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RUNNING HEAD: Motive-Oriented Therapeutic Relationship in Brief Psychodynamic
Intervention

Motive-Oriented Therapeutic Relationship in Brief Psychodynamic Intervention for Patients
with Depression and Personality Disorders

Ueli Kramer¹, Alessandra Rosciano¹, Mirjana Pavlovic¹, Laurent Berthoud¹, Jean-Nicolas
Despland¹, Yves de Roten¹ & Franz Caspar²

¹Institute of Psychotherapy, Dpt of Psychiatry-CHUV, University of Lausanne

²Clinical Psychology and Psychotherapy, University of Berne

All correspondance concerning this article should be addressed to Dr Ueli Kramer, IUP-Dpt
Psychiatry-CHUV, University of Lausanne, Cèdres-Cery, CH-1008 Prilly-Lausanne,
Switzerland, ph. +41-21-643 64 62, fax +41-21-643 65 93 ; e-mail : Ueli.Kramer@chuv.ch

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Key-Words: Therapeutic Relationship, Plan Analysis, Outcome, Depression, Personality
Disorders

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Abstract

Motive-Oriented Therapeutic Relationship (MOTR, also called Complementary Therapeutic Relationship) has already shown itself to be related to therapeutic outcome in several studies. The present study aims to test MOTR in a four-session Brief Psychodynamic Intervention (BPI) for patients presenting with Major Depressive Disorder (MDD) and co-morbid Personality Disorder (PD). In total, $N = 20$ patients were selected; $n = 10$ had MDD, $n = 10$ had MDD with co-morbid PD. The first therapy session was video-taped and analysed by means of Plan Analysis and the MOTR scale. Symptomatic change was assessed using the SCL-90-R. Results suggest a differential effect on outcome: only the non-verbal component of MOTR is related to symptomatic change in patients presenting with MDD and co-morbid PD; no such effect was found for patients with MDD alone. These results are discussed in line with the generalization and refinement of the conclusions of previous findings on the MOTR.

Key-Words: Therapeutic Relationship; Plan Analysis; Outcome; Depression; Personality Disorders

MOTIVE-ORIENTED THERAPEUTIC RELATIONSHIP IN BRIEF PSYCHODYNAMIC
INTERVENTION FOR PATIENTS WITH DEPRESSION AND PERSONALITY
DISORDERS

Relational-technique variables, *i.e.*, therapeutic techniques that, in the assessment and intervention, focus on the patient's interpersonal behavior within the therapeutic relationship, are important in the treatment of various disorders and across therapeutic approaches (Norcross, 2002). Hill and Knox (2009) underline the centrality of the quality of the therapeutic relationship for outcome. The latter authors put forward a comprehensive review on the research into the therapist's and patient's utterances on their therapeutic relationship, as well as its processing, which is more often the case when the relationship is difficult. This is particularly relevant for patients presenting with Personality Disorders, for whom Smith et al. (2006) point out that relational-technique variables, such as therapist self-disclosure, addressing impasses, providing mutual feedback and relational interpretations, management of counter-transference and the resolution of alliance ruptures, are "probable effective elements in facilitating productive therapeutic relationships" (Norcross, 2002, p. 441, cited by Smith et al., 2006, p. 223). The present exploratory study aims at describing and better understanding a particular relational-technique variable, the Motive-Oriented Therapeutic Relationship (MOTR; Caspar, 2007), formerly called "Complementary Therapeutic Relationship" (Caspar et al., 2005). We are interested in knowing (1) if therapists who are not specifically trained in the MOTR-concept, such as psychodynamic psychotherapists, show behavior that is consistent with this variable in their work with patients and (2) if this relational-technique variable is linked to therapeutic outcome in psychodynamic treatment for Major Depression and co-morbid Personality Disorders. The study of relational-technique variables in psychodynamic psychotherapy is particularly relevant, as this approach focuses on relationship stakes within sessions.

