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Authors: Keller S, Page D, de Roten Y, Despland J, Caspar F, Kramer U

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Adaptation of the Motive-Oriented Therapeutic Relationship Scale to Group Setting in Dialectical-Behaviour Therapy for Borderline Personality Disorder

Sabine Keller[1 2], Dominique Page[1], Yves de Roten[1], Jean-Nicolas Despland[1 2], Franz Caspar[3], Ueli Kramer[1 2]

[1] University Institute of Psychotherapy, Department of Psychiatry-CHUV, University of Lausanne

[2] General Psychiatry Service, Department of Psychiatry-CHUV, University of Lausanne

[3] Department of Clinical Psychology and Psychotherapy, University of Bern

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Corresponding author: Sabine Keller, Institut Universitaire de Psychothérapie – Centre de Recherche en Psychothérapie, Avenue de Morges 10, 1004 Lausanne, Switzerland. Phone: +41.21.314.19.38 ; email: Sabine.Keller@chuv.ch.

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Abstract

The therapeutic relationship as a process is usually studied in individual therapy, and less in group therapy. One reason for this paucity of research may be the complex methodology necessary to do process research on group therapy. One of the therapeutic approaches using the group as part of the therapy is Dialectical Behaviour Therapy (DBT) for Borderline Personality Disorder (BPD).

The purpose of the present study is to develop a group version of a process measure which has been successfully used in individual therapy, the Motive-Oriented Therapeutic Relationship (MOTR) scale, based on individualised case conceptualisations using the Plan Analysis approach. To do this, ten sessions of a DBT skills group therapy were analysed from a comprehensive dataset within a randomized controlled trial. Included were therapy completers: 3 patients and 2 therapists. The therapists were unaware of MOTR.

The results revealed that the adaptation of the MOTR to DBT skills group was feasible. Its adaptation showed differences of the therapists in their use of MOTR when comparing the different patients: Therapist presented with higher degrees of MOTR towards one patient, compared to another. Overall results suggest that effective therapists in DBT skills training intervene with rather low mean levels of MOTR, and great intra-session variability of MOTR. We conclude that the adaptation of the MOTR-instrument to group therapy is feasible and yields meaningful results. Therefore, this scale may be used in process research in group therapy, in particular when one wishes to have an individualized measure of the therapeutic relationship.

Key-Words: Group Therapy; Motive-Oriented Therapeutic Relationship; Dialectical Behaviour Therapy; Borderline Personality Disorder; Process

Adaptation of the Motive-Oriented Therapeutic Relationship Scale to Group Setting in Dialectical-Behaviour Therapy for Borderline Personality Disorder

Introduction

The process of the therapeutic relationship is more often studied in a setting of one therapist facing one patient; it is less analysed in group therapy (Norcross, 2011). The complexity of possible interactions and connections between several individuals – the members of the group and the therapist(s) – makes such an endeavour highly difficult. It is therefore useful to develop a method of measuring the therapeutic process that is adapted to the specific requirements of group therapy.

Group therapy in clinical settings is defined by the number of participants, by the fact that there are one or more mental health professionals to facilitate the group process, by the fact that participants suffer from a diagnosed psychiatric disorder and also by negotiated and pre-determined goals and tasks. Beyond symptom reduction associated to group therapy, in the context of a cost-effective treatment (Fals-Stewart, Marks, & Schafer, 1993; Kashner, Rost, Cohen, Anderson, & Smith, 1995; Weiss, Griffin, Greenfield, Najavits, Wyner, et al., 2000), the benefits of group therapy may "include a reduced sense of isolation and uniqueness, mutual support, exposure to positive models, and the opportunity to develop coping skills by interacting with others" (Levine & Hogg, 2010, p. 922). Norcross (2011) reviewed the process variables related to group therapy which include, among others, the therapeutic alliance, empathy, goal consensus, collaboration and group cohesion. Group cohesion, or cohesiveness, is the most prominent relationship variable in group therapy (Burlingame, Fuhriman, & Johnson, 2002; Norcross, 2011) and is an important relational aspect within the therapy group (Piper, Marrache, Lacroix, Richardsen, and Jones, 1983). Piper et al. (1983) reached this conclusion from studying nine groups composed of a total of 45 participants with the purpose of learning about processes in small groups. They measured

