference

Some evidence indicates that unresolved conflict may be associated with preconceived notions about cultures and ethnicities (Unger, 2012; Ford et al., 2015). These unresolved conflicts related to culture and race may be further associated with cultural conditioning. The way in which a clinician conceptualizes and understands factors of cultural conditioning, including assumptions, values, attitudes, stereotypes, and worldviews, may greatly influence the client.

As of 2018, the majority of psychologists in the United States identify as White, approximately 79%, while 10% identify as Hispanic or Latino, 4.7% identify as Black or African American, and 4.2% identify as Asian (Lin et al., 2018). In comparison, the US Census data from 2020 indicates that 57.8% of Americans identify as White, 18.7% as Hispanic or Latino, and 12.1% as Black or African American (US Census Bureau, 2020). These data regarding the racial identity of psychologists highlight the importance of identifying cultural countertransference, especially for White therapists involved in intercultural therapies. Countertransference in intercultural therapies can be the result of lifelong efforts to avoid complex issues related to

immigration, race, and cultural differences. This can result in unconscious efforts to avoid uncomfortable and complex emotions which manifest in several ways (Comas-Dıas & Jacobsen, 1991; Gailly, 2003; Gorkin, 1996; Holmes, 1992).

The first way in which this countertransference manifests for the white therapist involved in interracial therapy is through viewing the client as exotic (Qureshi & Collazos, 2011). This is best explained as the therapist viewing the client as "other," and this other represents a foreign or exotic culture. This results in a majority of the session focusing on interviewing the client as if the therapist were an anthropologist rather than focusing on therapeutic interventions and mental health.

Intercultural countertransference can manifest as the therapist viewing the client as "the White man's burden" (Qureshi & Collazos, 2011). This results in the therapist feeling as if the disadvantages of another cultural group are their responsibility as the White therapist. The therapist then unconsciously views themselves as part of a more advanced culture, and the client is part of an "inferior" culture.

Intercultural countertransference can also present as variations of colorblindness (Qureshi & Collazos, 2011). Colorblind countertransference denies the importance and relevance of race, racism, and cultural differences. The therapist will assert the idea that racism is an issue of the past or in other countries and that all clients, regardless of race and ethnicity, are part of the human race. Colorblindness countertransference can also present as refusing to see the client as a cultural being and putting forth the idea that the therapist sees the client as they "really are." This can minimize the importance of cultural identity and leaves the therapist open to underestimating their own unresolved issues related to cultural differences.

One additional way intercultural countertransference can manifest is overt and less unconscious than the others discussed (Qureshi & Collazos, 2011). In this form of countertransference, the therapist will view the client's racial or cultural group as the "problem." This is best explained within the statement stem, "I am not racist but…." If an individual uses this type of phrasing, it may be because they are trying to excuse away a misconception that they know is rooted in racism. In the case of countertransference, the therapist views some aspect of the client's cultural or racial group as the root of the distress in their lives. It becomes a more overt and direct expression of intercultural countertransference.

BPD Differences Across Cultures

The functioning of an individual's personality can be significantly influenced by the cultural context in which the individual exists (Bhugra & Becker, 2005). Social, family, and religious values, traditions, and practices of varying cultures greatly influence personality features. Additionally, the culture to which an individual belongs can significantly influence whether a behavior is considered acceptable and what is considered a deficit or socially unacceptable (Bhugra & Becker, 2005). There are inconsistencies across cultures when attempting to define what is considered healthy development and well-being (Leighton & Hughes, 2005). There are variations in acceptance, flexibility, openness, and containment of personality differences. While some cultures may pay less attention to personality differences, others may be able to contain them with cultural and subcultural units (Leighton & Hughes, 2005). When personality differences are less accepted, it can easily lead to conflicts and feelings of rejection, significantly affecting mental health and well-being (Leighton & Hughes, 2005). Some cultures may be more likely to encourage and promote personality traits and patterns, while others may devalue, suppress, or ignore these traits (Leighton & Hughes, 2005).