MOTR is based on the integrative case formulation method of Plan Analysis (see the works by Grawe and Dzielwas; Grawe, 1980). The notion of “Plan” goes back to Miller, Galanter and Pribram (1960). Its explicit and extensive use in clinical psychology and psychotherapy is known in two forms: the first was used by Sampson and Weiss (1989; Curtis & Silberschatz, 1994) in the psychodynamic theory framework. The term “Plan” is used for a largely unconscious attempt by the patient to overcome “pathogenic beliefs” (e.g., “I’m not lovable, others will reject me”) which have so far prevented him/her from having a satisfactory life. Based on such a Plan, the patient may “test” the therapist to see whether or not he/she confirms or disconfirms the pathogenic belief (e.g., by behaving in a nasty way which makes it really hard for the therapist not to behave in accordance with the pathogenic belief). Reliability of the method is reported as good, and it has been shown that session progress depends on whether or not the therapist behaves in a Plan-compatible way (Silberschatz, Fretter, & Curtis, 1986). The second use of the Plan concept, independently developed, has a cognitive-behavioral and integrative basis in the context of psychological psychotherapy (Grawe, 1998; Caspar, 2007). The Plan concept encompasses conscious and (in contrast with the colloquial meaning) unconscious processes (Miller et al., 1960). The clinical and empirical value of the Plan concept may be considered well-proven.

The instrumentality of behavior and experience is the main focus of Plan Analysis (PA): based on the patient’s verbal and in particular non-verbal behavior (in- and between sessions), the therapist makes inferences about the implied Plans and motives, answering the question: “Which conscious or unconscious purpose could underlie a particular aspect of an individual’s behavior or experience?” (Caspar, 2007, p. 251). The responses to this question, by definition multi-layered and multi-faceted, are related to the patient’s problematic experience or behavior, and oblige the therapist to prioritize, structure and hierarchize the information within a depicted network of instrumental connections, *i.e.*, the Plan structure of an individual patient. Prototypical Plan structures based on aggregated individual qualitative

analyses exist, for example for Major Depression (Caspar, 2007), Borderline Personality Disorder (Berthoud, Kramer, de Roten, Despland, & Caspar, submitted) and Bipolar Affective Disorder (Kramer, Berger, & Caspar, 2009). As formulated by Caspar (2007) and Eells (2007), there is no formal clinical, *i.e.*, patient-related, counter-indication for using PA as the case formulation method, but there is a therapist-related difficulty: not all psychotherapists feel sufficiently confident to apply this method which requires rigorous abstract thinking, as well as disciplined intuition, on complex issues. A clinical example is given in Figure 1 where a partial Plan structure is depicted on a female patient who devotes herself to her family and does not stand up for herself, but does everything her husband wants her to do, whilst being unhappy about her life. She presents herself to the therapist in a friendly-submissive manner. Among the behaviors identified, recurrent smiling at the therapist was reported (see Figure 1), a behavior that may be instrumentally related to the Plan “present yourself as friendly”, itself related to “present yourself as devoted”. Asking again what purpose the Plan “present yourself as devoted” serves, we may hypothesize “do everything to maintain an altruistic image of yourself”, behind which a basic motive of “maintain a positive image of yourself” (next to “control the relationship” which may be motivated by “avoid losing the other”). This example shows that “behind” an apparently friendly interpersonal behavior, several problematic elements may be found on the motive-level, in particular elements implying avoidance of hurt or of specific emotions.

From an interpersonal perspective in clinical psychology, Kiesler (1982, p. 8) observed in therapists “engagements elicited or pulled from interactants in the presence of a person”, whereas Benjamin (2003, p. 27) insists on the training of “therapist’s ‘ears’ so that they could accurately hear the interpersonal ‘harmonics’ in a moment.” Valid assessment of these observable interpersonal stakes in psychotherapy became feasible with these approaches and turned out to be useful for many cases. However, according to the MOTR concept, in many cases, problematic patient behavior in therapy can not be dealt with without going up in

the hierarchy of patient Plans until a level where the motives are no longer problematic is reached. Once such motives are reached, the therapist will actively and non-contingently satisfy or over-satisfy these motives with the intention of making the use of problematic means (behaviors) unnecessary, as the patient already has what he/she desires (Grawe, 1992; Caspar, et al., 2005; Caspar, 2007; Caspar & Ecker, 2008; Caspar & Grosse Holtforth, 2009; Kramer, 2009a). Thus, MOTR is based on Plan Analysis and represents a relational-technique variable that assures the patient that therapy will provide the means to satisfy his/her unproblematic basic needs or motives within the limits of the therapeutic relationship, without reinforcing problematic lower-level Plans, behaviors or experiences. Since the structure of motives is highly individual, the relationship offer is tailor-made and construed for each patient differently, based on the information collected in the Plan Analysis. This concept operationalizes in an elegant way what Stiles et al. (1998) formulated as a core research and clinical challenge in many psychotherapy studies, that is therapist responsiveness to patient characteristics (Caspar & Grosse Holtforth, 2009). It differs from other conceptualizations of the notion of complementarity in its emphasis on the “motive-orientedness”. Again coming back to the clinical example illustrated by the partial Plan structure in Figure 1, we may illustrate what the MOTR-based therapist should do when the Plan “present yourself as friendly” is activated in the patient at a particular moment in therapy. From our perspective, neither responding by simply smiling back nor pushing the patient to do a self-assertiveness training is helpful for the therapeutic relationship with this particular patient. But a truly motive-oriented stance implies that the therapist conceptualizes complementarity on the level of the acceptable motives, *i.e.* “maintain a positive image of yourself” (the intermediate step “do everything to maintain an altruistic image” was judged being potentially problematic in the sense of limiting the therapist). In this conceptualization, a MOTR-attitude may imply that the therapist follows the overarching interaction principle “show proactively the patient that she is valid as a person”, operationalized as “convey acceptance”. This may be

