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**Unpacking the Effects of Therapist Responsiveness in Borderline Personality Disorder: Motive-Oriented Therapeutic Relationship, Patient In-Session Experience, and the Therapeutic Alliance**

Ueli Kramer<sup>a, b, e</sup>, Christoph Flückiger<sup>c, d</sup>, Stéphane Kolly<sup>b</sup>, Franz Caspar<sup>c</sup>, Pierre Marquet<sup>b</sup>, Jean-Nicolas Despland<sup>a, b</sup>, Yves de Roten<sup>a</sup>

<sup>a</sup>University Institute of Psychotherapy and <sup>b</sup>General Psychiatry Service, Department of Psychiatry-CHUV, University of Lausanne, Lausanne, <sup>c</sup>Department of Clinical Psychology and Psychotherapy, University of Bern, Bern, and <sup>d</sup>Department of Psychology, University of Zurich, Zurich, Switzerland; <sup>e</sup>Department of Psychology, University of Windsor, Windsor, Ont., Canada

Therapist responsiveness is described as a pivotal concept contributing to therapeutic outcomes and denotes the mutual influence on the interaction partners – the therapist and the patient – of emerging context characteristics [1]. Despite accurate control for therapist adherence to a manual which may or may not relate to the outcome [2], it is unavoidable that the therapist will make decisions and take actions which are based on emerging client and interaction characteristics related to the idiosyncrasy of the clinical situation. As such, the responsiveness critique highlights limitations related to randomized controlled trials, in particular when relating a manualized therapy model to the process and outcome [1, 2]. Therapist responsiveness may be more or less productive or appropriate [1], which might be of particular importance in therapeutic interactions with patients presenting with borderline personality disorder (BPD). Among several ways of operationalizing appropriate therapist responsiveness, in the present letter we will focus on one specific method of conceptualization, i.e. Plan analysis (PA), and the motive-oriented therapeutic relationship (MOTR) [3, 4].

In patients with BPD, a randomized controlled trial [5] showed that the MOTR as an operationalization of how therapists can explicitly be responsive – based on the individualized case formulation related to the PA – had an effect on the global outcome and progression of the therapeutic alliance, rated by the therapist, over the course of 10 sessions of therapy. However, it is unclear what the exact patient change processes are in treatments based on appropriate responsiveness. The objective of the present process-outcome study, as a reanalysis of a larger data set [5], is to examine the potential predictive role of the patient’s in-session experience and the therapeutic alliance for outcome (i.e. symptom change af-

ter 10 sessions) in treatments based on the MOTR for BPD. We hypothesized that, compared to a short version of general psychiatric management (GPM) [6], the MOTR produced more positive in-session experiences and significant links between the patient’s in-session experience, the therapeutic alliance, and the outcome. We assumed that patient indices of good process, i.e. early therapeutic alliance and in-session experience, predicted the outcomes.

In the present process-outcome study, we included the intent-to-treat sample analyzed by Kramer et al. [5] which involved, due to missing responses to the self-reported questionnaires, 60 individuals (GPM, n = 28; MOTR, n = 32). In addition to the questionnaires used in the parent study, the present study used a 24-item short version of the Bern Post-Session Report 2000 (BPSR) [7], measuring the patient’s in-session experience, administered after each session. It comprises 7 dimensions: (1) control experiences, (2) self-esteem experiences, (3) contentment, (4) therapeutic relationship, (5) problem actuation, (6) experience of mastery of problems, and (7) experience of clarification.

A preliminary analysis of the links between MOTR scores and related session experiences on the BPRS revealed a mean correlation of  $r = 0.27$  (range between 0.17 and 0.41). Therefore, the therapist responsiveness was moderately appropriate from the patient’s perspective. A between-group comparison showed that MOTR produced on average better self-esteem experiences in patients [ $t(1, 27) = 1.80$ ;  $p = 0.05$ ;  $d = 0.46$ ] compared to GPM treatments. The hierarchical linear modeling model confirmed this result for the slope, using 2-level and 3-level modeling (time nested within patient within therapist; detailed results are obtainable from the first author). When examining the links between the patient’s experience of self-esteem session by session, the alliance, and the outcome, we found that the patient’s experience of self-esteem correlated with the outcome only for session 8 in the case of the MOTR ( $r = 0.39$ ; table 1). When comparing correlations according to therapy conditions, process-outcome correlations tended to be greater in the case of MOTR compared to GPM (see also the grand means). Patient alliance ratings correlated highest (positively; on average  $r = 0.36$ ) with outcome in the case of MOTR (GPM:  $r = 0.11$ ). Therapist alliance ratings correlated highest (negatively; on average  $r = -0.31$ ) with outcome in the case of MOTR (GPM:  $r = -0.05$ ). In a final hierarchical regression analysis, taking both groups together ( $n = 48$ ), we found that the patient’s experience of self-esteem rated after session 8 predicted outcomes in the most parsimonious model as a single predictor (9% of the outcome variance explained:  $B = 5.22$ ;  $SE = 2.50$ ;  $\beta = 0.29$ ;  $t = 2.09$ ;  $p = 0.04$ ). However, the full model, encompassing the MOTR, self-esteem rated at session 8, and the therapeutic alliance at session 3, explained 22% of the variance in symptom changes at the end of the treatment.

