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THERAPIST RESPONSIVENESS IN BORDERLINE PERSONALITY DISORDER

Running Head: THERAPIST RESPONSIVENESS IN BORDERLINE PERSONALITY
DISORDER

Unpacking the effects of therapist responsiveness in borderline personality disorder: motive-oriented therapeutic relationship, patient in-session experience and the therapeutic alliance

Research Letter to the Editor

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Running Head: Therapist Responsiveness in Borderline Personality Disorder

Unpacking the effects of therapist responsiveness in borderline personality disorder: motive-oriented therapeutic relationship, patient in-session experience and the therapeutic alliance

Key-Words: Therapist Responsiveness; Therapeutic Alliance; Self-esteem; Borderline Personality Disorder; Motive-Oriented Therapeutic Relationship; Plan Analysis; Randomized Controlled Trial

Unpacking the effects of therapist responsiveness in borderline personality disorder: motive-oriented therapeutic relationship, patient in-session experience and the therapeutic alliance

Research Letter to the Editor

Therapist responsiveness is described as a pivotal concept contributing to therapeutic outcome 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 outcome [2], it is unavoidable that the therapist makes decisions and takes 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 process and outcome [1; 2]. Therapist responsiveness may be more or less productive or appropriate [1] which might be of particular importance in the 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: Plan Analysis (PA) and the motive-oriented therapeutic relationship (MOTR) [3, 4].

For patients with BPD, a randomized controlled trial [5] showed that MOTR as operationalization of how therapists can explicitly be responsive - based on the individualized case formulation related to the PA - had an effect on global outcome and the progression of the therapeutic alliance, rated by the therapist, over the course of ten 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 reanalysis of a larger dataset [5], is to examine the potential predictive role of patient's in-session experience and the therapeutic alliance for outcome (i.e., symptom change after 10 sessions)

in treatments based on the MOTR for BPD. We hypothesized that, compared to General Psychiatric Management (GPM [6]), MOTR produced more positive in-session experiences and significant links between patient's in-session experience, the therapeutic alliance and outcome. We assumed that patient indices of good process, i.e., early therapeutic alliance and in-session experience, predicted outcome.

In the present process-outcome study, we included the Intent-to-Treat sample analyzed by Kramer, Kolly et al. [5] which involved, due to missings on the self-reported questionnaires, $N = 60$ (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 seven dimensions: (1) control experiences, (2) self-esteem experiences, (3) contentment, (4) therapeutic relationship, (5) problem actuation, (6) experience of mastery of problems, (7) experience of clarification.

The preliminary analysis of the links between MOTR-scores and related session-experience on the BPRS, revealed a mean correlation of $r = .27$ (range between .17 and .41). Therefore, therapist responsiveness is moderately appropriate from the patient perspective. The between-group comparison showed that MOTR produced on average better self-esteem experiences in the patient ($t(1, 27) = 1.80$; $p = .05$; $d = 0.46$), compared to the GPM-treatments. The Hierarchical Linear Modelling (HLM) model confirmed this result for the slope, using two-level and three-level modelling (time nested within patient within therapist; detailed results obtainable from first author). When examining the links between the patient experience of self-esteem session-by-session, the alliance and outcome, we found that the patient experience of self-esteem correlated with outcome only for session 8 in the case of MOTR ($r = .39$; see Table 1). When comparing the correlations according to the 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 $r = .36$) with outcome in the case of MOTR (GPM: $r = .11$). Therapist alliance ratings correlated highest (negatively; on average $r = -.31$) with outcome in the case of MOTR (GPM: $r = -.05$). 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 outcome in the most parsimonious model as a single predictor (9% of the outcome variance explained: $B = 5.22$; $SE = 2.50$; $\beta = .29$; $t = 2.09$; $p = .04$). However, the full model, encompassing the motive-oriented therapeutic relationship, self-esteem rated at session 8 and the therapeutic alliance at session 3, explained 22% of the variance of symptom change at the end of treatment.

Self-esteem tends to be low in patients presenting with borderline personality disorder entering treatment, as correlate of the disorder. Its importance in explaining change associated with appropriate therapist responsiveness, as operationalized by MOTR, points to the possible value of increase in these variables in early sessions of psychotherapy, as part of initial remoralization [8]. No other BPSR-scales were reached significance which may demonstrate relative independence from MOTR. Resource activation and the use of the patient's strengths is understood as a general mechanism of change in psychotherapy [9; 10].

The therapist's assessments of the alliance are linked to outcome in a negative way: the lower the alliance rated by the MOTR-therapist, the greater the therapeutic change. There are two hypotheses for this unexpected result: (1) The MOTR therapists might have assessed the already difficult collaboration in a more mindful and "realistic" fashion, as correlate of the individualized PA understanding of the case, and might actually have rated the alliance overly negative, inversely proportional to the actual subsequent patient change. (2) Alternatively, as 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. 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, multi-component treatment, involving both therapist and patient engagement. Appropriate therapist responsiveness, as introduced in the form of MOTR, may pose supplementary challenges to the therapist and at the same time facilitates a number of productive change processes.

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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 (<i>n</i>)	MOTR (<i>n</i>)	GPM (<i>n</i>)	MOTR (<i>n</i>)	GPM (<i>n</i>)	MOTR (<i>n</i>)
1	.40 (17)	.29 (18)	-.31 (13)	-.61*(15)	.39 (13)	-.07 (14)
2	.22 (25)	.36* (32)	.05 (29)	-.18 (34)	.26 (24)	.02 (32)
3	.15 (28)	.42*(32)	-.02 (29)	-.19 (33)	.28 (24)	.30 (32)
4	.08 (26)	.36* (31)	-.04 (27)	-.18 (33)	.11 (25)	.07 (31)
5	-.03 (21)	.09 (33)	-.05 (26)	-.38*(32)	.22 (28)	.10 (31)
6	.14 (19)	.37* (31)	-.11 (20)	-.24 (32)	.16 (23)	.17 (29)
7	-.09 (16)	.47* (27)	-.06 (18)	-.18 (30)	.04 (24)	.18 (29)
8	.11 (13)	.41* (24)	-.15 (16)	-.27(25)	.11 (24)	.39* (29)
9	-.03 (13)	.52* (19)	.37 (11)	-.43(21)	.02 (24)	.14 (29)
10	.11 (10)	.27 (17)	-.21 (11)	-.48 (17)	.30 (20)	.15 (25)
Mean	.13 (26)	.33 (32)	-.05 (26)	-.32* (32)	.13 (28)	.21 (32)

Note. GPM: General Psychiatric Management; MOTR: Motive-oriented Therapeutic

Relationship; Alliance measured using the WAI (Working Alliance Inventory) post-session;

Self-esteem measured using the BPSR (Bern Post-Session Report 2000) post-session;

Outcome measured using the OQ-45 (Outcome Questionnaire) total score at discharge

(change scores between intake and discharge). Grand means (patient and therapist

aggregated): total r (GPM and MOTR aggregated) = .23 ($n = 60$); r (GPM) = .10 ($n = 26$); r

(MOTR) = .24 ($n = 32$); total mean self-esteem: r (GPM and MOTR aggregated) = .18 ($n =$

60). Aggregation per therapist: r (patient alliance rating) = .17; r (therapist alliance rating) = -

.29; r (self-esteem) = .40.

* $p < .05$