the concept of cohesion using a self-report questionnaire, and it appeared that patient commitment to the group – a sub-scale of cohesion – was a crucial factor for individual members of the group to stay in treatment. In this study, patient commitment was also connected to the perception of the physical distance between the members of the group. Toren and Shechtman (2010) used Structural Equation Models to explain the interactional nature of relationship variables in groups. Finally, Tikkanen and Leiman (2014) used a fine-grained dialogical-sequence analysis to study relationship processes in groups, on the level of actual therapist-patient speech turns. The latter method is particularly prolific, as it becomes possible to take into account the therapist's responsiveness – the fact that the intervention choice is co-determined by emerging context variables, such as patient interactional features (Stiles, Honos-Webb, & Surko, 1998). Such features may emerge on a moment-by-moment basis. Therapist responsiveness is discussed as a particularly central variable in understanding and predicting variations in outcome (Caspar & Grosse Holtforth, 2009; Kramer & Stiles, 2015; McMain et al., 2015; Stiles et al., 1998). In this context, a group therapist who is appropriately responsive to the group may give particular attention to emerging productive relationship processes in the group and its members. So far, very little research has been conducted to understand group processes on such a detailed level of responsiveness.

One of the therapeutic approaches using the group as part of the therapy is Dialectical Behaviour Therapy (DBT) for Borderline Personality Disorder (BPD). Dialectical Behaviour Therapy was developed by Linehan (1993a/b) for patients presenting with BPD. Its effectiveness has been demonstrated by a number of studies (e.g., Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Comtois, Murray, Brown, Gallop, et al., 2006; Decker & Naugle, 2008). DBT has five components: individual therapy, skills training group therapy, therapists in consultation among themselves and with other DBT therapists, phone consultation between sessions and assistance in the

structure of the patient's environment. DBT has a specific vision of the therapeutic relationship, which is understood as the core of change in therapy. Indeed, the collaboration created between the therapist and the patient will allow the patient to oscillate between acceptance and change (Linehan, 1993a). Given this importance of the relationship in DBT group therapy, it might be particularly fruitful to deepen its understanding by using the responsiveness concept and analyse group sessions of DBT skills therapy in fine-grained manner. Such detailed description might help to understand the actual therapeutic interactions in DBT and might enable to determine appropriate responsiveness in DBT. This understanding may also help to refine therapy interventions, starting from the observation of actual in-session behaviours.

In addition, moment-by-moment relationship processes are particularly important to track in treatments with patients presenting with BPD. According to the DSM-IV-TR, BPD has an impact on cognitive, emotional and relational aspects. These features may affect the patient’s interaction style in group therapy but supposedly, in a different way for each patient; therefore, a particular attention to the idiosyncratic relationship variables at stake for each patient in the group process is necessary.

A method which takes into account the impact of emerging – idiosyncratic – patient interaction features is, based on Plan Analysis, the Motive-Oriented Therapeutic Relationship (MOTR; Caspar, 2007; Grawe, 1980). This concept is therefore consistent with the responsiveness concept previously described. The foundations of Plan Analysis were laid by Grawe (1980) with the Vertical Behaviour Analysis, which was based on a reflection of “difficult” patients in a group therapy for social anxiety. Despite the accurate implementation of a group intervention, according to a prescription of behaviour techniques, some patients did not optimally benefit from the treatment. How can we understand the individual patient’s underlying motives of these cases? By referring to Miller, Galanter, and Pribram (1960),

Caspar and Grawe developed Plan Analysis, an individualised procedure of case conceptualisation aiming at understanding the instrumental structure of Plans mediating between concrete behaviours as means, and motives; patient behaviours, as well as experiencing are seen from the perspective of instrumental Plans. The latter word is capitalised following a suggestion by Miller and colleagues (1960) to highlight the difference in meaning as compared to the everyday language use of the word, above all presuming that most Plans are not rational or conscious. The theoretical basis of this approach is large, including interpersonal approaches as well as social and developmental psychology, and cognitive science (i.e., information processing, schemas; Grawe, 1980; 1992; Caspar, 2007).