BPD is a controversial diagnosis in countries with Eastern worldviews, particularly China, partly due to how the diagnosis is classified in the DSM-5. The Chinese psychiatric communities contend that criteria are inappropriate within the context of Chinese culture, such as fear of abandonment and examples of impulsivity (Ronningstam et al., 2018). This is likely due to collectivistic cultures' tremendous value on community, collective identity, and relationships. However, there is evidence in the research that suggests a certain level of BPD prevalence in Chinese culture and across Asia (Kim et al., 2001). The prevalence of BPD in China specifically ranges from 1% in college students to 8.4% in high school populations. Ranges of prevalence in clinical settings are from 1.3% to 7.1%. These numbers vary across countries within the continent. For example, the prevalence of BPD in Southeast Asia is 13% in outpatient and inpatient settings (Kim et al., 2001). While in Singapore, prison settings have a 16% prevalence, with 36% in psychiatric settings.

Overall, there is evidence to suggest similarities and differences in the presentation of BPD in Asian cultures when compared to Western cultures. There was a similar clinical picture in specific comparisons of Japanese BPD clients with U.S. BPD clients. However, there are notable differences overall. Eastern Asians with BPD may be more likely to suppress emotions and reduce behavioral reactivity to emotional stimuli (Zhang et al., 2012). It appears there are significant differences in interpersonal, behavioral, and emotional dysregulation presentation across these two broad cultural groups.

In examining a different collectivistic culture, Italian immigrants in the United States have been found to be more effective and expressive when compared to other White ethnicities. There is an emphasis on family, which plays a dominant role in the culture, and the high affectivity levels. For example, Italian mothers have been found to show higher levels of

affective expression, socialization, physical handling, and holding of their children than American mothers (Hsu & Lavelli, 2005). Perhaps relatedly, Italians show less impulsivity and parasuicidal behaviors overall. However, those with BPD will often display high levels of social anxiety and interpersonal hypersensitivity than Italians without BPD (Paris, 1996). This is especially present when one pursues expressions of assertiveness and individualistic goals. Many clinicians may misdiagnose or miss diagnoses of BPD in Italians, as evidence suggests they often internalize emotions, such as emotional sensitivity, emptiness, and painful interpersonal relationships (Paris, 1996).

Several ethnic groups and sub-cultures are found in Australia, and there exists a significant stigma against mental illness, particularly personality disorders, within many of these groups. This creates significant challenges in examining the occurrence and presentation of the diagnosis. There is a hesitation to diagnose personality dysfunctions and treat these disorders and dysfunctions (Tyrer et al., 2010). Over the last 200 years, many individuals have experienced trauma in the country, most notably the indigenous peoples, due to colonization. As a result, responses to these ongoing traumas are seen as personality characteristics rather than treatable conditions (Belli et al., 2013). This, in turn, results in the over-pathologizing of an entire culture. There are additional challenges with the undertreatment of men diagnosed with personality disorders. Despite the presence of the diagnosis being similar across genders, prevalence studies suggest that there are slightly higher rates of men with personality disorders in general in Australia (Belli et al., 2013). Yet, fewer men receive treatment. There is, however, a growing trend in recognition of the need for services, treatment, and research of personality disorders within Australian culture.

Just as it is vital to examine worldwide differences in cultural expression of BPD, it is also important to examine differences across cultural groups within the Unities States. Several studies examining the prevalence and symptom endorsement related to BPD have varied when comparing Hispanic, White, and African Americans (Paris, 2010). For example, in an analysis of data from treatment-seeking individuals, there were higher rates of BPD in Hispanic Americans than in African Americans and Whites. Additionally, Hispanic Americans were more likely to endorse unstable relationships, lack of anger control, and affective lability (Grant et al., 2008).

One facet of BPD that has been largely explored across ethnicities in the context of BPD is suicide and parasuicide behavior among White and African American women (Guertin et al., 2001; Gratz, 2006)). Despite the higher levels of adversity that African American women face, there are higher rates of parasuicidal behavior in White women. However, the results differ when males and females are included in the analysis, as results indicate only lower rates of parasuicidal behavior in African American women, not men, compared to White Americans (Walker et al., 2006). The authors hypothesized that African American women have several protective factors, such as spiritually-based coping, close kinship bonds, and support networks (Rockett et al., 2006). Parasuicidal behaviors are often studied in the context of BPD and used to examine prevalence. The scarcity of these behaviors in African American women may leave them misdiagnosed or underdiagnosed.