operationalized in turn, on the non-verbal level, by the therapist adopting a calming or soothing attitude when doubts arise in the patient on her value as a person and may imply, on the verbal level, the therapist acknowledging that it is important to her to know the patient feels accepted and valued as a person (see Figure 1; for yet another example, see Caspar et al., 2005).

Previous findings on the Motive-Oriented Therapeutic Relationship

In a naturalistic study conducted by Grawe, Caspar and Ambühl (1990), two treatment forms based on PA (individual and group psychotherapy) were compared with two treatment forms which were not based on PA (cognitive-behavioral and humanistic psychotherapy) for patients with various psychiatric disorders. On the process-level, Grawe et al. (1990) have shown that therapists trained in Plan Analysis feel that they are more competent and directive in the therapeutic process than therapists practicing other types of case conceptualizations. These therapists reported being more satisfied with the way they carried out their work. They also used a wider range of different therapeutic techniques and were more creative. This wider range of different therapeutic techniques is consistent with the greater technical flexibility in the therapist attitude which may be due to the use of PA (Caspar et al., 2000; Grawe et al., 1990). Technical flexibility is postulated to be particularly effective in the treatment of PD (Norcross, 2002; Fernandez-Alvarez et al., 2006). The effects of Plan Analysis on therapist interaction competencies were investigated by means of an experimental study in psychosomatic medical training (Schmitt, Kammerer, & Holtmann, 2003). The results indicate that the trainees, advanced medical students, were able at the end of their training to describe the patient's non-verbal behavior more precisely and to link it cogently to the patient's basic needs. Moreover, the students were able to reflect more thoroughly on their emotional implication when facing a patient, *i.e.*, their own insecurity or rejecting tendencies, and to conceive these reactions as part of their own personal history and, finally, to link these reactions with the patient's unconscious interpersonal Plans and motives. Finally, several

studies have shown effects on the therapeutic outcome of the MOTR as a relational-technique variable. Moderate links between this individualized therapeutic relationship and outcome were found. Caspar et al. (2005) have shown that in particular the non-verbal component of the MOTR – the quality of the moment-by-moment non-verbal complementarity to the client's Plans activated in session or the therapist's convincing way of ensuring the client that his activated specific motives are not threatened in therapy – was related to the therapeutic outcome in a sample of inpatient interpersonal psychotherapy for depression, whereas the verbal component of MOTR was not related to outcome. Several case studies underline the clinical utility of Plan Analysis and Motive-Oriented Therapeutic Relationship in the treatment of Personality Disorder (Caspar & Ecker, 2008; Kramer et al., 2010) and Post-Traumatic Stress Disorder after childhood abuse (Caspar, 2009; Kramer, 2009a/b). The importance of the non-verbal component of MOTR is consistent with the importance for outcome of micro-processes in the patient, *i.e.*, *how* the content is conveyed, as opposed to the contents themselves (e.g., Caspar et al., 2000).

The aim of the present study is to extend Caspar et al.'s (2005) method to Brief Psychodynamic Intervention, with the hypothesis that the effect of MOTR on therapeutic outcome is present in this very short-term psychodynamic intervention for patients presenting with depression and co-morbid personality disorders. We hypothesize that in particular the non-verbal component of MOTR is related to the therapeutic outcome after four sessions of Brief Psychodynamic Intervention. This may particularly be the case for patients presenting with MDD and co-morbid PD.

