Chapter 11: Therapist Responsiveness in Treatments for Personality Disorders[1]

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Therapist responsiveness may be both understood as an obstacle for psychotherapy researchers and as an opportunity for clinicians. For psychotherapy researchers, therapist responsiveness represents an almost insurmountable obstacle standing in the way of clean and neat research conclusions: The therapist, like any other human being, is affected by emerging contexts, such as specific client behaviors (Stiles et al., 1998; Stiles, 2009). For psychotherapists, therapist responsiveness may be the "glue" that makes their relational and technical interventions work for a particular client: It is doing the right thing at the right time (Kramer & Stiles, 2015; Stiles & Horvath, 2017).

In this chapter, I argue that treatments for clients with personality disorders represent a particularly fruitful context to demonstrate responsiveness effects; to find a context-appropriate definition of therapist responsiveness; to show which interventions work with which client behavior; and, finally, to help clinicians make productive, or appropriate, use of opportunities that arise in the therapy process. In the first section, I discuss personality disorders and explain why these disorders may represent a paradigmatic context to study (appropriate) therapist responsiveness, then move to three different operationalizations of therapist responsiveness. These are (a) generic responsiveness, (b) disorder-specific responsiveness and (c) individualized responsiveness. Each is illustrated and discussed by using a particular study focusing on clients with personality disorders.

In the second section of the chapter, I illustrate therapist responsiveness with a clinical example from early in therapy. I discuss considerations about how to take account of diversity in the study of responsiveness with clients with personality disorders, and I make some

recommendations for training and practice.

Why Is Responsiveness So Important in the Treatment of Clients With Personality Disorders?

Personality disorders may be understood as disturbances of the individual's interpersonal, regulatory and identity functional domains (APA, 2013; Livesley, 2017; Livesley, Dimaggio, & Clarkin, 2016; Zanarini & Frankenburg, 2007). As a consequence of these dysfunctions, clients with personality disorders may present interpersonal dysfunction, which may appear in the here and now of the therapeutic interaction and affect the course of therapy (Kramer, 2019a; Kramer & Levy, 2017; McMain et al., 2015). In session, clients with personality disorders (PDs) may adopt an external focus; this may mean that they present a particular aspect of themselves and neglect the presentation of certain others (i.e., more central and fragile processes and contents), in order to evoke a particular reaction, or feeling, in the interaction partner. For example, a client may present as particularly weak in order for the other to feel guilty if he or she does not take care of the client immediately, or in order to increase the likelihood that he or she takes on tasks the client aims to delegate (see Pos & Greenberg, 2012; Sachse, 2020). A client with PD may ask for extraordinary treatment in order to avoid making a full commitment to psychotherapy. For example, he/she may ask the therapist to be more present, offer longer sessions, or organize extra sessions. Clients with PD may at times use border-crossing behaviors, such as aggressive or sexually connoted behaviors, which may have the function of (a) testing the stability of the therapeutic relationship (Weiss, 1993) and/or (b) deterring attention from the core content of therapeutic work (because it seems too hard for the client to focus on this content; Sachse, 2020). Clients with PD, in particular borderline personality disorder (BPD), may present with self-harming behaviors, or suicidal behaviors, with an instrumental, or interpersonally functional,

component. Some clients may, for example, seek attention from the other, or, by self-harming, seek comfort, or make sure that the other is permanently available.

These psychopathological presentations of clients with PDs may have an impact on the course of therapy, in particular therapist responsiveness, and may represent risks for the collaborative process. As a response to the client adopting an external focus – meaning behaving in ways that are oriented towards producing a specific effect on the other – and present as particularly weak and in need, the therapist may take on client's tasks, which may hinder the client's growth towards responsible action. As a response to the client requiring special treatment (e.g., evening sessions), the therapist may offer sessions beyond regular office hours, which may prove problematic to the necessary limit-setting and ending of the sessions. As a response to client border-crossing behaviors, such as aggressive behaviors, the therapist may react with hostility using a personally dismissive voice or express contempt non-verbally to the client (instead of addressing it verbally), either of which may prove problematic for further collaboration. As a response to the client engaging in self-harming behaviors aiming to gain attention from the therapist and the team, the latter may offer extra time after a session to take care of the client's sense of woundedness, which may prove problematic with the treatment aim of reducing the frequency of his/her self-harming behaviors. With such interactions in mind, certain psychotherapists may even decide not to take on these clients in order to avoid potential problems.

These examples show that a fine line is to be drawn between appropriate and less appropriate therapist responsiveness in the process of facing interpersonally constraining behaviors on the client's part. These examples illustrate how central appropriate therapist responsiveness is for the treatment of clients with PDs, and its understanding in this paradigmatic

context might inform the generic understanding of mechanisms involved in therapist responsiveness in psychotherapy (Kramer, 2019a). I would assume that while responsiveness is certainly ubiquitous in psychotherapy facing all types of clients, psychotherapy for clients with PDs may represent a particular challenge to clinicians because of stronger effects related to responsiveness (as compared to any clients). Clients with PDs may pose an extra responsiveness challenge to clinicians who treat them in psychotherapy; psychotherapy researchers must address this challenge when studying treatments for clients with PDs. The question may be, as formulated by Van Kessel and Lietaer (1998, p. 159) when they ask, in the context of client-centered and interpersonal therapies, "How does the therapist steer clear of following the client's preferred style of interaction in a complementary way?" This question may be interpreted as pointing towards any good form of therapy, and *a fortiori* towards the notion of therapist competence.