Overall, examining cross-cultural and ethnic variations in symptomology and the prevalence of BPD is essential for researchers and clinicians. The cultural context of a diagnosis is vital. The DSM-5-TR contains the cultural formulation interview to help the clinician focus on how the various aspects of culture can affect their perspective of their conditions (APA, 2022). This includes their background, social context, and developmental experiences. An individual

cultural perception can contribute to treatment motivation and self-coping and help-seeking behaviors. This is especially true of personality functioning, which includes identity, self-directions, and in the context of cultural agency, acceptance, authorship, and autonomy. These tools can provide context for the development of BPD for the individual within their culture and background when otherwise overlooked when not fitting into Western understandings of the diagnosis.

Discussion

Summary of Findings

BPD is a complex diagnosis with varying origins, presentations, and treatment approaches. It is well known to be conceptualized by marked impulsivity and instability in interpersonal relationships, affect, self-image, and emotion regulation (APA, 2013). Despite this well-known and accepted conceptualization, the symptomology of the disorder can vary across gender, age, and ethnicity (Selby et al., 2008). The development of the diagnosis has numerous theories by which it may occur, including childhood traumatic experiences, alterations in brain development, neurotransmitter abnormalities, genetic factors, and temperament styles combined with parenting styles (Kernberg, 1967; Herman & van der Kolk, 1987, 1989: Herman et al., 1989; Fonagy et al., 2017; Skoglund et al., 2021; Bozzatello et al., 2021; Baird et al., 2005). The prevalence of the diagnosis varies depending on the setting and population examined. Broad community samples estimate a 0.04% to 1.8% prevalence, while outpatient client samples estimated prevalence is 8% to 27%, and clinical samples range from 40% to 44% (Meaney et al., 2016; Korzekwa et al., 2008; Newhill et al., 2009). Historical treatment for BPD has included pharmacological methods and psychoanalytic and behavioral approaches. However, the most

widely utilized and efficacious treatment is DBT. Other approaches for treatment include TFP, SFT, and MBT (Kliem et al., 2010; Clarkin et al., 2007; Giesen-Bloo et al., 2006; Doering et al., 2010).

The concepts of transference and countertransference have evolved over time. Both concepts first appeared in the revolutionary writings of Freud in 1888 (Almond, 2011). However, over the years, theorists and researchers explored transference and countertransference to expand upon their importance within the therapeutic relationship (Levy et al., 2012; Holmes, 2014; Hayes & Gelso, 2001). Transference is the unconscious process of ascribing representational aspects of foundational relationships to another person in conscious and unconscious ways (Levy, 2009). In contrast, countertransference is a clinician's interpersonal reactions to a client, typically from unresolved conflicts (Hayes et al., 2011).

These concepts are essential in working with BPD because they will likely be present during the therapeutic relationship. The misinterpretations of self and others that tend to be present in the client with BPD lead to difficulties in integration interpretations and representations (Young et al., 2003; Giesen-Bloo et al., 2006). These tend to be overly positive and negative and often present in transference towards the clinician in therapeutic settings (Hayes & Gelso, 1991, 1993; Hayes et al., 1998; Hayes, Gelso, & Hummel, 2011; Bhola & Mehrotra, 2021; Cambanis, 2012). Countertransference in therapeutic work with a client with BPD can come from various sources, including the transference the client displays. This can create a vicious cycle of countertransference and transference, and when left unchecked, it can lead to negative therapeutic outcomes (Blatt et al., 1996). It is important to note that both overly positive and negative countertransference and transference can occur in therapeutic relationships working with those diagnosed with BPD (Landonson & Welton, 2007; Liebman & Burnette,

2013). This transference and countertransference can be addressed in various ways, including therapeutic approaches such as TFT and clinical consultation with more experienced clinicians (Clarkin et al., 2007).

