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ORIGINAL PAPER

Motive-Oriented Psychotherapeutic Relationship Facing a Patient Presenting with Narcissistic Personality Disorder: A Case Study

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Abstract Motive-oriented therapeutic relationship (MOTHER), a prescriptive concept based on an integrative form of case formulation, the Plan Analysis (PA) method (Caspar, in: Eells (ed.), Handbook of psychotherapy case formulations, 2007), has shown to be of particular relevance for the treatment of patients presenting with personality disorders, in particular contributing to better therapeutic outcome and to a more constructive development of the therapeutic alliance over time (Kramer et al., J Nerv Ment Dis 199:244–250, 2011). Several therapy models refer to MOTHER as intervention principle with regard to borderline and Narcissistic Personality Disorder (NPD) (Sachse et al., Clarification-oriented psychotherapy of narcissistic personality disorder, 2011; Caspar and Berger, in: Dulz et al. (eds.), Handbuch der Borderline-Störungen, 2011). The present case study discusses the case of Mark, a 40-year-old patient presenting with NPD, along with anxious, depressive and anger problems. This patient underwent a seven-session long pre-therapy process, based on psychiatric and psychotherapeutic principles complemented with PA and MOTHER, in preparation for further treatment. MOTHER will be illustrated with patient–therapist verbatim from session 4 and the links between MOTHER and confrontation techniques will be discussed in the context of process-outcome hypotheses, in particular the effect of MOTHER on symptom reduction.

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Introduction

Narcissistic Personality Disorder (NPD) is usually considered a difficult-to-treat mental condition. Patients presenting with NPD rarely seek therapy because of high levels of ego-syntonic functioning and thus, little psychological distance with their own functioning (Dimaggio et al. 2007; Fiedler 2000; Sachse et al. 2011); these patients usually consult for surface problems, such as anxiety, depression, substance abuse and psychosomatic disorders, without being aware of the possible links with personality aspects and interpersonal functioning related with NPD. In parallel, understanding NPD psychopathology and developing adapted treatment is an important endeavor which was undertaken from interpersonal (Benjamin 1993; Dimaggio and Attina 2012; Dimaggio et al. 2007), cognitive (Beck and Freeman 1990), psychodynamic (Kernberg 2007; Kohut 1971) and humanistic (Sachse et al. 2011) perspectives. So there are potentially beneficial treatments, but the patients find it difficult to engage. This calls for efficient therapeutic procedures at the very beginning of treatment, helping these patients to enter a specific therapy for problems related to NPD, and calls for efficient therapeutic procedures enabling constructive work on core issues in NPD. These core issues include vulnerable self-image, difficulties in reflecting on mental states (Dimaggio et al. 2007; Levy 2012), lack of empathy (Fan et al. 2011; Ritter et al. 2011), problems related to shame as central emotional state (Dimaggio 2012), along with problematic emotion regulation, destructive interpersonal patterns related to

grandiosity and dominance or aggressivity, superficiality, and interpersonal avoidance processes (APA 1994; Fiedler 2000). It also becomes clear that therapists need efficient case conceptualization tools helping to deal with counter-transferential issues which are actuated within the therapeutic relationship.

So far, psychotherapy outcome studies on NPD are scarce (Ellison et al. 2013; Levy et al. 2009). Experts generally recommend the use of techniques which have shown their efficacy and effectiveness for other PDs (see Gaebel and Falkai 2009), such as Borderline Personality Disorder, a "near neighbor disorder" (Levy 2012, p. 892). In cognitive-behavior therapy the teaching of problem solving and social competence skills and the modification of underlying dysfunctional schemas on self-worth is recommended (Beck and Freeman 1990). In psychodynamic therapy, the interpretation and clarification of transference and counter-transference within the therapeutic encounter, in particular elements related with aggression, hate and jealousy are at the forefront (Gabbard 2009; Kernberg 2004).

Beyond strictly technical aspects of the psychotherapy with NPD, the centrality of relationship variables is discussed in the literature, for example de importance of the therapeutic alliance building at the very beginning of therapy (Ronningstam 2012; Smith et al. 2006). One concept at the core of the therapeutic relationship is the notion of complementarity. Since we are using a particular definition of complementarity for purposes of this paper, we first wish to present the classical assumptions regarding the concept before embarking in the presentation of the specific definition of the motive-oriented therapeutic relationship.

Complementarity: More than Just Being Friendly with Patients

The concept of *complementarity* arose within interpersonal theory which suggests the use of the interpersonal transaction context to best understand personality. The interpersonal perspective supports a two-dimensional conceptualization of personality differentiating interpersonal style according to the dimensions of affiliation (love–hate) and power (dominance–submission; Leary 1957), where complementarity specifies ways in which a person behaves on an interpersonal level from a restricted number of classes of behavior "inviting" an interactional partner to adopt a complementary attitude in respect to both dimensions (Carson 1969). Structural Analysis of Social Behavior (SASB; Benjamin 1974, 1993) predicts which particular behaviors tend to be associated with each other in terms of three different circular planes of social behavior instead of one: focus on others, focus on the self and introjections of others' treatment of self. Here, complementarity is seen as how an individual typically behaves towards other people in terms of complements, opposites and antidotes allowing a refined description of dyadic social interactions. Kiesler (1983) adapted interpersonal complementarity to the entire perimeter of the Interpersonal Circumplex (so-called "Kiesler" cercle), in such a way that complementary interactions represent "pulls" person B experiences as a reaction to person A's interpersonal behavior. As such, complementarity encompasses "reciprocality" in respect to the power dimension (i.e., dominance invites submission, submission invites dominance) and "correspondence" in regards to the affiliation dimension (i.e., friendliness invites friendliness, hostility invites hostility). While an adjusted person can deal with a broader range of interpersonal positions, a maladjusted person's interpersonal behavior is more rigid as it is limited to but a few types of possible interpersonal behaviors across situations. Therefore, maladjusted persons tend to impose particular interpersonal reactions to others, including psychotherapists (e.g., Colli et al. 2013). Therapist awareness of these dynamics is therefore of foremost importance.