Method

Participants

Patients

In total, $N = 20$ French-speaking outpatients with Major Depressive Disorder (MDD) were included in the study. Their mean age was 34.0 years ($SD = 8.09$, range between 21 and

49), 50% were female; all patients were Caucasian. We noted a rather high percentage of males in this sample. The patients were selected out of a larger sample recruited for a naturalistic study on Brief Psychodynamic Intervention (BPI; Despland, Drapeau, & de Roten, 2005) with a total N of 122. Selection criteria were the presence of a full MDD diagnosis (single or recurrent episodes) for the entire sample and the presence of any co-morbid PD for half of the sample. For the pure MDD sub-group ($n = 10$), the mean age was 34.4 years ($SD = 8.69$, range between 21 and 47), 40% were female. For the MDD sub-group with co-morbid PD ($n = 10$), the mean age was 33.5 years ($SD = 7.89$; range between 25 and 49); 60% were female. The following PD diagnoses were present in the sub-sample (multiple diagnoses possible): avoidant ($n = 7$), depressive ($n = 5$), obsessive-compulsive ($n = 4$), negativistic ($n = 2$), narcissistic ($n = 2$), and dependent ($n = 1$). The relative absence of Cluster B PD was noted. All diagnoses were established by trained clinicians using the SCID-I and -II semi-structured interviews for the DSM-IV (First et al., 2004; APA, 1994). Reliability of the diagnoses for the entire sample was reported elsewhere (Despland et al., 2005); mean kappas were considered sufficient (DSM-IV axis I: $\kappa = .65$; DSM-IV axis II: $\kappa = .54$).

Therapists

In total, $N = 6$ therapists participated in the study, all experts having more than 5 years post-training clinical experience and teaching experience in the field of psychodynamic psychotherapy (according to the model developed by Gilliéron, 2004). There were $n = 1$ female and $n = 5$ male therapists, with a mean age of 42 years ($SD = 3$), all therapists were Caucasian. Each therapist treated between 1 and 5 patients; patients were assigned to the therapists by a clinical coordinator according to their availability. Therefore, the same therapists treated patients with pure MDD, as well as those with co-morbid PD. Therapist competence was assessed in the entire sample using the the Brief Psychodynamic Intervention Competence Scale and considered sufficient, as reported by Despland, de Roten et al. (2009).

Raters

In total, $N = 4$ raters participated in the study, three junior researchers (Master-level psychologists) and one senior researcher (PhD psychologist and psychotherapist). They were $n = 2$ female and $n = 2$ male raters, their mean age was 28 ($SD = 2$), all raters were Caucasian.

Treatment

Brief Psychodynamic Intervention (BPI; Despland, Michel, & de Roten, 2010; Gilliéron, 2004) is a four-session outpatient ultra-brief intervention based on psychodynamic principles (Sifneos, 1987). These interventions involve the interpretation of core relationship themes, defensive functioning and on the providing of a synthesis relating interpersonal characteristics to the current situation. BPI has been empirically investigated and has shown sufficient effectiveness (Despland, Drapeau, & de Roten, 2005).

Instruments

Plan Analysis (Caspar, 2007)

Plan Analysis is an individual-based qualitative method yielding a complete case conceptualization for each patient (for more information, see the Introduction and Procedure sections).

Motive-Oriented Therapeutic Relationship (MOTR) scale (Caspar et al., 2005)

The MOTR scale is a seven-point Likert rating scale ranging from -3 (completely anti-complementary) to +3 (completely complementary) assessing the therapist's degree of complementarity in a specific therapeutic situation with regard to the *in-situ* activated Plan in the patient (see example given in Figure 1). Two sub-scales are specified by Caspar et al. (2005): verbal and non-verbal complementarity, along with the total complementarity defined as the mean of the afore-mentioned components. Each session yields three mean scores: verbal, non-verbal and total complementarity.

Symptom Check-List-90-R (Derogatis, 1994)

This questionnaire includes 90 items addressing various psychological and somatic signs of distress. These items are scored using a Likert-type scale ranging from 0 (“not at all”) to 4 (“very much”). Our study used only the Global Severity Index (GSI, score ranging from 0 to 4), which is a mean rated over all symptoms. The clinical cut-off score is 0.80. The French validation study was carried out by Pariente and Guelfi (1990) and yielded satisfactory coefficients.

Procedure

First, the patients were selected out of the Despland et al. (2005) data pool (see under Patients). Then, a four-month-long rater training took place using video material of psychotherapy sessions. Three junior raters were trained by the senior researcher and first author of the article in the elaboration of Plan Analyses and the MOTR ratings. Four cases were used as training cases for Plan Analysis and four for MOTR; these cases are not part of the present study. Sufficient reliability (for the definition, see below and the procedure described by Caspar et al., 2005) was reached by the raters at the end of the training.