The Difference Between Therapist Competence and Therapist Responsiveness

While the concepts of therapist competence and responsiveness overlap – both focus on what the therapist may do in terms of the "right thing at the right time" – these concepts also differ on a number of aspects. As argued by Stiles (2013), therapist competence may be understood as an "evaluative" variable indicating the global quality of the client-therapist interaction (and in particular the therapist contribution to the latter). Therapist responsiveness operates on a different level: It *describes* the therapist interpersonal behavior—moment-by-moment, session-by-session, and over the course of the entire therapy—in response to the client behaviors. As such, responsiveness may be a core principle that contributes to therapist competence and may be understood as one of the primary principles of change in therapy for clients with personality disorders. It may also explain why some treatments with these clients do

not work. While the study of therapist competence may be an attempt to solve and control effects related to responsiveness in psychotherapy research (Kramer & Stiles, 2015), it remains an open empirical question whether specific therapy-approach-related therapist competence captures the more descriptive interaction-based principle of responsiveness.

Three Operationalizations of Therapist Responsiveness in Action

Therapist responsiveness may be examined by focusing on the behaviors used by the therapist when being responsive ("responsive with") and may be examined by focusing on the client and context markers the therapist responds to ("responsive to"). In the following section, I focus mostly on the latter and differentiate between three degrees of granularity of the "responsive to" conceptualization. The therapist can be responsive to any client behavior ("generic" responsiveness), to processes supposedly underlying the disorder ("disorder-specific" responsiveness), and to idiosyncratic behaviors as formulated for an individual client ("individualized" responsiveness).

Generic Responsiveness

> Generic therapist responsiveness describes
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> the degree to which the therapist is attentive to the patient; is acknowledging and attempting to understand the patient's current concerns; is clearly interested in and responding to the patient's communication, both in terms of content and feelings; and is caring, affirming and respectful towards the patient. (Elkin et al., 2014, p. 53)

Generic responsiveness thus encompasses a number of appropriate therapist reactions to client behaviors which are meant to cut across therapy approaches and client contexts (e.g., therapist empathy, attentiveness, positive therapeutic atmosphere, along with the negative therapist behavior, inversely coded). Based on this conceptualization, Elkin et al. (2014) developed an

observer-rated measure (Elkin & Smith, 2007) aiming to capture these generic responsiveness processes. The scale encompasses three levels of assessment: (a) assessment every five minutes, (b) averaged scores across all the five-minute excerpts of a session, and (c) global ratings of a session of appropriate responsiveness. Elkin showed acceptable coefficients of internal and external validity, as well as inter-rater reliability, of the scale in the context of treatment for depression. In particular, the sub-scale positive therapeutic atmosphere (i.e., caring and compassionate, respectful, compatible level of discourse, and appropriate emotional quality and intensity) assessed at the first two sessions of therapy predicted client engagement and (inversely) drop-out in psychotherapy. The global (summary) item of responsiveness was also a strong predictor of engagement and drop-out (but therapist empathy and attentiveness were not). So far, it is unclear whether this generic operationalization of therapist responsiveness applies to treatments for personality disorders.

Disorder-Specific Responsiveness

Disorder-specific appropriate therapist responsiveness captures therapist reactions and interventions thought to focus on the disorder-specific underlying psychological processes. As such, it was argued that epistemic trust and mentalization lack in personality disorders, in particular BPD (Fonagy et al., 2017). To address this problem, specific mentalization-fostering therapist interventions, in the context of mentalization-based therapy (MBT) – an evidence-based treatment for personality disorders (Bateman & Fonagy, 2006, 2009) – may be implemented. They include addressing the client's pretend mode, focusing on interpersonal affects and discussing the therapeutic relationship. As such, they may represent central building blocks of disorder-specific responsiveness facing clients with personality disorders. The scale used to operationalize responsiveness in this context describes therapist competence in the quality of

mentalization-fostering processes (Karterud et al., 2011). Even though this measure was not explicitly developed as a measure of responsiveness, but rather as an assessment of adherence and competence in the context of MBT, it may be used in this particular context. Therapist competence goes beyond the mere adherence to a protocol: It encompasses the timing, quality and appropriateness of a specific intervention. As such, the competence may address some of the problems posed by responsiveness (Kramer & Stiles, 2015). Karterud et al. (2011) showed good validity coefficients for most items of the scale from both an adherence and a competence perspective. Competent delivery of mentalization-fostering interventions predicted a better quality of in-session reflective functioning in clients with BPD (Möller et al., 2016), particularly when therapists focused on increasing the client's curiosity about their own (and others') mental states. So far, this scale, developed in the context of MBT, has not been applied to different therapy contexts with clients presenting with personality disorder, where interpersonal and mentalization deficits may be equally important to consider and to address therapeutically.