One way of fostering therapist awareness and constructive handling of these interpersonal dynamics is Grawe (1992) and Caspar's (2007) complementarity concept. It goes further than the classical assumptions of the interpersonal approaches in that the therapist offering to each patient an individually custom-tailored relationship which satisfies underlying motives. This basic therapeutic strategy is based on the Plan Analysis (PA) case formulation method (Grawe 1980; Caspar 2007; Caspar and Berger, 2011; Plan traditionnally written in the upper case to remind of the difference in definition as compared to the everyday use). Plan Analysis radically adopts an instrumental perspective on behaviors and experiences. This integrative, approach-independent method enables the therapist to generate hypotheses on patient's action-underlying and -generating principles, in the form of Plans, which are hierarchically ordered. It helps to understand the instrumental function of behavior in the hierarchy between needs (representing the highest-order motives) depicted on top of the Plan structure and concrete behaviors at the bottom of the Plan structure. As such, the complete Plan structure of a patient, as established by the therapist and drawn on paper (see the example in Fig. 1), helps the individualized understanding of a patient's inter- and intrapersonal functioning. PA assumes that the meaning of a behavior or an experience of a particular person in a particular situation cannot be determined in a standardized way: the same behavior may relate to radically different Plans across persons. For example, hostile behavior may serve the regulation of frustration irrespective of the therapeutic relationship, or represent a highly specific relationship test, where the patient "tests" if the therapist supports the patient in a reliable fashion, even if the patient is behaving in an interpersonally "nasty" (i.e., hostile)

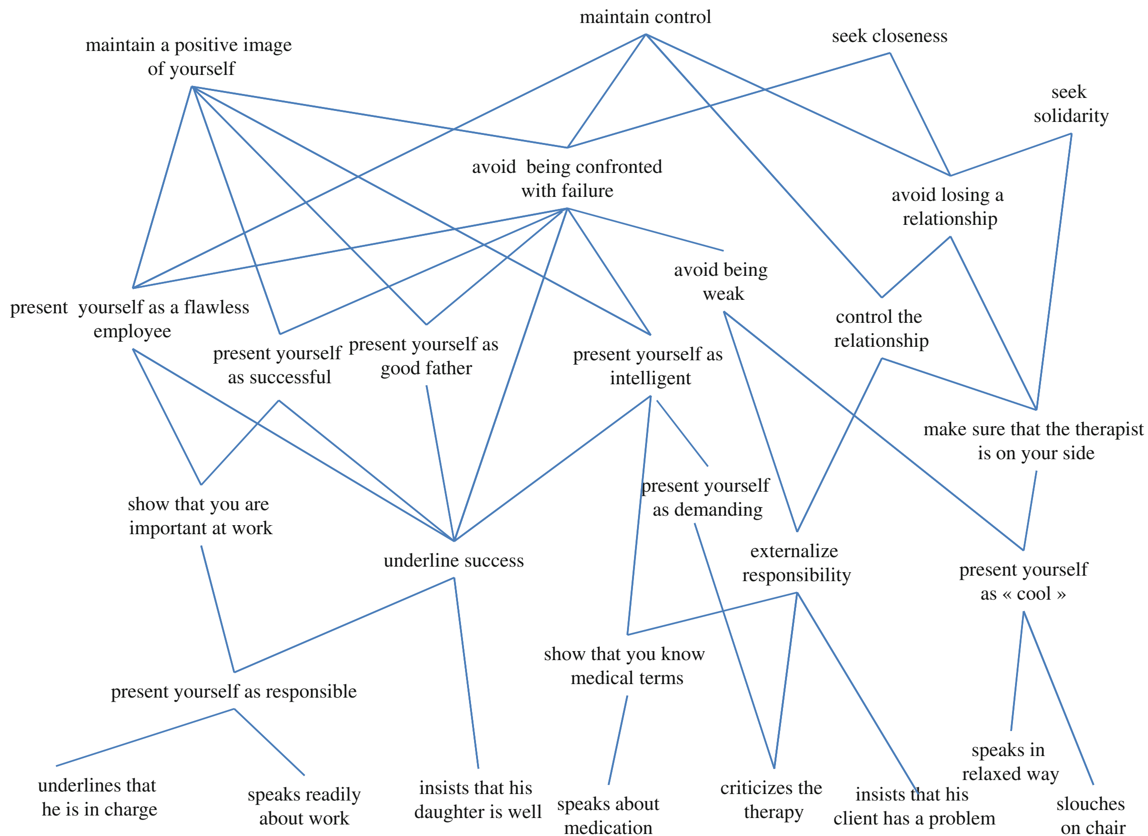

Fig. 1 Mark's Plan Analysis (*explanations in the text*)

way. As such, the PA shares with the circumplex models the idea of interaction fit, however, PA proposes an additional dimension: the understanding of instrumentality between behaviours and motives via the Plan concept. Once this Plan structure is established by the therapist—which is done usually in the beginning of therapy—it helps the therapist to create with this patient an idiosyncratically safe therapeutic relationship (Grawe 1992), the motive-oriented therapeutic relationship (MOTHER).

The MOTHER-principle assumes that even the most problematic patient behavior in the therapeutic relationship serves specific motives (as assessed by PA) which in themselves are acceptable. It is assumed that facing a therapeutic intervention consistent with the MOTHER-principle, the patient's non-problematic motives and higher-order Plans are satisfied (e.g., to avoid harm, to be understood, accepted as a person, to be a good mother, to be interpersonally attached), as these are acceptable goals "behind" problematic Plans and behaviors. Focusing on and proactively reassuring acceptable motives is a profound and individualized way of being empathic with the patient, going much beyond general relationship conditions. This intervention strategy is assumed to foster collaboration and proactively prevent—in an individualized fashion—ruptures in the therapeutic alliance (Safran and Muran 2000). It should help the patient to focus on constructive means to bring about change, and make new and potentially corrective experiences in the actual therapeutic interaction. It is postulated that these new experiences make it unnecessary for the patient to use instrumentally related lower-level problematic means (Plans and behaviors), as the patient, when faced with a MOTHER-therapist, is already able to get his/her basic needs and concerns met within the actual therapeutic interaction. This principle is believed to be of particular importance in the beginning of treatment with interpersonally challenging patients, but also throughout treatment (Caspar 2007; Kramer et al. 2011). As such, MOTHER is not a distinct therapy form, but rather a set of therapeutic principles derived from a specific case conceptualization method, the PA, which can be used in any therapy or can be added to any treatment form. Most typically, the "what" of a particular therapeutic intervention is determined by specific psychotherapeutic techniques and the "how" of a therapeutic intervention can be determined by the MOTHER-principle.