Starting from observable behaviours and with a particular focus on the patient's non-verbals, the assessor infers behaviour-related motives and goals (Caspar, 2007). In order to do this, the therapist asks the question: "Which conscious or unconscious purpose could underlie a particular aspect of an individual's behaviour or experience?" (Caspar, 2007, p. 251). Here, the motives are understood as a possible instrumental explanation for the observed behaviours and experiences. There may be several motives underlying the same behaviour and several behaviours that serve the same motive. Accordingly, the therapist or rater establishes a hierarchy of Plans, each Plan being a purpose for the one (or ones) below. Higher-order Plans may or may not directly relate to fundamental human needs, which are understood to be limited in number and are generally the same for everyone. Human fundamental needs may include, but are not limited to, the need for control, for maintaining self-esteem, the need to be close (or, the avoidance of being alone), to maintain one's psychic and/or physical integrity, and the need for protection and healing (Grawe, 2004).

As an example, consider the following observed in-session behaviour: a patient who does not remove his jacket during the session, despite the warm room temperature. We can infer for this particular behaviour the Plan "get ready to leave", which may stem from "keep

your distance" and by the basic needs "protect yourself" and "keep control". Alternatively, it may also be possible to infer the Plan "keep control of yourself", which may imply "keep control of your life", and "keep control"; also the therapist or rater can infer "show the therapist that you can go at any time", and then "control the therapy situation", to arrive at "maintain your autonomy" (see Figure 1). Despite the individualised methodology, there is a qualitative study which established a prototypical Plan Analysis with patients presenting with BPD (Berthoud, Kramer, de Roten, Despland, & Caspar, 2013).

The Motive-Oriented Therapeutic Relationship (MOTR; Grawe, 1992; Caspar, 2007; Caspar & Grosse Holtforth, 2009) is a type of relationship in which the therapist, using such a Plan Analysis case formulation makes interventions responding to the patient's acceptable motives in a proactive fashion. The aim is to assure a patient’s underlying acceptable motives, thereby preventing the need for specific instrumental behaviours used by the patient. An acceptable motive is one that does not threaten the therapeutic relationship or unduly restrict the therapeutic possibilities. According to this concept (Caspar, 2007), non-verbal aspects are just as important as verbal aspects. Indeed, if the therapist’s intervention aims to address an acceptable Plan at a verbal level, but does this with contradictory non-verbal attitude and para-verbal markers, it will not have the same impact. Correlated to this notion, process and content can be distinguished (Caspar, Pessier, Stuart, Safran, Wallner Samstag, et al., 2000).

Referring to the example of the jacket, a therapist using a complementary – or motive-oriented – intervention, could, for example, address the acceptable Plan "keep control" by saying to the patient "it is you who makes the decisions", in a soft voice. A non-complementary intervention may be: "take off your jacket immediately" in an authoritative tone. For a more detailed clinical example of intervention, the reader may refer to Kramer, Berthoud, Keller, and Caspar (2014).

MOTR has shown links with outcome. Various studies have focused on MOTR, some with patients suffering from depression (Caspar, Grossman, Unmüssig, & Schramm, 2005; Schmutz, 2012), and others with patients presenting with personality disorders (Kramer, Rosciano, Pavlovic, Berthoud, Despland, et al., 2011; Kramer, Kolly, Berthoud, Keller, Preisig, et al., 2014).

MOTR, currently used for measuring process in individual therapy, had originally emerged from elaborations related to group therapy (Grawe, 1980). We think it is time to take it back to its roots by applying this concept to relationship processes in group therapy. Therefore, the purpose of this study is to adapt a method of measuring process, the MOTR scale, to a group setting. In the present study, we also aim at presenting first exploratory data with regard to the specific application of such a scale to the role of MOTR in DBT skills groups therapy.

Method

Context

The sample of patients studied here is taken from a larger randomised controlled trial on DBT skills group training for BPD (for more information see Page & Kramer, 2011; Kramer, Pascual-Leone, et al., 2016). In addition to the group therapy, all patients had individual therapy.

Sample

Patients.

The selected therapy group is constituted of three patient completers who are all diagnosed with BPD. The group is composed of two women and one man, with a mean age of 39.34 (range between 29 and 48).