We used the video-taped intake session as the data source for the establishment of the Plan Analysis. We chose to analyze the intake session, because it optimally reflects the interpersonal dynamics the therapist needs to deal with right from the start of therapy; their early analysis and elucidation has clinical potential in preventing unproductive therapeutic attitudes from the second session onwards. Psychotherapy research has invested much effort in demonstrating the importance of early alliance in the prediction of outcome (Martin et al., 2000), this may be particularly true for patients with inflexible Plan structures who tend to reproduce their inner assumptions within the therapeutic relationship (see the “test” concept example in the Introduction section). Data analysis for each patient follows a two-step procedure: (1) Establishment of so-called “extensions” on instrumental events (verbal and non-verbal) in the session to be coded later, according to the description by Caspar (2007; this intermediary step, including summarizing and preparing raw material for further analysis, enhances transparency in the process of inferring Plans

from concrete behaviors); (2) Construction of an individualized Plan structure based on these extensions. Inter-rater agreement analyses were carried out on the ratings, based on independent analyses on 60% of the cases (12 out of 20 cases; only the video material was available to both raters) focusing on the 10 (judged by the rater) most important Plans in one Plan structure, compared to all Plans in the second structure (Caspar, Wirtz, & Spiegelhalter, submitted; Kramer et al., 2009; Wirtz & Caspar, 2002). For each of the ten compared Plans, the following correspondence criteria and ratings were applied: 1 point for correspondence in the Plan itself, 2 points for correspondence in hierarchically superior Plans and 2 points for correspondence in hierarchically inferior Plans, yielding a possible total of 5 points. Percentages of the total correspondence of the ten main Plans between the two Plan structures were computed and averaged. A mean correspondence of 60% was defined as sufficient (Caspar et al., submitted). For the MOTR-ratings done for our study, the same video-taped intake sessions were used as the data source; these ratings were done by a different rater pair than the final Plan Analysis. The MOTR-rater only had the video and the Plan Analysis. The rater proceeded in three steps: (1) selection of an event, such as an intervention done by the therapist addressing a patient's activated Plan (the beginning of the the event was the start of the intervention and the endpoint the end of the intervention); (2) selection of the Plan (according to the Plan Analysis previously established by a different rater) activated in the patient, prior to the event; (3) MOTR-rating on both items (verbal and non-verbal) for the particular event. This procedure was repeated for each therapeutic intervention/event. Then, inter-rater agreement analyses were carried out on the three aforementioned steps of the MOTR-ratings (according to Caspar et al., 2005): (1) A percentage of correspondence of the selection of the event was computed; (2) A percentage of correspondence was computed for the choice of Plans considered to be activated in the patient prior to that therapeutic event; (3) A Spearman rank correlation was calculated for all three scores (verbal, non-verbal and total complementarity) of the MOTR-rating.

Statistical analyses

In order to test the research hypotheses, *t*-tests and Pearson correlations were computed.

Results

Inter-rater agreement

For Plan Analysis, twelve cases (6 MDD and 6 MDD with PD; 60%) out of 20 were analyzed independently by two trained raters. On average, the inter-rater agreement was 73.5% (range between 55% and 85%) and considered sufficient; no difference between the patient groups in terms of reliability was observed. If there were discrepancies between the two raters, they were considered minor, but were discussed and a consensual formulation was defined which was then used for further analyses.

For the Motive-Oriented Therapeutic Relationship scale, twelve cases (6 MD and 6 MD with PD; 60%) out of 20 were analyzed independently by two raters according to the three-step procedure outlined above: (1) On average, both raters selected the same therapeutic situations to be rated with an overlap of 79.3% (range between 69% and 89%), which is considered sufficient; (2) On average, both raters selected the same Plan considered to be activated in the patients in these therapeutic events to the extent of 77.0% (range between 68% and 89%); (3) Spearman rank correlations for the three scores were .76 for verbal, .71 for non-verbal and .75 for total complementarity. These reliability coefficients were all considered satisfactory. Discrepancies were not discussed on the level of MOTR-ratings; one rating was defined *a priori* as the main rating and entered the statistical analyses, enabling a consistent rating per session and a clear separation between the inter-rater reliability procedure and the rating itself which was kept for further analysis.

Within-scale Pearson correlations indicate high correlations between the sub-scales and the total scale (mean of $r = .42$), but the absence of correlations between the sub-scales

(verbal and non-verbal) themselves ($r = .04$). The latter result indicates that the differentiation between verbal and non-verbal components of MOTR is empirically meaningful.