Self-esteem tends to be low in patients presenting with BPD who are entering treatment, as a correlate of the disorder. Its importance in explaining change associated with appropriate thera-

**Table 1.** Pearson's correlations between therapeutic alliance, patient's experience of self-esteem, and outcome by condition, session by session

Session	Alliance (patient)		Alliance (therapist)		Self-esteem (patient)	
	GPM (n)	MOTR (n)	GPM (n)	MOTR (n)	GPM (n)	MOTR (n)
1	0.40 (17)	0.29 (18)	-0.31 (13)	-0.61*(15)	0.39 (13)	-0.07 (14)
2	0.22 (25)	0.36* (32)	0.05 (29)	-0.18 (34)	0.26 (24)	0.02 (32)
3	0.15 (28)	0.42*(32)	-0.02 (29)	-0.19 (33)	0.28 (24)	0.30 (32)
4	0.08 (26)	0.36* (31)	-0.04 (27)	-0.18 (33)	0.11 (25)	0.07 (31)
5	-0.03 (21)	0.09 (33)	-0.05 (26)	-0.38*(32)	0.22 (28)	0.10 (31)
6	0.14 (19)	0.37* (31)	-0.11 (20)	-0.24 (32)	0.16 (23)	0.17 (29)
7	-0.09 (16)	0.47* (27)	-0.06 (18)	-0.18 (30)	0.04 (24)	0.18 (29)
8	0.11 (13)	0.41* (24)	-0.15 (16)	-0.27(25)	0.11 (24)	0.39* (29)
9	-0.03 (13)	0.52* (19)	0.37 (11)	-0.43(21)	0.02 (24)	0.14 (29)
10	0.11 (10)	0.27 (17)	-0.21 (11)	-0.48 (17)	0.30 (20)	0.15 (25)
Mean	0.13 (26)	0.33 (32)	-0.05 (26)	-0.32* (32)	0.13 (28)	0.21 (32)

Alliance was measured using the Working Alliance Inventory (WAI) after each session. Self-esteem was measured using the BPSR after each session. Outcome was measured using the OQ-45 (outcome questionnaire) total score at discharge (change in scores between intake and discharge). Grand means (patient and therapist aggregated): total r (GPM and MOTR aggregated) = 0.23 (n = 60); r (GPM) = 0.10 (n = 26); r (MOTR) = 0.24 (n = 32); total mean self-esteem: r (GPM and MOTR aggregated) = 0.18 (n = 60). Aggregation per therapist: r (patient alliance rating) = 0.17; r (therapist alliance rating) = -0.29; r (self-esteem) = 0.40. \* p < 0.05.

pist responsiveness, as operationalized by the MOTR, points to the possible value of increases in these variables in early sessions of psychotherapy as part of the initial remoralization [8]. No other BPSR scales reached significance, which may demonstrate a relative independence from the MOTR. Resource activation and use of the patient's strengths is understood to be a general mechanism of change in psychotherapy [9, 10].

The therapist's assessments of the alliance are linked to outcomes in a negative way: the lower the alliance rated by the MOTR therapist, the greater the therapeutic change. There are 2 hypotheses for this unexpected result: (1) the MOTR therapists might have assessed the already difficult collaboration in a more mindful and 'realistic' fashion, as a correlate of the individualized PA understanding of the case, and might actually have rated the alliance overly negatively, inversely proportional to the actual subsequent patient change; (2) alternatively, as a correlate of the PA case formulation and MOTR heuristics, the therapists may have overestimated the positive relationship. The moderate-to-low therapist mean ratings of the alliance [5] would speak in favor of the first hypothesis. The MOTR may have a specific impact on the therapist's awareness and interaction style, which produces in the patient an additional symptom relief.

Psychotherapy is a complex, multicomponent treatment involving both therapist and patient engagement. Appropriate therapist responsiveness, as introduced in the form of the MOTR, may pose supplementary challenges for the therapist and at the same time facilitates a number of productive change processes.

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