One of the three patients, Anna, is 41 years old and remains stable regarding her symptoms over the course of DBT skills training. Betty, another patient, is 29 years old and shows great improvement in her symptoms. The third patient is Gary, a 48-year-old man, whose symptoms also decline over the course of the therapy (see table 1). The group was originally composed of five patients but two patients had dropped out of the therapy group during the two first sessions (and were therefore excluded from this particular process analysis). This particular group was selected for analysis in terms of feasibility of the process analysis in question: such a small group might present with a manageable degree of complexity and at the same time, is able to accurately address our research question on the adaptation of the MOTR to group therapy.

Therapists.

Two therapists, a woman and a man, facilitated the therapy group. They were trained in DBT techniques and were supervised weekly. One of the therapists is a psychologist and psychotherapist, and the other is a nurse. They both are between 35 and 45 years old. They followed a DBT basic training course for several months, as well as a specific three-day intensive training to be able to facilitate this particular group. They were unaware of the MOTR-concept.

Treatment

Therapy sessions were scheduled once a week and each one lasted one hour and thirty minutes. According to Linehan's method (1993a/b), patients were given the opportunity to train their skills in managing emotions through mindfulness (sessions two to six), improving their distress tolerance (sessions eight to ten) and by learning to regulate their emotions through different techniques (sessions 11 to 18). Therapists followed a specific manual (for

more details: Page, 2010).

Instruments

All questionnaires were given at intake, mid-way through the group treatment, and at discharge.

The Outcome Questionnaire (OQ-45; Lambert, Burlingame, Umphress, Hanson, Vermeersch, et al., 1996) is a self-report questionnaire and includes 45 items to assess results of psychotherapy. It describes general symptoms with a global score and has three subscales: symptom distress, interpersonal role and social role. The French version was translated and validated by Emond, Savard, Lalande, Boisvert, Boutin, et al., (2004). Cronbach alpha for this small sample was .92.

The Borderline Symptom List (BSL-23; Bohus, Kleindienst, Limberger, Stieglitz, Domsalla, et al., 2009) is a short version, which includes 23 items to assess borderline symptoms. The French version was approved by the authors. It is a self-rating instrument and uses a general score. Cronbach alpha for this small sample was .93.

The Working Alliance Inventory-short version (WAI-short version; Horvath & Greenberg, 1989) assesses the therapeutic alliance with 12 items. The patient answers the questions by himself/herself. The questions evaluate the therapeutic alliance, the link between the patient and the therapist and the degree of agreement about the tasks and aims of the therapy. The French translation and validation was presented by Corbière, Bisson, Lauzon, and Richard (2006). Cronbach alpha for this small sample was .95.

Plan Analysis and the Motive-oriented therapeutic relationship (MOTR) scale

The original method of the MOTR scale (Caspar et al., 2005) was conceived for an individual setting, meaning one therapist facing one patient. For a detailed description of the

procedure of application in an individual setting, one may refer to Caspar and Grosse Holtforth (2009).

First of all, in this research, a rater constructed the Plan Analysis of each of the three patients using the first session, based on videotape. The rater noted all instrumental behaviour, both on a non-verbal and verbal level. The rater then inferred underlying Plans. Consistent with the method, behaviours were written in the third person singular of the indicative present, and the Plans were written in the second person singular of the imperative present (see Figure 1).

To rate the MOTR, the rater analysed video sessions that were different from the session used to establish the Plan Analysis. The sessions to be rated with MOTR were divided into time segments, based on an initial step of analysis using the identification of themes (Caspar, 2007). Each time unit lasted a maximum of 10 minutes, but may have been as short as a few words. To code MOTR for each time segment, the rater initially focused on the patient in order to determine which Plan was being activated. Based on that, the rater focused on the therapist's speech and behaviour patterns during this time segment. He/she then described the interventions of the therapist. The rater assessed whether the therapist addressed the acceptable Plan connected to the patient’s activated Plan; the rater coded the intervention. The seven-point MOTR-scale ranges from -3 (anti-complementary: meaning therapist behaviours contradict central patient Plans) to +3 (complementary: meaning therapist behaviours favour central patient Plans) through zero (neutral), both on verbal and para- and non-verbal levels. An acceptable Plan, or “central Plan”, is the one that does not threaten the therapeutic relationship. If the therapist happened to address a different Plan in the patient, the rater coded this intervention less positively on the seven-point Likert scale (either verbally or non-verbally). The therapist could address several Plans within a given sequence, up to a maximum of three. One code was given for the verbal aspects and one for the non-verbal

aspects of each Plan; as such, a maximum of nine codes could be given. All these elements were rated on a coding sheet (see Table 4).