Outcome

For the SCL-90-R, Cronbach's alpha for our sample was .89 and the Global Severity Index at intake was on average 1.07 (SD = .50; range 0.29 – 1.84). In order to compute symptomatic change over the course of BPI (four sessions), the Reliable Clinical Change Index was used (Jacobson & Truax, 1991). RCI raw scores, based on the change on the GSI, were used as outcome scores in this study. The results indicate that 50% ($n = 10$ cases) improved significantly, 45% ($n = 9$ cases) remained unchanged and 5% ($n = 1$ case) deteriorated. Positive numbers indicate improvement.

Motive-Oriented Therapeutic Relationship and therapeutic outcome

On average, 20.26 MOTR-events were coded (SD = 7.12; range 10 - 36) per session. Overall, the therapists present mean MOTR scores above the scale average and scored higher on the non-verbal than the verbal sub-scale ($t(1, 18) = 2.75$; $p = .03$; see Table 1). No significant difference was found when comparing the sub-groups; there was a small effect size favouring the non-verbal component facing patients presenting with Personality Disorder.

Pearson correlations between MOTR and symptom level at intake showed a differential pattern as a function of sub-group (Table 2): MOTR (total score) correlates with symptom level at intake when the therapist faces patients presenting with MDD alone ($r = -.68$; $p = .03$; $n = 10$), which is not true for patients presenting with MDD with co-morbid PD. In the latter, no significant correlation was found ($r = -.20$; $p = .59$; $n = 10$), indicating that greater therapist complementarity was associated with less symptomatology, but only in patients with non-co-morbid MDD.

The general score of MOTR correlated with therapeutic change for the entire sample ($r = .47$; $p = .03$; $N = 20$) and the MOTR non-verbal sub-scale with the PD patients: the more

complementary the therapists are on the non-verbal level facing patients with MDD and co-morbid PD, the better the outcome after four sessions in these patients ($r = .62$; $p = .05$; $n = 10$). On the other hand, for the MDD-alone group, no significant correlation with outcome was found.

Discussion

The results are in line with our research question and with previous findings (Caspar et al., 2005) on inpatient psychotherapy for MDD using an interpersonal therapy model. Both studies, Caspar et al.'s and ours, are based on a sample of therapists who were unaware of the concepts of Plan Analysis and MOTR. Our results indicated that these psychodynamically-oriented psychotherapists were able to build a MOTR to a small to moderate extent, irrespective of the psychopathology of the patient. We were able to show, in this small sample, that the non-verbal component of MOTR is related to symptomatic change over the course of very brief psychodynamic interventions, but only in cases presenting with co-morbid Personality Disorder. The importance of the non-verbal MOTR is also confirmed by a small effect in this component when facing PD, compared to MDD only. For patients presenting with PD, as underlined by Smith et al. (2006), relational-technique variables are of particular importance in producing favorable outcome. These patients are known to present with "difficult" interpersonal patterns, *i.e.*, criticizing the therapist, presenting as very needy or as overly competent, splitting teams of therapists and with testing behavior (Caspar & Berger, in press; Sachse, 2003, 2004; Sampson & Weiss, 1989); therefore, the therapist needs to be able to conceptualize these patterns within a meaningful framework based on the individual motives and to construct an adapted relational attitude for the particular patient. Even if this principle may be true for any psychotherapy patient (Caspar, 2007; Eells, 2007), our data indicate that it holds particularly true for patients presenting with Personality Disorders.

In order to make our point as clear as possible, an example of a therapist intervention with a female patient presenting PD is given, in its verbal and non-verbal components. After

39 minutes 16 seconds of the intake session, the Plan (previously assessed in the Plan Analysis) “do everything to be taken charge of” is activated in the patient and the therapist conveys interest in the patient’s situation, reformulates the sentence just uttered by the patient (the therapist addresses the suffering related to the problems and the motivation to change) and underlines that this psychotherapy will help to understand her problems better (verbal MOTR-component coded as +3). This is done while empathically assuring his presence of therapist by looking at the patient, instead of at his sessions notes, as he did before repeatedly (non-verbal MOTR-component coded as +3). Note the therapist’s pro-active stance which goes beyond being simply warm, accepting and compassionate. Another example is a male patient with co-morbid PD in which after 40 minutes 2 seconds, the Plan “present yourself as intelligent” is activated. Here, the therapist decides to confront by asking if the patient confuses lies and reality (verbal MOTR-component coded as -1), while writing down something on his notepad (non-verbal MOTR-component coded as -2). Note the therapist’s non-complementarity on both verbal and non-verbal levels, in relation to the patient’s Plan “present yourself as intelligent”.