Evidence Favoring the MOTHER

There are several correlational studies on various patient populations attesting links between MOTHER as a

psychotherapy ingredient of larger treatment packages and outcome. In most of these studies, MOTHER is used as a descriptive feature of therapist intervention. For example, the level of therapist's non-verbal aspects consistent with MOTHER was linked with therapeutic change in an interpersonally-focused inpatient treatment for depression (Caspar et al. 2005). Schmutz et al. (2011) have shown, using path analysis methodology in a sub-sample of patients presenting with domineering interaction features, that MOTHER significantly contributes to the therapeutic outcome on an independent pathway from the therapeutic alliance. For patients presenting Cluster B and C Personality Disorder (except Borderline) with co-morbid depression, Kramer et al. (2011) replicated the correlational findings reported by Caspar et al. (2005) for very brief psychodynamic intervention; this study only found links between MOTHER and outcome in the case of PD.

In the first randomized controlled trial testing the effect of the isolated MOTHER-variable within a larger psychiatric treatment package for Borderline Personality Disorder, Kramer et al. (2011) showed in a pilot study that the delivery of MOTHER as prescriptive variable had a specific effect on the decrease of problems in the interpersonal realm. In addition, specific effects were found as regards the evolution of the therapeutic alliance and the quality of the therapeutic relationship. Finally, previous case studies have shown the relevance of PA as a tool for case conceptualization and of MOTHER as an efficient treatment component for avoidant personality disorder (Caspar and Ecker 2008) and post-traumatic stress disorder (Kramer 2009).

Studying possible mediating processes associated with the effects reported for patients presenting with Borderline Personality Disorder, Berthoud et al. (2013), found progression in emotional processing, towards more frequent in-session meaning-making emotional processing, as related with MOTHER, whereas Kramer et al. (2013) found that the reduction of over-generalizing cognitions was associated with treatments based on MOTHER principles, which was not the case in the comparison group.

MOTHER and Confrontation in the Beginning of Treatment of NPD

The establishment of a MOTHER is described as a useful initial step in therapy with patients presenting with NPD, as it makes a constructive collaboration on core issues actually possible (Sachse et al. 2011). Indeed, a prototypical threat to these patients' self-image—the idea of being in need of psychotherapeutic help—makes these patients fundamentally distrustful of the therapist and of the therapy context (Ronningstam 2012; Sachse et al. 2011). Thus, a particular focus needs to be laid on (reassuring) relationship aspects from the very first contact on, on which productive therapeutic work can be built. Besides creating such a solid trusting relational basis using the idiosyncratically anchored MOTHER-principles, Sachse et al. (2011) underline the importance of creating very early an at least approximate work focus which implies several forms of confrontation by the therapist. Here, the concept of confrontation is understood in a very broad sense, i.e., therapist addressing discrepant patient messages perceived by the latter in an incomplete way (Bastine and Kommer 1978). The patient may for example need to see that there is actually a problem in his/her life in order for him/her to be able to make sense out of the therapeutic encounters, which may in turn be again a threat to his self-image related to grandiosity and flawlessness.

A therapist entering treatment with a NPD patient needs therefore to continuously strike a balance between serving the patient's motives and acceptable Plans (without reinforcing problematic lower-level Plans and behaviors; the MOTHER-principle) on the one hand and confrontation with core issues for which the patient actually consults on the other hand. While such interventions are confrontative with regard to some patient motives (e.g., related to self-esteem), they are complementary to others, particularly change-related motives.

The aim of the present study is to illustrate on a moment-by-moment verbatim level the notion of MOTHER in the very first sessions of therapy. We also aim at contrasting MOTHER with the role of confrontation.

Method

Design

The present case study is based on a case within a seven-session psychiatric and psychodynamic treatment setting for personality disorders that took place at an outpatient University Consultation Center. After this short treatment, a long-term psychotherapy was proposed which was accepted by the patient.

The patient accepted to be part of a larger research project which was approved by local Ethic Committee. The patient accepted that data be used for publications. All personal information regarding the patient's identity is veiled.

The Patient

Mark, 40 years old, came to therapy for marital problems and problems related with anger, anxiety, depression and impulsivity. There are situations, in particular in the relationship with his wife Linda, but also at work, where Mark

gets extremely angry and feels overwhelmed by his emotions. These problems have led his wife to consider separation and to urge him to go into therapy. The patient feels under pressure by the threats exerted by his wife and he contacted the outpatient clinic.

At intake, the patient presented with a total score of 83 on the Outcome Questionnaire (OQ-45; sub-scale symptom distress 51, sub-scale interpersonal relationships 19 and sub-scale social role 13) which represents a clinically meaningful distress (clinical cut-off 60). Mark presented with a mean score of .83 on the Inventory of Interpersonal Problems (IIP) which was not considered in the clinical range (cut-off 1.36). On the Borderline Symptom List (BSL-23), Mark presented with a mean of .17 which was below the clinical cut-off of 1. On the Structured Clinical Interview for DSM-IV (SCID-II; First et al. 2004), full criteria for Narcissistic (5 criteria) and sub-threshold for Borderline features (3 out of 5 criteria) were met. In total on the SCID-II, Mark had 16 criteria met. In addition, on the Mini International Neuropsychiatric Interview (MINI; Lecrubier et al. 1997), Mark met criteria for Major Depression at intake.

His interpersonal style in relating with the therapist can be described as presenting as laid-back, friendly, in charge and in control of things in life. We also need to note that at intake, he rapidly criticizes the therapist and the therapeutic setting and he insists that the actual problem would be his wife or his employer. Note that the current psychotherapeutic treatment is the first of its kind for Mark.

Mark grew up as the only child in the context of an early divorced parental couple; the patient lived with his mother. The latter suffered from chronic exhaustion, depression and chronic alcohol dependency. There was psychological neglect, psychological and physical violence in the relationship with his mother. For example, aged 14, the patient was physically "attacked" by his mother and he used "self-defense"—according to his version of the facts—and repeatedly hit his mother. Shortly after this situation, the patient was separated from the mother and lived in a boys' boarding school until adulthood. During these years, the patient said he was very withdrawn, had very few social contacts and no friends at all. He describes himself as having had an "armor" around his Self during this period. The only occasion to actually be with other boys and young men was when he played hockey. In early adulthood, he lived with a teammate's family; this situation helped him to open up and feel more comfortable with himself. Mark had little contact with his father and only says of him that he was at the origin of him feeling completely discarded, profoundly uncapable and insignificant as a person. Mark's maternal grand-father provided a meaningful and profoundly supportive relationship to the patient. He was always helpful, soothing in the parental conflict and supportive of Mark's interests. The grand-father fundamentally helped Mark to access the feeling of being an existing and acceptable person and to have some "optimism" in his life. Mark's father re-married when he was 10 years old and Mark describes his step-mother as a "witch" who actually made sure that the patient was finally separated from his mother and placed in a boarding school. Still today, Mark resents this woman's intrusion in his life.