Culture, cultural identity, and preconceived perceptions of culture can influence the presentations of countertransference and transference in the therapeutic relationship (Prasko et al., 2022). Cultural transference includes conscious and unconscious distortions that display as interpersonal behaviors and interactions with the therapist and are specifically related to culture (de Haan et al., 2018; Berger et al., 2014). This transference can occur when a client is from a minority or majority group. Cultural transference can be present in the therapeutic relationship through perceptions of authority and privilege (Comas-Dıas & Jacobsen, 1991; Gailly, 2003). Cultural countertransference in intercultural therapy can stem from lifelong efforts of avoidance of complex issues related to race, which can be unconscious and manifest in several ways (Comas-Dıas & Jacobsen, 1991; Gailly, 2003; Gorkin, 1996; Holmes, 1992).

In examinations of BPD in Western countries and individual differences in Americans, several studies examining prevalence and symptoms endorsement of BPD have varied when comparing Hispanic, White, and African Americans (Paris, 2010). An analysis of data from treatment-seeking individuals showed higher rates of BPD in Hispanic Americans than in African Americans and Whites (Grant et al., 2008). Additionally, Hispanic Americans were more likely to endorse unstable relationships, lack of anger control, and affective lability (Grant et al., 2008).

Overall, examining cross-cultural and ethnic variations in symptomology and the prevalence of BPD is vital for researchers and clinicians. These diagnostic understandings of the diagnosis help clinicians avoid and address the countertransference and transference issues that

will come up in the therapeutic relationship. This is especially true when working with clients with BPD, as these transference and countertransference issues are much more likely to present themselves.

Strengths and Limitations of Existing Literature

The literature examining BPD, countertransference, transference, and cultural identity as separate concepts is well-established and extensive. One major challenge in identifying articles for the present review was the lack of studies jointly focused on the constructs under review. To effectively address the interplay of culture, transference, and countertransference in cases involving BPD, it was necessary to draw conclusions by piecing together the findings of studies often not intended to focus on one or more of these variables. Relevant information was often embedded as a minor narrative within a manuscript focused on other primary variables. Ultimately, however, though the existing literature seldom explored interrelations between culture and the other constructs of current interest, some meaningful conclusions could be drawn for the present review. Strengths and limitations of the extant body of literature involving these constructs are included below.

Strengths of Existing Literature

A common strength that arose from examining the literature in all of the construct present in this review is the breadth and depth of each body of literature. There was extensive literature on culture, BPD, transference, and countertransference. This breadth and depth of literature allowed for overlap of the constructs in the present review, and thus, conclusions were drawn from those that did not overlap. The best examples of these strengths are the bodies of literature that explored culture and transference, as well as BPD and culture.

Studies examining transference and culture had strengths in the diversity of participants included in the surveys, psychometric assessments, and theoretical understandings. Multiple cultural perspectives were examined and included in the literature as a whole. There were conceptualizations of transference between a White therapist and a client of color, between a therapist of color and White clients, and lastly, culturally similar therapist and client pairings. This allowed for greater generalizability in the concepts of culture, transference, and even BPD due to the depth of topical focus on transference and BPD.

The topical focus of BPD and cultural variations in the existing literature was vast in the number of studies examining differences and the cultures examined. Studies exploring the jointed constructs included different cultures within the U.S., as well as different cultures across the world. These inclusions allow for greater generalizability to cultural differences that may be present in those diagnosed with BPD. Additionally, studies examining the diagnosis criteria across cultures were longitudinal and cross-sectional in nature, which allows for continued generalizability as the understanding of BPD across cultures grows.

Limitations of Existing Literature

Although the breadth and depth of the existing literature in the constructs included in this review provided strengths, there were limitations present in the collective and separative bodies of literature. These limitations went beyond the lack of literature jointly exploring the constructs of the present review.

A theme that arose throughout the collective literature is Western conceptualizations of transference, countertransference, and BPD. Although there was some acknowledgment that clinician diagnostic understandings might be different for BPD across the globe, there was a lack

of mentioning this in the literature examining countertransference and transference. This led to limitations in the overall generalizability in some of these concepts across cultures, as the prevalence rates examined may have limited accuracy.