On the other hand, for patients presenting with MDD alone, no link with outcome was found, but a link was found between MOTR and symptom level at intake for these patients: the higher the symptoms at the beginning of therapy, the more the therapists display behaviors consistent with the relational-technique variable of MOTR, even if they have not been specifically trained in this model. This seems to be a specific effect for patients with MDD alone; it was not found for the sub-sample with co-morbid PD. It can be hypothesized that even if the therapist may need to counter the more severely depressed patient with a therapeutic stance focusing on the patient’s motives, this relationship attitude alone does not produce therapeutic outcome. The establishment of a MOTR facing depressive symptoms, even if severe, is not sufficient for the short-term change of the symptomatology; more specific techniques need to be added, in order to attain this objective. This hypothesis

parallels with the notion of therapist competence in psychodynamic psychotherapy (Despland et al., 2009) and is in line with the MOTR concept implying that MOTR merely creates a basis on which the therapeutic procedure, *i.e.*, specific techniques to reduce depressive mood, can be built. Whilst in some cases, the patient's experiences in the therapeutic relationship by and in itself may be therapeutic in the sense of corrective emotional experiences, the therapist should not simply rely on such events. The question as to what extent therapists also need to be non-complementary in a disciplined, targeted way to stimulate change, is currently under investigation. For example, severely depressed patients are normally not those who encourage therapists to challenge them, even if it is thought that challenging these patients in a disciplined way may be a particularly fruitful approach for especially trained therapists.

The present study suggests that the Motive-Oriented Therapeutic Relationship and Plan Analysis may be understood as therapy-school-independent and integrative concepts for building the therapeutic relationship, by using specifically patient-adapted techniques. It may be useful, learnable and applicable for clinicians with various therapeutic backgrounds, *i.e.* psychodynamic, interpersonal, cognitive-behavioral or experiential psychotherapy. In particular for the psychotherapy of PD, we have formulated clinical implications of the present study. Plan Analysis and MOTR seem to be particularly helpful tools for understanding interpersonal stakes in the way that these patients enter the relationship with their therapist. The more the therapist acts on a non-verbal level, *i.e.*, the way he/she conveys the message with the tone of his/her voice and entire body language - and not the content of the message - in a complementary way with the patient, the better the results. Should these findings be confirmed in controlled studies, psychotherapy training programs may be complemented by the systematic teaching of elements on these individualized conceptualization and treatment tools. This may imply that trainees from different therapeutic approaches who are working with patients presenting with PD may benefit from a specific training in MOTR and Plan Analysis. Training in individualized case formulation of the non-

verbal behavior in session, in terms of the motives “behind” those behaviors may increase the therapist’s sense of interpersonal efficiency (Schmitt et al., 2003). To take the illustration from the Introduction section with the female patient whose activated Plan was “present yourself as friendly”. the therapist may learn to avoid a direct response on the behavioral level, *i.e.*, avoid smiling back, but learn how to build an individualized attitude to this particular patient in this particular situation, when she recurrently smiles at the therapist. The therapist may learn not to focus on the low-level Plans, which are potentially problematic, but learns how to respond by conveying acceptance with regard to the patient’s important motive of a positive self-image.

The findings in this exploratory study need to be interpreted with caution, as the number of observations is very low; the small sample size prevented us from conducting more sophisticated statistical analyses. It needs to be underlined that no causal effect may be established using correlational statistics as was the case in the present study. Moreover, the in-depth analyses are based on the intake session only and, although the reliability procedures were in line with the literature, we did not correct for chance in the procedure. We also need to acknowledge that we did not control for the number of significance tests in the correlational analyses.

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Table 1

Mean (SD) of Motive-Oriented Therapeutic Relationship (MOTR) for MDD and co-morbid PD
 sub-samples

MOTR	MDD (<i>n</i> = 10)	MDD+PD (<i>n</i> = 10)	<i>t</i> (1, 18)	ES
Total	1.86 (.37)	1.89 (.23)	.18	.09
Verbal	1.58 (.60)	1.67 (.50)	.35	.16
Non-verbal	2.04 (.41)	2.11 (.26)	.42	.20

Note. ES: Effect size (Cohen's *d*).