During early adulthood and based on these experiences, it was difficult for Mark to make a commitment to a woman. He reports some short relationships, along with several sexual adventures with women, but systematically felt unable to pursue the relationship and engage fully with the person. Only at the age of 30, he became engaged to his current wife Linda. Mark described her as his psychological "savior" who actually made it possible for him to commit himself to a profound intimate relationship. The couple has one child, Michelle, 5 years old at the time of consultation. Linda has suffered from a similar story to Mark; this helped him to relate with her and to finally feel understood in his sufferings. Whereas the initial years with Linda are like a honeymoon period, more recently, profound problems in the marital relationship emerged and contributed to the current conflictual situation.

Mark is a salesman in charge of a department at a large insurance company and is very successful in his work. He supervises a large team at the company. Recently however, conflicts between Mark and one of his clients emerged. This female client is described by Mark as "domineering" and "cold", and when interacting with her, Mark felt belittled and out of control; he started to yell at the client over minor disagreements and needed to be called to order by his superior.

Treatment and Therapist

In order to assess Mark's problems in detail and to respond to his request, a number of assessment procedures and interventions were proposed during the seven-session process according to APA recommendations for psychiatric treatments for Borderline Personality Disorder (see Gunderson and Links 2008). This very short treatment was already somewhat effective in reducing central symptoms. At discharge, the total score on the OQ-45 was 49 (symptom distress 25; interpersonal relationships 11 and social role 13). Also at discharge, the mean score on the IIP was .61 and the mean score on the BSL-23 was .09. Marital sessions were repeatedly proposed, but the couple did not wish to follow-up.

The therapist and first author of the present case study is considered an expert in psychotherapy for Personality Disorders. He is also an expert in using PA and MOTHER concepts as part of case formulation and intervention planning and delivery.

Instruments

Outcome Questionnaire-45.2 (*OQ-45*; Lambert et al. 2004). This self-report questionnaire includes 45 items addressing three main domains of distress: symptom distress, interpersonal relations and social role functioning. A general sum score was computed. A Likert-type scale is used to assess the items, from 0 (never) to 4 (almost all the time). Validation coefficients of the original English version are satisfactory, in particular for internal consistency and sensitivity to change over psychotherapeutic treatment. The validation of the French version used in this study was carried out by Emond et al. (2004) and yielded satisfactory results. Cronbach's alpha across all items for this case was .83. This questionnaire was given at intake and at discharge (after session 7) of Mark's treatment.

Inventory of Interpersonal Problems (IIP; Horowitz et al. 1988). This self-report questionnaire assesses interpersonal patterns on several dimensions, such as affirmation, affiliation, submission, intimacy, responsibility and control. Only the total score was used in this case study. In total, this questionnaire comprises 64 items. Cronbach's alpha across all items for this case was .81. This questionnaire was given at intake and at discharge (after session 7) of Mark's treatment.

Borderline Symptom List (BSL-23; Bohus et al. 2009). This self-report questionnaire assesses the borderline symptomatology using 23 items; excellent psychometric properties were reported. Cronbach'a alpha across all items for this case was .79. This questionnaire was given at intake and at discharge (after session 7).

Plan Analysis and MOTHER-Scale (Caspar 2007; Caspar and Grosse Holtforth 2009). Plan Analysis is an integrative method of case formulation that enables the therapist to understand the patient's behaviors and experiences from an instrumental perspective. In order to infer a Plan structure, the therapist analyzes video material (here the intake session) and answers the question "Which conscious or unconscious purpose could underlie a particular aspect of an individual's behavior or experience?" (Caspar 2007, p. 251) for each observation. Reliability for this individualized method was described and used in an earlier study by Kramer et al. (2009). For the current case, the reliability of the Plan structure elaborated by the therapist was high (75 %).

The MOTHER-Scale (Caspar et al. 2005) was applied to an audio- or video-recorded therapy session different from the intake session. The MOTHER-rating is done in three steps: (1) Identification of the therapist intervention sequence to be rated, (2) Identification of the central (acceptable) Plans or motives (maximum three per sequence) addressed by the therapist in this sequence, (3) Rating on two dimensions, (a) verbal and (b) non-/para-verbal, of MOTHER on a 7-point Likert-type scale (ranging from −3 "not complementary at all" over 0 "neutral" to +3 "absolutely complementary"). The anchor of the MOTHER-rating is always the central (acceptable) Plan as defined in the PA for this individual patient in this particular sequence. It is therefore a method of rating fully based on idiosyncratic content. Positive numbers indicate high therapist complementarity with regard to the patient's central Plan per sequence; negative numbers indicate low therapist complementarity with regard to the patient's central Plan per sequence.

Reliability for the present sample (1 session rated by 2 independent raters; session 4) was high on every step of the procedure: (1) Both raters selected the same therapeutic events to be rated with an overlap of 83 %, which is considered sufficient; (2) Both raters selected the same central Plan to be considered for MOTHER in these therapeutic events to the extent of 78 %; (3) Spearman rank correlations for the three scores were .85 for verbal, .81 for nonverbal and .83 for total complementarity.

Procedure

All the sessions were video or audio taped. This case was chosen after the completion of treatment because of its potential informative value in regards to the very early sessions of a patient presenting with NPD, undergoing a treatment that was infused with the MOTHER-principle, which, as a whole, was effective in reducing central symptoms over a short period of time. In addition, this case was chosen for its informative value for the articulation between MOTHER and therapeutic confrontation techniques.

The research procedure involved reliability checks, in which an independent researcher performed a PA (using the intake session as raw material) which was then compared with the Plan structure performed by the therapist (for reliability results, see under PA, above). In order to select a particular session to be analyzed using the MOTHER-scale, the therapist worked through the entire video- and audio-material of the case (seven sessions) and chose session 4 as being particularly informative. Two independent researchers (excluding the therapist) then rated the therapist behavior in this particular session (reliability coefficients for this session, see under MOTHER, above).

Results

How Mark's PA Helped in the Conceptualization of the Case

The PA (Fig. 1) shows that Mark presented with a number of behaviors and experiences (at the bottom row, for

example “criticizes the therapy”) which can be instrumentally linked to lower- and higher-order Plans (intermediate and uppermost levels). An instrumental link means that the lower item “serves” the upper item, or in other words, the lower item is the means to the end situated on the upper level. For example, we ask what purpose is behind the behavior “criticizes the therapy” and find that there are two hypothetical purposes for this particular patient (“present yourself as demanding”, “externalize responsibility”). In its turn, the Plan “externalize responsibility” is underlied by two different upper-level Plans, i.e., “avoid presenting as weak” and “control the relationship”. Again, we ask what the purpose is behind a Plan like “control the relationship” for this particular patient and find that it is a means to avoid losing a relationship and to maintain control; “avoid losing a relationship” is then instrumentally connected with the basic needs related to control, closeness and solidarity in this patient.