Procedure

This research is based on data taken from a pool used for a main study, a randomized controlled trial that aimed at assessing the effectiveness of a 20-session short version of DBT group therapy (Kramer, Pascual-Leone et al., 2016). The research was accepted by the ethics committee in 2011. Every patient was informed of the aim of the study and what would be required of him/her throughout the study. Each patient signed a written consent. The 20 sessions were videotaped. For reasons of coding feasibility, the authors of the present paper chose to analyse only half of the sessions, i.e., a total of 10 group sessions lasting 90 minutes each. To increase intersession comparability, only sessions involving the same two therapists and the same three patients were analysed. Accordingly, the following 10 sessions were evaluated with MOTR: sessions number 4, 5, 11, 12, 13, 14, 15, 16, 17 and 18.

Pseudonyms were used for the three patients: Anna, Betty and Gary. The MOTR (Caspar et al., 2005; Caspar & Grosse Holtforth, 2009) was rated and the reliability computed.

Results

Adaptation to group setting of the Motive-oriented therapeutic relationship (MOTR) scale

The adaptation of the MOTR rating scale to a group format yielded the following results. In what follows, we will use the term of MOTR-group to specify the group version. The actual adaptation involved several operational steps. The original version of the MOTR coding scheme has five columns, to which two columns for the group version were added in

order to retain additional information. One column is used to record to whom the therapist is speaking (an individual patient or the group as a whole; all segments where the two therapists were talking amongst each other were excluded), and one column is used to record which therapist is speaking during the sequence (a specific therapist or both therapists together). The resulting seven columns of the MOTR-group rating scheme are therefore the following: (a) the time of occurrence in the session (sequence to be rated), (b) the initials of the therapists, (c) to whom the therapists is speaking, (d) Plans activated in the patient, (e) central Plans (acceptable Plans in the patient's Plan Analysis; as explained above), (f) a brief description of the behaviors (verbal and non-verbal behaviour of patients and therapists), and (g) MOTR-scale, one sub-column for the verbal code and another one sub-column for the non-verbal code.

No adaptation was required concerning the fact of noting the time and cutting sequences during a session. That means that like for an individual session, the sequence changes at the point when the theme of conversation changes or, the latest, after 10 minutes.

Concerning the first additional column, the initials of the therapist(s) speaking were noted for each sequence. With two therapists, as in the present case, there are four ways to record which therapist speaks. In one sequence, it may be only the (1) first or (2) second therapist who speaks; alternatively, (3 and 4) two therapists speak in the same sequence, complementing each other, but therapist 1 may be the "main speaker" and therapist 2 the "second speaker" (option 3), or vice versa (option 4), as a function of time of actual speech per therapist per sequence. The other added column refers to the speech addressee, we noted to whom the therapist(s) speak(s): (1-3) to one or another of the three individual patients, or (4) to the group as a whole.

Normally, one code is used for the verbal aspects and one for the non-verbal aspects to rate a therapist's degree of using the MOTR for each patient. In the case of a group with two

therapists, the authors chose to have one code for the two therapists concerning verbal aspects (taking both therapist as “one” person) and have two differentiated codes for both therapists regarding non-verbal aspects of MOTR.

It might be counter-intuitive why we chose a single code for the verbal level for the two therapists for each segment, whereas both therapists were rated separately on the non-verbal level. First, the non-verbal component of MOTR has shown to relate to various aspects of pathology and intervention outcome across studies, which was less the case for the verbal aspects of MOTR (Caspar et al., 2005; Kramer et al., 2011). Second, for the context of group therapy, it seemed particularly promising to code the non-verbal aspects for each therapist for each sequence. However, it did not seem useful to code the strict verbal aspects in such a differentiated way. The only situation which was neglected as a result of this method was one in which both therapists spoke at the same time; this may have merited different verbal codes of MOTR. For this particular case, which was extremely rare in the dataset used, it was agreed that therapist talking at the same time would be coded as a non-verbal aspect of communication.