Table 2

Pearson's Correlations between Motive-Oriented Therapeutic Relationship (MOTR) and Outcome for the total sample, and for MDD and co-morbid PD sub-samples

Variables	MDD (<i>n</i> = 10)		MDD+PD (<i>n</i> = 10)	
	GSI	RCI	GSI	RCI
MOTR total	-.68*	.40	-.20	.54
MOTR verbal	-.47	.56	-.43	.31
MOTR non-verbal	-.31	.36	.24	.62*

Note. GSI: Global Severity Index of SCL-90-R at intake. RCI: Reliable Clinical Change Index between intake and discharge (on GSI of SCL-90-R). Two-tailed significance testing

Figure 1

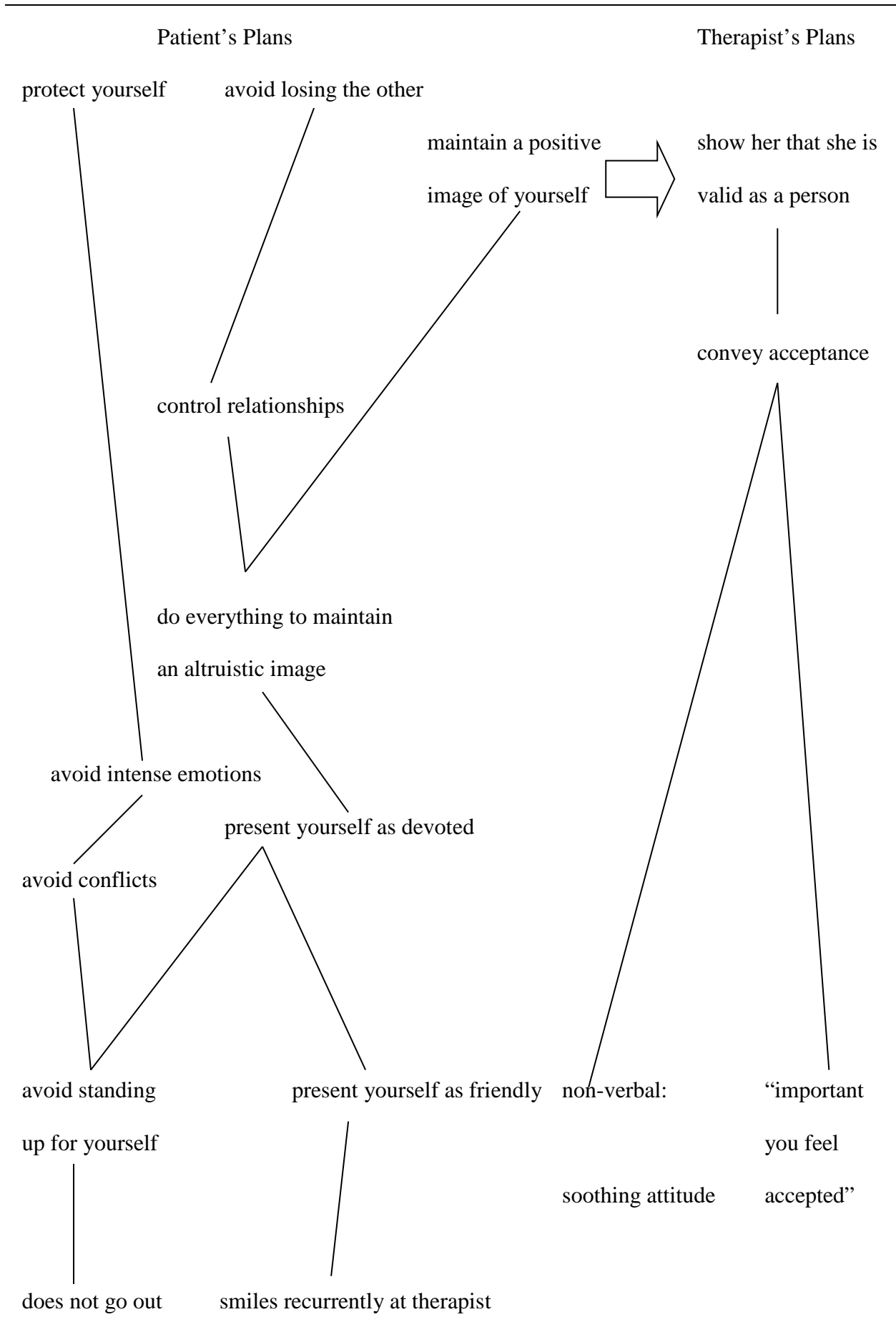


Figure Caption

Figure 1. An example of a patient's partial Plan structure (left hand-side of the figure) with an example of a possible therapist's motive-oriented therapeutic relationship attitude (right hand-side of the figure)

Patient's Plans

Therapist's Plans