Studies that did examine the prevalence of BPD were limited to online surveys and self-report and may not have accounted for misunderstandings of the diagnostic criteria for BPD. Additionally, studies acknowledged that understandings of BPD across cultures might lead to over or underdiagnosis, which again may have an effect on the accuracy of the prevalence rates.

One area that contained some of the greatest limitations, despite the depth and breadth of the concept in general, is countertransference as it relates to culture. Studies that examined countertransference in clinicians working with a client with a different cultural background than their own had a lack of diversity in their samples and participants. These studies focused on the countertransference experience of the White therapist, the White client, and the client of color. However, these samples and participants did not include therapists of color. Leading to a lack of generalizability of concepts of countertransference management, but a large gap within the literature itself. This also leads to gaps in the current review to come to conclusions regarding clinicians of color working with clients diagnosed with BPD.

Clinical Training Implications

In outpatient client samples, the estimated prevalence of BPD is 8% to 27%, and clinical samples range from 40% to 44% (Meaney et al., 2016; Korzekwa et al., 2008; Newhill et al., 2009). These prevalence rates are comparable to that of depression and anxiety. However, clinicians' training in clinical and counseling psychology doctoral programs is not comparable to training in addressing depression and anxiety (Levy, 2021). Although there are numerous

approaches to the treatment of personality disorders, and specifically BPD, such as DBT and TFT, these approaches are often not examined as closely as approaches to depression and anxiety in doctoral training programs (Levy, 2021). This can lead to new clinicians feeling unprepared to work with the complexities of therapeutic interventions often utilized when treating BPD (Levy, 2021).

This leads to more significant issues, such as only 16% of doctoral programs having faculty that specialize or are interested in personality disorders in general, let alone BPD specifically. If few student clinicians are being trained in BPD approaches (Levy, 2010), they may be likely to avoid continued work with the disorder; as they represent the next generation of training faculty, this may perpetuate the cycle of programs lacking faculty with experience with the diagnosis (Levy, 2010). Meanwhile, the prevalence of the diagnosis in outpatient and clinical settings does not change and continues to grow as diagnostic understandings and representations are fine-tuned. It is important to note that there are numerous opportunities for student clinicians to seek out their training in DBT and TFT if they desire to work with the diagnosis in their post-doctoral placements. However, these opportunities should also be available within their programs.

An important aspect of therapeutic work with any client, and BPD in particular, is countertransference. There are often preconceived notions about clients with BPD regarding their interpersonal interactions with a therapist. However, there is also the strain that working with these individuals can cause on the therapist. Thus, examinations of countertransference issues with new and seasoned clinicians become essential. The negative consequences of countertransference are endorsed less often by more experienced clinicians than the training or student clinicians (Liebman & Burnette, 2013). This is not to say that countertransference does

not happen; instead, the negative consequences or issues are less likely to impact the therapeutic relationship. This is a significant indicator that something is missing within the training for countertransference-related issues in the therapeutic relationship. Although it is essential to recognize that there will be a natural decrease in these issues as clinicians gain more experience, it is also essential to acknowledge and bridge the gap as much as possible. Somewhere along the way, the more seasoned clinician is learning ways to more effectively manage their countertransference. However, these ways of addressing countertransference should be taught to newer psychologists and student clinicians with more intentionality. This is a fundamental way student clinicians could be better prepared to deal with interpersonal conflicts in their clinical work in general, particularly with their clients diagnosed with BPD.

There are several ways in which clinical training for borderline personality disorder could improve during doctoral training as well as after. For training during doctoral programs, Ph.D. and PsyD programs may need to go beyond hiring professors and researchers with a focus or interest in personality disorders. Programs should examine their current curriculum for gaps in training related to personality disorders. Classes such as those that focus on diagnostic competence (e.g., utilizing the DSM-5-TR) should emphasize personality disorders and, specifically, differential and comorbid diagnoses related to disorders such as BPD. One example of this could be including case studies and vignettes engaging the class in diagnostic differentiation between BPD and bipolar disorder or multiple presentations of BPD in clients from diverse backgrounds. These tasks would afford students the opportunity to think critically about the various manifestations of BPD in different cultures rather than simply checking off symptoms from a list in the latest edition of the DSM.