It can be concluded that Mark has several behavioral items related to work, where he emphasizes that he is the person in charge; work takes up a lot of time in his presentation of the Self. These observations are instrumentally linked with the Plan “present yourself as responsible” which, in turn, is related with “show that you are important at work” which serves the Plans “present as a flawless employee” and “present as someone who has success”. Ultimately, these Plans serve the basic needs of maintenance of control and of maintenance of a positive self-image. Mark also criticizes therapy and its context (“these discussions are just blabla”, “I only do the questionnaires to satisfy the secretary”) and externalizes the causes of some aspects of his functioning, including the attribution of positive effects to anti-depressants. These behaviors serve on the one hand the Plans to present himself as difficult, but on the other hand to avoid taking responsibility, to avoid talking about his affective life and to present himself as an intelligent person. Again, following the set of instrumental links until the uppermost levels, these behaviors and Plans may be linked to maintenance of control and to maintenance of a positive self-image. There are a number of behaviors and Plans related to the solidarity motive (i.e., “seek solidarity”). Mark speaks in a laid-back fashion and slouches in the chair, almost like as if he was sitting in a bar with a friend. These behaviors serve the Plan “present as cool” and “make sure that the therapist is on your side”, which are means to control the therapeutic relationship and ultimately serve the basic needs of seeking closeness and of finding solidarity.

From the MOTHER perspective, one need to ask which higher-order Plans and motives are acceptable within the therapeutic relationship. Acceptable is not meant in a normative/valuing sense, but means, in a pragmatic sense, that the motive in itself does not unduly hinder therapy, while the behavior or subordinated Plans serving this motive may do so. Once a therapist has identified such acceptable Plans or motives, the therapist may develop complementary therapist Plans. The overall therapeutic strategy or aim here is, consistent with the classic interpersonal concepts, the interpersonal fit between patient and therapist which is postulated to enhance collaboration, and avoid, if possible, alliance and treatment ruptures and giving space to a productive focus towards the patient’s internal world (as opposed to the initial interpersonal focus). On the level of the therapeutic tasks in each session (or as defined by Yeomans et al. (2002) as therapeutic “tactics”), the therapist need to concretely develop therapist Plans serving the higher-order complementary therapist Plans (e.g., “show to the patient that you, therapist, are on the patient’s side”). On the level of the therapeutic techniques, and this is because the MOTHER-principle is an integrative therapy ingredient, it can be argued that any therapeutic technique is potentially acceptable, as long as it serves the acceptable motives identified.

We give some examples of concrete therapist interventions which respond to these criteria for Mark, based on the PA depicted in Fig. 1. A therapist using MOTHER-principles may productively underline that Mark is a good father and a good employee in charge (both serving the need of positive self-image), or the therapist may convey such messages on a non-verbal level, as the patient elaborates on these themes. The therapist may also explicitly assure the patient that within the therapeutic relationship, Mark will not lose control or if he happens to feel that he is doing so, he should let the therapist know openly and explicitly, so the latter can do something about it. Moreover, the therapist using MOTHER can assure Mark that within the therapeutic setting, the therapist is there for him, and convey his therapeutic presence also through non-verbal marking (e.g., using timely head-nodding) of related contents in the patient’s narrative.

In-Session MOTHER Facing Mark: “A Glass of Water”

At all sequences during session 4, the levels of MOTHER-components, related to the idiosyncratic central patient’s Plans activated, were above 0, indicating positive values on the MOTHER-scale, which means for verbal MOTHER (Mean = 1.67, SD = .47, ranging between +1 and +2) and non-verbal MOTHER (Mean = 2.3; SD = .47, ranging between +2 and +3) components. Therefore, MOTHER, as rated from independent perspectives, was in the top range and considered excellent for this session. We will illustrate this session using a series of excerpts from the second part of session 4.

Mark starts out telling the episode of the glass of water (session 4, minute 20:45) by explaining that he gets very angry when his 5-year old daughter Michelle inadvertently pushes over a glass of water, creating a watermark on the tablecloth. In such situations, Mark usually yells at his 5-year old; in this therapy session, he starts realizing that his behavior could be a problem.

P(Patient)1: Actually, (*hesitates*) it's no big deal… but on the spur of the moment, I completely freak out (C Commentary: The patient takes a "risk" by declaring that there is a problem, threatening Plans related to "present yourself as a good father", "avoid being weak", "avoid losing control")
T(Therapist)1: It's as if there are two sides in you. You fundamentally know that it is no big deal and I agree with you, but even if you definitely know that, you react differently. How do you react? (C: The therapist expands on the "safe" side and gives a transparent message addressing the patient's hesitation ("I agree with you"); "you definitely know that" is complementary to "show that you are intelligent". After having established some interpersonal safety, the therapist also gives the patient the opportunity to be *confronted* with his avoided or "dreaded" side, which the therapist considers as central to this patient's problems).
P2: As I told you before, let's take the example of the glass of water. I would get quite uncomfortable and harsh with my daughter, instead of just saying to her "please pay attention", telling her that "it's no big deal, take a tissue and clean up"! With the tone of voice emphasizing she needs to pay more attention.
T2: This is what you would like to be able to do, but what do you actually do? (C: The therapist insists on the confrontation).
P3: I would be harsh. (*yells*) "Pay attention!" Or with accusing tone (*dismissive tone of voice*) "Not you again!" (C: In this ultimate situation, the patient takes a further "risk" facing the therapist by actually opening up and showing his avoided side to the therapist.)
(…)
T3: On the one side, the reality is that everybody sees that your daughter Michelle is doing well, there are no problems with her, she's a great five-year old, well-educated and well-dressed, this is what everybody knows (C: Again, the therapist repeats with a convinced voice some elements from the patient's earlier statements to make sure the patient knows that the therapist is on his side regarding this issue which is complementary to the solidarity and self-esteem motives). Moreover, there is your ideal behavior and you exactly know, you know it Mark, how a good father should be, right?! (C: Again, the therapist conveys that he is convinced about Mark being fundamentally a good father) (*with soft voice*) But on the other side, in specific situations, you start to convey a completely different message to your daughter saying: "You're no good. You're not good enough." I know it's not what you really want to say, but you still say it. (C: This is another ultimate confrontation with the "dreaded" side. Because it was said in a soft voice by the therapist, non-verbal aspects of MOTHER are high here; it enables the therapist to connect on a deeper level with the patient's non-affirmative and shameful components).
P4: (*pause*) I know, I am so afraid…. when I see kids on the road, 14-15-year-old,… this freaks me out. I want to pass values on to my daughter, respect and everything. But it's true, I am too much of a man of principles, as you say, the glass of water, that's true. Little things drive me crazy. I want her too much to be perfect.
(…)
P5: Maybe it will help her when she is grown-up. You know I imagine her in the schoolyard…
T5: I completely understand, Mark. At the same time, you are not sure. You are not sure how Michelle integrates what you tell her.
P6: I am a person who projects too much into the future. When she disobeys, I get so afraid….(*pause*) I don't want her to go away.
T6: Mhm.
P7: (*pause*)…I feel an emotion that comes up in me here…. I don't want her to go away (*patient cries*).
T7: Mhm,…. yeah, mhm,….. mhm.
P8:…
T8: (*soothing voice*) Your daughter is so important to you (C: The therapist renders explicit the attachment to the daughter in a soothing fashion which is complementary to the need of seeking closeness).
P9: (*pause*) As I told you, I think about bad things sometimes. When Michelle cries because she has hurt herself, I feel the hurt inside of me. (*cries*). I don't want her to go away.
T9: Mhm.
(C: The patient's experience of underlying hurt facing the imagined separation from his daughter emerges in this sequence. Attachment-related Plans are activated in the patient, hypothetically partially soothed by the therapist.)
(…)
In the last sequence, the focus slightly changes to the underlying experiences related to the fear the patient has from his personal history.