In order to respect parsimony, only one Plan was selected by patient and by sequence of time. Given that there were three patients and two therapists, a maximum of six codes per sequence and for all patients was possible. This is a restriction with regard to the individual coding of MOTR.

In some sequences, the therapists talked to the group as a whole and only one patient responded, whereas the other two were silent. In order to code such a therapist intervention in reference to an activated Plan in the patient (who remains silent and thus does not give any indicator as to which Plan may be activated), a specific Plan, called a "lead-Plan", was identified a priori for each patient. This concept can also be understood as a "default Plan". This lead-Plan is one that is used when no other Plan can be addressed and when the rater

assesses that the utilisation of this “lead-Plan” is coherent. The lead-Plan was determined on the basis of one session in which all Plans were considered but only one Plan was selected as being the most representative of the patient. In selecting this lead-Plan, the following question was asked: "if we had to keep only one Plan of the full Plan Analysis, which one would it be?". For Anna, the lead-Plan was "be normal"; for Betty "show that you make an effort" and for Gary "avoid showing your feelings". Thus, acceptable lead-Plans related to each were respectively "keep up your image", "show that you have the resources", and "avoid being hurt". By identifying these acceptable lead-Plans, the eventual impact of a therapist’s motive-oriented behaviour on one specific patient, as the session unfolded, was able to be measured, even if the latter remained silent in the first place.

Reliability

Reliability was established for one (out of three; 33% reliability sample) Plan Analysis by two raters, as per the Caspar and colleagues’ (2005) procedure, and was sufficient (60%). Concerning the reliability of the MOTR-group scale, the Caspar and colleagues’ (2005) procedure was used. Acceptable reliability for the MOTR-group was found. The agreement on identification of sequences was 80%; the agreement on choice of Plans relevant for a specific sequence (mean across three patients and two therapists) was 65%; the Spearman rank correlations (mean across three patients and two therapists) was 0.78 for verbal, 0.70 for non-verbal, and 0.74 overall.

Level of motive-oriented therapeutic relationship (MOTR)

The verbal and non-verbal average of MOTR was obtained by adding each score and by dividing this sum by the number of codes in a session. The overall verbal score for all sessions for all three patients and two therapists was 0.14 (SD = 0.15) and the general non-verbal score was 0.33 (SD = 0.20). Therapists did not differ in their overall non-verbal score, since they received a score of 0.32 (SD = 0.25) and 0.34 (SD = 0.20) respectively (see Table

2). The verbal mean scores were 0.31 (SD = 0.23) for Anna, 0.10 (SD = 0.15) for Betty and 0.05 (SD = 0.27) for Gary (see table 3). A between-patient *t*-test ($t(13) = .021$; $p = .05$) showed a small, but significant difference between verbal interventions for Anna relative to Gary: on average, Anna received a little more complementary interventions than Gary. It may be interesting to relate this result to the specific Plans in both patients. Regarding the non-verbal level, the therapists had comparable scores relative to each patient.

Discussion

In the present study, a scale for measuring the relationship process in great details was adapted for a group therapy setting. The Motive-Oriented Therapeutic Relationship (MOTR) scale analyses verbal, non- and para-verbal levels of patient-focused idiosyncratic therapist interventions.

Adapting the MOTR scale to group therapy

In order to take into account the complexity of a group setting, the main changes to the MOTR scale are actually very simple: we added two additional columns on the coding sheet. In the case of several therapists, it is meaningful to (a) specify which therapist is speaking and (b) to whom the therapist is addressing his/her message (i.e. the group or a particular patient). Our adaptation proposes that verbal aspects of the interventions made by more than one therapist form a single code, whereas it remains highly meaningful to measure moment-by-moment differences between the two therapists for the non-verbal aspect of the interventions, delineated therefore, in two separate codes. The concept of lead-Plan is created and integrated into the coding. Finally, we demonstrated that the reliabilities for all coding steps are satisfying.