Classes that focus on treatment approaches and modalities, whether psychodynamic, cognitive behavioral, group, or otherwise, should emphasize efficacious treatment modalities for BPD. These would include time spent learning how to apply DBT or TFT approaches to BPD case examples and how to adapt these modalities to appropriately treat clients with BPD from diverse cultural backgrounds.

Lastly, courses focusing on professional development, such as clinical practicum courses, should address countertransference and transference that may be more likely to occur with BPD. Clinical practicum courses introducing and exploring countertransference concepts may focus on general approaches to managing countertransference but may not adequately prepare students for some of the more intense countertransference that is often experienced with BPD. One way to bridge this gap in competency in work with BPD is to introduce the countertransference challenges that may arise with case studies, role plays, and class discussions early on in training, and to continue the discussions throughout training.

Just as there is a gap in competency training for BPD and countertransference during doctoral training programs, there are similar gaps in post-doctoral training. Overcoming these shortcomings could occur in several ways, such as increasing the use of role-play exercises, discussion of case studies, and placing an emphasis on training in therapeutic approaches such as DBT and TFT. Additionally, initial licensure applications could begin to include a requirement that a certain number of training hours be completed that involve identifying and treating personality disorders, managing related countertransference, and treatment modalities that have demonstrated effectiveness with personality disorders, such as DBT and TFT.

Future Research Directions

In examining the research on countertransference related to the therapist and client's cultural identities in therapeutic work with BPD, some gaps link these key concepts. Three major areas of future research came from this review of current literature examining these concepts. First, key concepts must be included in examining cultural countertransference and transference and precisely how this may impact BPD. The diagnostic underpinnings of BPD in countries dominated by a Western worldview appear to be more solidified than in countries with Eastern worldviews. The existing literature demonstrates that worldview–sometimes understood as cultural values that drive behavior–can influence the presentation of a diagnosis and, relatedly, the clinician's assumptions in working with these individuals. Future research should focus on how the client's cultural identity can impact diagnostic presentations and, therefore, understandings of how to effectively work with such a complex personality disorder.

The second area stems from the lack of research on countertransference issues for minority-identifying clinicians. Most of the research into countertransference issues related to cultural and ethnic identity focused on White clinicians. Although this research is vital as it comprises most psychology communities, it leaves the work of entire groups of clinicians unexamined. There may be separate cultural countertransference issues for minority-identifying clinicians in the therapeutic relationship. Suppose these issues remain unexamined in the clinical literature. In that case, the result is an entire group of clinicians left without guidance on dealing with the specific countertransference presentations that may differ from those of Western and/or White therapists. This would be especially harmful in working with BPD, a diagnosis more likely to bring about countertransference issues.

A third area that could guide future research of BPD is based on the understanding of BPD in the psychiatric and psychopharmacology fields of research. In psychopharmacology,

BPD is divided into three different presentations. These presentations include hysteroid-dysphoric, schizotypal, and angry impulsive (Preston et al., 2008). The individual with a hysteroid-dysphoric presentation has a higher degree of emotional lability and is more sensitive to perceived interpersonal loss, rejection, and abandonment, resulting in desperate attempts to avoid this rejection and abandonment (Preston et al., 2008). The schizotypal presentation tends to display odd thinking, specifically ideas of reference, vagueness, idiosyncratic beliefs, magical thinking, and periods of depersonalization. The angry-impulsive presentation or subtype presents with hostile and aggressive interpersonal interactions, with low levels of frustration tolerance, and often can be volatile (Preston et al., 2008).

These presentations or subtypes of BPD guide psychiatry in the type of psychotropic medication that can be prescribed. This is partly because there is no specific medication for BPD, but there are ways to treat the symptoms (Preston et al., 2008). Existing clinical psychology research has not tended to examine BPD in this same way. Instead, the diagnosis is considered one whole rather than as a single diagnosis with a diverse set of subtypes. If future researchers were to examine the reliability and validity of these subtypes, it could potentially guide how the diagnosis is differentially treated in psychotherapy. Additionally, these different symptom clusters could have varying impacts on the countertransference and transference experienced by participants in the therapy process. Consequently, this could guide the development of more effective training regarding the management of countertransference and transference. These symptom clusters and subtypes may also explain the diagnosis's varying diagnostic presentations and its underpinnings across cultures and worldviews.