P10: It's like somebody has robbed me of my childhood (*cries*).
T10: What does this mean to you as you say this?
P11: I have not had a good childhood (*holds back his tears*).
T11: I understand this from what you reported, Mark. Who would you say has robbed you of your childhood?
P12: My mother, my father. I've never had a family. Nor a good relationship with my mother nor my father.
T12: This is what you terribly want to create with your daughter now.
P13: Yes (*cries*)…
T13: And the actual catastrophe would be, Mark, that your daughter would have to live the same as you did.
P14: Yes. I am terribly afraid for her. So I do everything possible to protect her.
(C: In this final paragraph, very little MOTHER-consistent interventions are used, as the focus of the patient is on the content and internal processes, and not on the interpersonal "risks" (e.g. losing face) in the actual relationship).

Discussion

The present case study aimed at illustrating how PA and motive-oriented psychotherapeutic relationship may inform therapeutic intervention choice, intervention style and timing of interventions, on the level of patient-therapist speech turns. As such, it should help to actually see how an individualized case formulation method not only influences the therapist's conceptualization of the case, but also has in-session implications in terms of the therapist's pro-active relationship offer on a moment-by-moment basis. In the present case, it has become clear that Mark, suffering from NPD, based on highly neglectful and impoverished attachment bonds with his parents, continuously feels his profound inadequacy in interpersonal encounters (Martens 2005), including with the therapist in the Here and Now. He continuously fears losing control and losing face in the therapeutic relationship, ultimately being afraid of being treated in a discarding manner, along with underlying attachment issues. The therapist, as early as in session 4 of the process and based on his understanding from the PA, pro-actively and authentically conveys soothing messages and makes highly specific reassuring comments like "as you already know", "you are a good father", "your daughter is doing great" (T1), serving directly the patient's higher-order acceptable Plans and motives (in turn "present yourself as intelligent", "present yourself as a good father", "maintain a positive image of yourself", along with the uppermost motive of maintaining control). We would argue that what might look like simple good clinical practice is actually part of a coherent therapist relationship message which has an individual impact on Mark, as postulated by the hypotheses in his Plan structure: a different patient would not need MOTHER-interventions along those lines; those interventions have therefore a high subjective value for this particular patient. This makes them supposedly so powerful.

In addition, the present case study illustrates concrete patient-therapist interaction sequences that help to disentangle, to some extent, confrontative interventions from interventions consistent with the MOTHER-principle. Right after the provision by the therapist of a safe relationship context, at several occasions in the transcript, the therapist attracts the patient's attention to his behavior in the situation being a problem, along with the core issues related to negative consequences (T1, T2, T3; Sachse 2003; Sachse et al. 2011) of this behavior. These well-timed interventions aim at raising awareness in the patient that interpersonal problems were more dependent on his own appraisal of relationships that on the actual behaviors of others, with corresponding linking to concrete behavior in situation which is described as particularly useful for patients with NPD (Dimaggio et al. 2012; Dimaggio and Attina 2012; Levy 2012). This set of interventions contributes to making the patient less defensive and absorbed by control and impression management in the ongoing interaction with the therapist, and to raise motivation for internal change, as the patient actually starts seeing the problem within himself and the need for change and helps to formulate a clear therapeutic question to be treated in psychotherapy (Sachse et al. 2011). These aspects are of foremost importance for the treatment of patients with NPD but, also, they usually lack at the beginning of treatment, because of the nature of the problems in NPD (i.e., profound vulnerability, perceived flawlessness, grandiosity, problems related with shame and anger; Fiedler 2000; Levy 2012). It can therefore be argued that MOTHER is a collaboration-enhancing intervention strategy which is, in its sensitive tailoring of the therapist relationship offer, particularly useful for patients presenting these problems related with NPD.

Non-verbal and para-verbal aspects of MOTHER are generally rated higher in this session than strictly verbal aspects. Previous research has suggested that it is the non-verbal component that relate most to symptom change (Caspar et al. 2005), in particular facing patients presenting with Personality Disorders (Kramer et al. 2011). The therapist's soothing, calm and, at times, fragile voice is a nice illustration. Timely use of this intervention form sends a relationship message to the patient ("I'm taking care of you and your anxiety", "you are profoundly OK as a

person"; T3) which is complementary to the patient's central Plans (e.g., "seek closeness", "seek solidarity", "maintain a positive image of yourself", "make sure that the therapist is on your side", "avoid losing a relationship"). In this particular excerpt, confrontative interventions are done on a verbal level, thus resulting in an interesting assemblage of, in parallel, non-verbal MOTHER soothing of central non-problematic Plans on the relationship level and explicit verbal confrontation on the content level of the patient-therapist interaction, pushing the productive process further. This assemblage corresponds to the model of balancing reassurance vs. challenge as optimal condition for change (Caspar 2007).