Concerning the adaptation of the actual coding, it seems meaningful to add a column to specify which therapist is speaking and at which times. This may also help in performing more advanced analyses on speech turns and duration of speech per therapist (Tikkanen &

Leiman, 2014). Although this was not the objective of the present research, it would nonetheless be interesting to see whether this variable would have an impact on the therapeutic process: is there a measurable difference between sessions in which therapists are involved unequally and those in which the therapists are involved similarly in terms of frequency of verbal expression?

It was noted, as part of our results, that some patients do not speak during a specific sequence, which led to the introduction of the notion of a lead (or default) Plan for each patient, for coding integrity. Even though only one patient was addressed by a particular therapist intervention, and the other patients remained silent, it was necessary to have a patient Plan to consider, to which the therapist was actually addressing his/her intervention. This was based on the assumption that each intervention in a group has an impact on all patients, which may differ according to their individual Plan structure.

Consider, for example, session 14 at minute 19, when one of the patients speaks about a friend who is losing her brother to cancer. One of the therapists responds, "We are all deeply touched by what you are saying". This quite simple disclosure of affection may have influenced each patient in a different way. One may feel sad, but understood by the therapist's intervention; one may feel empathy for the other patient, and also for the therapist as he/she discloses affect; one may also be helped towards becoming potentially aware of all of his/her emotions. This therapist intervention could also encourage other patients – the "listeners" – to open up more about other individual difficulties, by the creation of an emotionally validating and welcoming group atmosphere. This example shows that even if the patient is silent in such a group process, each therapist intervention needs to be rated for each "listening" patient, as well.

The adaptation of this research tool opens the field of possible components to examine in a group setting. It allows one to systematize the observation of certain elements, such as the

frequency of therapists' – patient-focused – interventions compared with given sequences, as well as to note which patient the therapist addresses. It also allows one to observe the therapeutic relationship in a new way, radically taking into account the idiosyncrasy of the therapeutic dialogue (Stiles, Honos-Webb, & Surko, 1998), as applied to group processes.

Responsiveness in DBT skills training

On a descriptive level, when applying this coding scheme to DBT skills training group, the levels of MOTR (both verbal and non-verbal) were around 0, with a trend towards overall positive MOTR. This means that, on average, DBT group therapy does not seem to rely much on this particular process variable, despite good outcome. This is consistent with findings in another study (Kramer, Kolly et al., 2014) where the authors found similar levels of MOTR in a comparison group which included therapists who were not intended to use MOTR, but who applied an effective psychiatric treatment.

This result could be interpreted as DBT potentially presenting with low levels of MOTR as a feature of responsive therapy cooperation and relationship: we argue that average session-levels of MOTR close to zero hide a great variability in the use of MOTR, in the present case varying between -2 and +2. An increased level of MOTR at only one point in therapy might be sufficient for a particular patient, as it is understood that such interventions have a particularly precious subjective value for that individual patient. The average level of MOTR might therefore not indicate the actual quality of the therapist responsiveness to the patient or to the patient group, but the peak may. Individual non-complementary interventions, in the form of specific therapist confrontations, for example, might also be beneficial if conducted within a complementary relationship context. The latter explanation particularly applies to our context, as the relationship theory of the DBT intervention proposes to balance out challenging with acceptance interventions in the relationship between the therapist(s) and each participant enrolled in the skills group training (Linehan, 1993a). In

order to test these assumptions on a micro-basis, the in-session fluctuation (i.e., the therapist's adaptation to the patient's Plans) of the responsive intervention – or its in-session peak (i.e.., here +2) – may be linked with session outcome in DBT skills.

Alternatively, a stimulating integrative follow-up question may be the added value of the use by the therapists of MOTR in DBT skills groups. Would the process and outcome of the skills training be enhanced when the therapists is trained in formulating a case according to the Plan Analysis and when he applies the motive-oriented therapeutic relationship? Independent of the answer to this important question, we would say that there might always be difficult interactional situations facing patients with BPD in the DBT group therapy, therefore, a fine-grained patient-focused understanding of the underlying interpersonal stakes (i.e., the motives) might be beneficial. As such, we would hypothesize that these assumed beneficial effects of MOTR would not necessarily be related, nor limited, to DBT skills group, but to any group therapy facing patients with BPD, and any patient population where the interpersonal problems might impede on the therapeutic cooperation in the here and now of the group therapy.