In summary, BPD continues to be a complex diagnosis that evokes strong feelings from participants on all sides of the clinical encounter. To serve most effectively those suffering the

consequences of the instability involved with the diagnosis, clinicians much continue to expand their understanding of the many iterations of the BPD symptom spectrum that can differ based upon a number of factors, including cultural identity.

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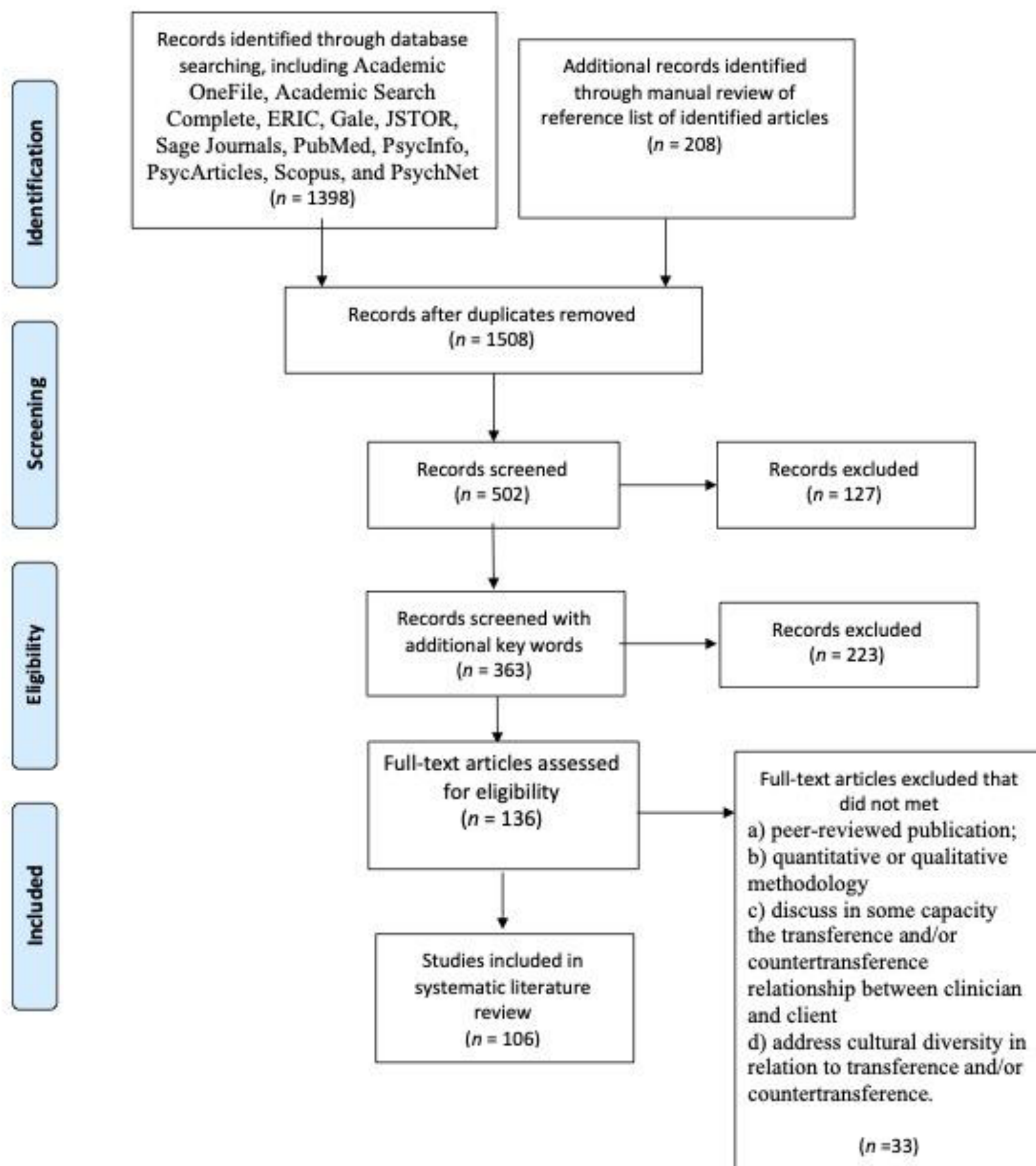
Figure 1