Finally, taking these sets of interventions together, pro-active (verbal and non-verbal) MOTHER-consistent relationship messages as well as confrontation with core issues, the session excerpt also illustrates some micro-outcome associated with session 4. As the session progresses, Mark starts taking more and more interpersonal "risks" by opening up to the therapist, focusing on the inside, experientially accessing his underlying fear of being left alone, which he links with biographical elements, and also acknowledging the profound hurt at the imagination of a significant interpersonal loss (i.e., Michelle). A high level of in-session emotional arousal, exemplified by tears rolling down the patient's cheeks at some point of the session (P9), but also an increasing level of experiencing towards the end of the excerpt, may be coined as micro-outcome of the couple of interventions described earlier: MOTHER and step-wise confrontation with core problematic issues.

Therapeutic confrontation was helpful in this affect-avoiding patient, probably because it was performed in a "homeopathic" dosage, exactly at the "cutting edge" of what this particular patient, within the actual relationship with the therapist, was able to process moment-by-moment. This "homeopathic" dosage was informed by the MOTHER-principle, implying for the therapist to check at all times which Plans, low-order behaviors and experiences may interfere with productive therapeutic work and pro-actively reassure underlying Plans. It seems that this homeopathic dosage of therapeutic confrontation is in Mark's moment-by-moment therapeutic zone of proximal development (Leiman and Stiles 2001) and can therefore be integrated by the patient.

Finally, we wish to underline that this very short therapeutic intervention, lasting only seven sessions, did not aim at changing the core problems, but only at unveiling and defining them in a clear fashion, in order for the patient to be able to work on them in a later therapy stage. However, the symptom change produced in this long-standing NPD over the course of this 2-month treatment is rather impressive. This might be explained by the phase-model of psychotherapy where initial symptom relief is expected due to the fundamental function of remoralization of the early therapy phase (Howard et al. 1986). We need to acknowledge that by using only one case, we cannot confirm that there is a link between a set of interventions and therapeutic change. Rather, the present case study calls for more studies on individualized formulation and intervention methods in the very beginning of treatment of Personality Disorders in general and of NPD in particular. In particular, a creative assemblage of timely therapist interventions that are consistent with MOTHER, along with confrontation techniques, may be a promising clinical avenue for future treatments of patients presenting with NPD, in order for them to be able benefit from adapted treatment.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Bastine, R., & Kommer, D. (1978). Konfrontation als Strategie psychotherapeutischen Handelns (confrontation as a strategy of psychotherapeutic intervention). In L. H. Eckensberger (Ed.), *Bericht über den 31. Kongress der Deutschen Gesellschaft für Psychologie*. Mannheim: DGP.

Beck, A. T., Freeman, A., et al. (1990). *Cognitive therapy of personality disorders*. New York: Guilford Press.

Benjamin, L. S. (1974). Structural analysis of social behavior. *Psychological Review, 81*, 392–425.

Benjamin, L. S. (1993). *Interpersonal diagnosis and treatment of personality disorders*. New York: Guilford Press.

Berthoud, L., Kramer, U., Pascual-Leone, A., & Caspar, F. (2013). Exploring the effects of motive-oriented therapeutic relationship on emotional processing using two borderline personality disorder case studies (submitted).

Bohus, M., Kleindienst, N., Limberger, M. F., Stieglitz, R.-D., Domsalla, M., Chapman, A. L., et al. (2009). The Short version of the borderline symptom list (BSL-23): Development and initial data on psychometric properties. *Psychopathology, 42*, 32–39.

Carson, R. C. (1969). *Interaction concepts of personality*. Chicago: Adeline.

Caspar, F. (2007). Plan analysis. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulations* (2nd ed., pp. 221–289). New York: Guilford Press.

Caspar, F., & Berger, T. (2011). Allgemeine psychotherapie (general psychotherapy). In B. Dulz, S. Herpertz, O. F. Kernberg, & U. Sachsse (Eds.), *Handbuch der Borderline-Störungen* (2nd ed., pp. 667–680). Stuttgart: Schattauer.

Caspar, F., & Ecker, S. (2008). Treatment of an avoidant patient with comorbid psychopathology: A plan analysis perspective. *Journal of Clinical Psychology: In Session, 64*(2), 139–153.

Caspar, F., & Grosse Holtforth, M. (2009). Responsiveness: Eine entscheidende Prozessvariable in der Psychotherapie (Responsiveness: A decisive process-variable in psychotherapy). *Zeitschrift für Klinische Psychologie und Psychotherapie, 38*(1), 61–69.

Caspar, F., Grossmann, C., Unmüssig, C., & Schramm, E. (2005). Complementary therapeutic relationship: Therapist behavior, interpersonal patterns, and therapeutic effects. *Psychotherapy Research, 15*(1–2), 91–105.