Limitations and perspectives

The present research is important, as it widens the scope of study and ultimately allows for a greater understanding of the therapeutic process in therapy groups. However, it has a number of limitations, amongst others, the small number of patients and therapists included, the fact that the results are based on only one type of group, which cannot be generalised to all types of groups. Also, we only analysed 10 sessions. However, the methodological adaptation described here may be applied to all group contexts. It would be interesting to use this adapted process measure to less structured group therapy formats, in order to examine therapist responsiveness in these therapies.

This type of therapeutic relationship can conceptualise the patient's problems without relying on a therapeutic approach, which allows for an agreement between therapist approaches, and therefore remains close to the patient's behaviour. Now that this study has demonstrated that the MOTR scale is indeed applicable in a group setting, it seems propitious to test the application of this type of relationship with research in which therapists apply this kind of individualised case formulation and intervention facing several patients at the same time in a group setting. This is a particularly promising area of development of integrative clinical models, as we know now that the adding of the motive-oriented therapeutic relationship, based on the Plan Analysis, in individual therapy has small to medium short-term effects (Kramer et al., 2014) on symptom change, over a generalized psychiatric treatment, for patients with borderline personality disorder.

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Table 1

Descriptives of the patients

	Age	Evolution								
		OQ-45			BSL-23			WAI		
		Intake	Middle	End	Intake	Middle	End	Intake	Middle	End
Anna	41	95	96	101	2.05	2.10	2.26	61	31	63
Betty	29	87	70	15	0.91	0.57	0.09	63	70	80
Gary	48	122	120	30	3.57	3.78	0.43	41	22	74

Table 2

Mean, standard deviation and range of verbal and non-verbal MOTR (Motive-oriented therapeutic relationship)-group

	Mean	SD	Range	
			Min	Max
Verbal	0.14	0.15	-0.06	0.48
Non-verbal	0.33	0.20	0.00	0.71
Non-verbal Therapist1	0.32	0.25	0.00	0.79
Non-verbal Therapist2	0.34	0.20	0.00	0.62

Table 3

Mean and standard deviation per session and patient for the verbal aspect of MOTR (Motive-oriented therapeutic relationship)-group

Session	Anna		Betty		Gary		Mean	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Session 4	0.60	0.84	-0.21	0.80	0.00	0.74	0.08	0.84
Session 5	0.23	0.44	0.21	0.80	-0.17	0.58	0.10	0.64
Session 11	0.22	0.67	0.11	0.33	-0.22	0.67	0.04	0.59
Session 12	0.33	0.82	0.20	0.42	-0.13	0.83	0.08	0.70
Session 13	0.00	0.45	0.00	1.00	-0.10	0.88	-0.06	0.80
Session 14	0.55	0.69	0.00	0.89	0.00	0.47	0.19	0.74
Session 15	0.30	0.48	0.00	0.00	0.30	0.48	0.21	0.41
Session 16	-0.11	0.78	0.22	0.83	0.00	0.53	0.04	0.72
Session 17	0.44	0.53	0.18	0.40	0.09	0.54	0.23	0.50
Session 18	0.50	0.53	0.27	0.47	0.70	0.48	0.48	0.51
Total	0.31	0.23	0.10	0.15	0.05	0.27	0.14	0.15

Table 4

MOTR rating scale: individual versus group coding sheet (according to Caspar et al., 2005)

Individual MOTR rating scale					
Time during the session	Plans activated in the patient	Central Plans	Brief description of the situation (verbal and non-verbal behaviour of the patient and the therapist	MOTR scale (7 point scale) Anti-complementary: -3, -2, -1 0 Complementary: +1, +2, +3 Verbal Non-verbal	

Group MOTR rating scale							
Time during the session	**Therapist**	**This speaks to** (e.g., group, Anna, Betty, Gary)	Plans activated in the patient	Central Plans	Brief description of the situation	MOTR scale (7 point scale) Anti-complementary: -3, -2, -1 0 Complementary: +1, +2, +3 Verbal Non-verbal	

Note. Adaptations required for MOTR-group highlighted using bold font.

Figure 1

An example of a part of a Plan Analysis