Flow Diagram



APPENDIX C

CURRICULUM VITA

Melanie E. Estrada

Fontana, Ca | 909-233-3204 | melaniee.estrada@calbabptist.edu

EDUCATION

Doctor of Psychology, Clinical Psychology Degree Anticipated August 2023

California Baptist University, Riverside CA

Master of Arts, Clinical Psychology August 2020

California Baptist University, Riverside CA

Bachelor of Art, Psychology August 2018

California Baptist University, Riverside CA

DOCTORAL CLINICAL TRAINING

Federal Bureau of Prisons-FCC Tucson **Tucson, AZ**

August 2022-Present

Psychology Predoctoral Intern

1475 hours and counting

- Intensive treatment rotations involved providing assessment, individual, group, and milieu therapies, interdisciplinary consultation, and program administration activities to diverse populations of inmates with various offense types.
- Severe mental illness rotation involves providing assessment, crisis intervention, and individual and group treatment.
- General population/restrictive rotation involved providing mental health screening, crisis intervention/suicide risk assessment, individual and group therapy, and assessment.

Helping Hearts Inc **San Bernardino, CA**

July 2021-July 2022

Intern Therapist

298 hours and counting.

- Provided individualized services for conserved and non-conserved adults with severe and persistent mental illness, including but not limited to schizophrenia, schizoaffective disorder, and bipolar disorder in a residential facility.
- Participated in weekly individual and group supervision.
- Participated in interdisciplinary teams for client care.
- Provided weekly seeking safety group therapy services.
- Developed and provided weekly group art therapy services.

San Bernardino County Department of Behavioral Health **San Bernardino, CA**

October 2020-July 2021

Graduate Student Intern-CHOICE Program

270 hours.

- Provided individualized therapy for adults with severe mental illness, including Schizophrenia, PTSD and Bipolar Disorder, in conjunction with the probation department.
- Conducted in-depth intake assessments, screenings, and treatment planning
- Participated in weekly individual, group, and peer supervision.

Psychological Services of Riverside **Riverside, CA**

September 2019 – August 2020

Doctoral Practicum Student

150 hours.

- Utilized ACORN system to formally monitor and assess client outcome consistently
- Provide individual, couple, family therapy for children, adolescents, adults, and families
- Administer assessments to aid in diagnosis, interventions, and treatment planning
- Participate in weekly individual and group supervision

PROFESSIONAL EXPERIENCE

Aegis Treatment Centers **Ontario, CA**

June 2018-December 2018

Case Manager

- Provided professional individual and case management services to patients.
- Completed initial needs assessment and individualized treatment plan to effectively help patients to improve the quality of their lives.
- Conducted intakes, discharge planning, initial needs assessments, and treatment plans in a professional manner
- Maintained patient charts and document all counseling services according to local, state and federal regulations.
- Followed the supervision of Clinic Management.

GRADUATE ASSISTANTSHIPS

California Baptist University Industrial and Organizational Psychology Program Riverside, CA

August 2020-December 2020

Graduate Assistant

- assist the administration in master's level program management.
- provide support to faculty in bachelor's and master's level courses in the form of research and securing resources.

California Baptist University Sport and Performance Psychology Program Riverside, CA

August 2019-June 2020

Graduate Assistant

- assist the administration in master's level program management.
- provide support to faculty in bachelor's and master's level courses in the form of research and securing resources.

California Baptist University Forensic Psychology Program Riverside, CA

August 2018-July 2019

Graduate Assistant

- providing support to faculty in bachelor’s, and master’s level courses in tutoring students, grading, and lectures as needed.
- help faculty with research projects, as well as assist the administration with other activities.