Colli, A., Tanzilli, A., Dimaggio, G., & Lingiardi, V. (2013). Patient personality and therapist responses: An empirical investigation. *American Journal of Psychiatry* (in press).
Dimaggio, G. (2012). Narcissistic personality disorder: Rethinking what we know. *Psychiatric Times, 29*, 17–25.
Dimaggio, G., & Attina, G. (2012). Metacognitive interpersonal therapy for narcissistic personality disorder and associated perfectionism. *Journal of Clinical Psychology, 68*(8), 922–934.
Dimaggio, G., Salvatore, G., Fiore, D., Carcione, A., Nicolo, G., & Semerari, A. (2012). General principles for treating personality disorder with a prominent inhibitedness trait: Towards an operationalizing integrated technique. *Journal of Personality Disorders, 26*(1), 63–83.
Dimaggio, G., Semerari, A., Carcione, A., Nicolo, G., & Procacci, M. (2007). *Psychotherapy of personality disorders. Metacognition, states of mind and interpersonal cycles.* London: Routledge.
Ellison, W. D., Levy, K. N., Cain, N. M., Ansell, E. B., & Pincus, A. L. (2013). The impact of pathological narcissism on psychotherapy utilization, initial symptom severity, and early-treatment symptom change: A naturalistic investigation. *Journal of Personality Assessment, 95*(3), 291–300. doi:10.1080/00223891.2012.742904.
Emond, C., Savard, K., Lalande, G., Boisvert, N., Boutin, M., & Simard, V. (2004). Propriétés Psychométriques de la Mesure d'Impact (MI-45), version francophone du Outcome Questionnaire: (OQ-45.2) (Psychometric characteristics of the OQ-45, French Version). Annual Conference of ACFAS. Montreal, Canada.
Fan, Y., Wonneberger, C., Enzi, B., de Greck, M., Ulrich, C., Tempelmann, C., et al. (2011). The narcissistic self and its psychological and neural correlates: an exploratory fMRI study. *Psychological Medicine, 41*(8), 1641–1650. doi:10.1017/S003329171000228X.
Fiedler, P. (2000). *Integrative Psychotherapie bei Persönlichkeitsstörungen (Integrative psychotherapy for personality disorders)*. Göttingen: Hogrefe.
First, M. B., Spitzer, R. L., Williams, J. B. W., & Gibbons, M. (2004). *Structured clinical interview for DSM-IV* (French translation by M. Cottraux & J. Cottraux). New York: Biometrics Research Department.
Gabbard, G. O. (2009). Transference and countertransference: Developments in the treatment of narcissistic personality disorder. *Psychiatric Annals, 39*, 129–136.
Gaebel, W., & Falkai, P. (2009). *Behandlungsleitlinie Persönlichkeitsstörungen (Personality disorders. Practice guidelines)*. Berlin: Steinkopff Verlag.
Grawe, K. (1980). Die diagnostisch-therapeutische Funktion der Gruppeninteraktion in verhaltenstherapeutischen Gruppen (The diagnostic-therapeutic function of group interaction in behavioral treatment groups). In K. Grawe (Ed.), *Verhaltenstherapie in Gruppen* (pp. 88–223). München: Urban & Schwarzenberg.
Grawe, K. (1992). Komplementäre Beziehungsgestaltung als Mittel zur Herstellung einer guten Therapiebeziehung (Complementary therapeutic relationship as a mean for the establishment of a good therapeutic relationship). In J. Margraf & J. C. Brengelmann (Eds.), *Die Therapeut-Patient-Beziehung in der Verhaltenstherapie* (pp. 215–244). München: Röttger-Verlag.
Gunderson, J. G., & Links, P. S. (2008). *Borderline personality disorder: A clinical guide*. Washington, DC: American Psychiatric Publishing.
Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasenor, B. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*(6), 885–892.
Howard, K. I., Kopta, S. M., Krause, M. S., Merton, S., & Orlinksy, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41*(2), 159–164.
Kernberg, O. F. (2004). *Aggressivity, narcissism, and self-destructivness in the psychotherapeutic relationship*. New Haven, CT: Yale.
Kernberg, O. F. (2007). The almost untreatable narcissistic patient. *Journal of the American Psychoanalytic Association, 55*, 503–539.
Kiesler, D. J. (1983). The 1982 interpersonal circle: A taxonomy for complementarity in human transactions. *Psychological Review, 90*, 185–214.
Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. Madison, CT: International Universities Press.
Kramer, U. (2009). Individualizing exposure therapy of PTSD: The case of Caroline. *Pragmatic case studies in psychotherapy, 5*(2), 1–24.
Kramer, U., Berger, T., & Caspar, F. (2009). Psychotherapeutic case conceptualization using plan analysis for bipolar affective disorder. *Journal of Clinical Psychology, 65*(4), 352–367.
Kramer, U., Berger, T., Kolly, S., Marquet, P., Preisig, M., de Roten, Y., et al. (2011a). Effects of motive-oriented therapeutic relationship in early-phase treatment of borderline personality disorder: A pilot study of a randomized trial. *Journal of Nervous and Mental Disease, 199*(4), 244–250.
Kramer, U., Caspar, F., & Drapeau, M. (2013). Change in biased thinking in a 10-session treatment for borderline personality disorder: Further evidence of the motive-oriented therapeutic relationship. *Psychotherapy Research*. doi:10.1080/10503307.2013.791404.
Kramer, U., Rosciano, A., Pavlovic, M., Berthoud, L., Despland, J.-N., de Roten, Y., et al. (2011b). Motive-oriented therapeutic relationship in brief psychodynamic intervention for patients with depression and personality disorders. *Journal of Clinical Psychology, 76*(10), 1017–1027.
Lambert, M. J., Morton, J. J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R. C., et al. (2004). *Administration and scoring manual for the outcome questionnaire-45*. Orem, UT: American Professional Credentialing Services.
Leary, T. (1957). *Interpersonal diagnosis of personality*. New York: Ronald Press.
Lecrubier, Y., Sheehan, D. V., Weiller, E., Amorim, P., Bonora, I., Harnett Sheehan, K., et al. (1997). The mini international neuropsychiatric interview (MINI). A short diagnostic structured interview: reliability and validity according to the CIDI. *European Psychiatry, 12*, 224–231.
Leiman, M., & Stiles, W. B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the assimilation model: The case of Jan revisited. *Psychotherapy Research, 11*, 311–330.
Levy, K. N. (2012). Subtypes, dimensions, levels and mental states in narcissism and narcissistic personality disorder. *Journal of Clinical Psychology: In Session, 68*(8), 886–897. doi:10.1002/jclp.21893.
Levy, K. N., Chauhan, P., Clarkin, J. F., Wasserman, R. H., & Reynoso, J. S. (2009). Narcissistic pathology: Empirical approaches. *Psychiatric Annals, 39*, 203–213.
Martens, W. (2005). Shame and narcissism. *Annals of the American Psychotherapy Association, 8*, 10–17.
Ritter, K., Dziobek, I., Preissler, S., Rüter, A., Vater, A., Fydrich, T., et al. (2011). Lack of empathy in patients with narcissistic personality disorder. *Psychiatry Research, 187*, 241–247. doi:10.1016/j.psychres.2010.09.013.
Ronningstam, E. (2012). Alliance building and narcissistic personality disorder. *Journal of Clinical Psychology: In Session, 68*(8), 943–953.
Sachse, R. (2003). *Klärungsorientierte Psychotherapie (Clarification-oriented psychotherapy)*. Göttingen: Hogrefe.

Sachse, R., Sachse, M., & Fasbender, J. (2011). *Klärungsorientierte Psychotherapie der narzisstischen Persönlichkeitsstörung (Clarification-oriented psychotherapy of narcissistic personality disorder)*. Göttingen: Hogrefe.

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology, In Session: Psychotherapy in Practice, 56*, 233–243.

Schmutz, I., Berger, T., & Caspar, F. (2011). *Motive-oriented therapeutic relationship: Conditions and relation to therapy outcome*. Presentation at the Annual Meeting of the Society for Psychotherapy Research (SPR). University of Bern, Bern.

Smith, T. L., Barrett, M. S., Benjamin, L. S., & Barber, J. P. (2006). Relationship factors in treating personality disorders. In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work* (pp. 219–238). New York: Oxford University Press.

Yeomans, F., Clarkin, J. F., & Kernberg, O. F. (2002). *A primer of transference-focused psychotherapy for the borderline patient*. Lanham, MD: Rowman & Littlefield.