Individualized Responsiveness

Individualized therapist responsiveness describes therapist reactions, behaviors and interventions as they ensue from an individualized case formulation that may, or may not, be independent of a specific therapy approach. Case formulation serves the overarching goal of tailoring psychotherapy to the individual client and fostering the therapeutic relationship in a manner that is unique to each individual (Kramer, 2019b). In order to do this, an idiographic model of understanding may be formulated; one method particularly adapted to clients with personality disorders is the Plan^2 Analysis (Caspar, 2007; 2019). Beyond being useful in the clinical context, as a research tool Plan Analysis has been shown to have good inter-rater reliability, and the ensuing motive-oriented therapeutic relationship (MOTR; Grawe, 1992;

Caspar, 2019) may be reliably rated in the therapy session. MOTR encompasses therapist behaviors and interventions that foster direct therapeutic work with the behavior-underlying acceptable Plans and motives, rather than therapists responding to the presenting behaviors and experiences per se. It is assumed that when the therapist focuses on the behavior-underlying motives, and holds back from responding to certain more problematic Plans and behaviors, the motivational basis for the latter is taken away, and, thus, the intensity and frequency of these behaviors should lessen and the collaboration should increase (Caspar, 2019; Grawe, 1992).

Clinical experience with this formulation method, as well as research data, tend to confirm these assumptions. In a study of interpersonal therapy for depression, the verbal and non-verbal components of therapist MOTR were reliably differentiated and rated with regard to the individual client's activated Plans (Caspar et al., 2005). It was found that the non-verbal component of MOTR (i.e., the *manner* in which the therapist focused on the individual client's motives) was related to symptom change, but the verbal component of MOTR (i.e., the actual content the therapist expresses to focus on the individual client's motives) was not (for a clinical example, see Kramer, Berthoud, Keller, & Caspar, 2014). A second study confirmed this link between non-verbal MOTR (assessed at the first session of treatment) and outcome in a small sample of brief psychodynamic psychotherapy for personality disorders, while the verbal component of therapist MOTR did not relate with outcome in this study (Kramer et al., 2011). So far, it is unclear whether these effects hold in larger samples with clients presenting with BPD.

Impact of Therapist Responsiveness on the Therapeutic Alliance and Outcomes in BPD

In this section, I discuss three studies carried out with the three operationalizations of therapist responsiveness. Because of lack of space, methodological aspects are not discussed in detail and only some of the results are presented. The focus is on the links between therapist

responsiveness (generic, disorder-specific and individualized) and (a) the session-by-session progression of the therapeutic alliance and (b) symptom change at the end of brief treatment for borderline personality disorder. All three studies draw on a larger dataset testing the effects of the motive-oriented therapeutic relationship in the first four months of psychiatric treatment for borderline personality disorder (for the treatment, see Charbon et al., 2019; Gunderson & Links, 2014). A controlled outcome study (Kramer, Kolly, et al., 2014) showed significant pre-post changes for this psychiatric treatment for $N = 85$ clients with BPD, with slight advantages favoring clients who received the individualized (motive-oriented therapeutic relationship) treatment, as compared to the standard (general psychiatric) treatment.

In this section, I present re-analyses of specific sub-samples. Responsiveness was measured using observer-rated measures at the first session (for generic and disorder-specific responsiveness) and at a random session during the therapy process (for individualized responsiveness, with the case formulation based on the first session). The therapeutic alliance was measured after each session for the client and the therapist using the self-reported Working Alliance Inventory-12 (WAI; Horvath & Greenberg, 1989), and outcome was measured after the first and tenth session of therapy (at the last session of the 4-month long intervention) using client self-reported OQ-45.2 (Lambert et al., 2004).

Empirical Demonstrations

Generic Responsiveness

Generic responsiveness, as defined by Elkin et al. (2014), was examined with regard to its links with the progression of the therapeutic alliance (client and therapist perspectives) and outcome (symptom change after a brief psychiatric treatment). The global (summary) item of generic responsiveness was used. Results, presented in Table 11.1, suggest that while there was

no link between generic responsiveness and outcomes (Fiscalini, 2019), a differentiated picture was drawn for the therapeutic alliance. The session-by-session progression of the therapeutic alliance rated by the therapist was affected by the level of the global measure of generic responsiveness at session 1, whereas the session-by-session progression of the therapeutic alliance rated by the clients remained unaffected by therapist responsiveness (Culina, 2019). Precisely, generic responsiveness in the first session was linked with increasingly stronger therapist rated alliances.

[INSERT TABLE 11.]

Thus, the global quality of the interaction – defined as appropriate responsiveness – from the very first session of psychotherapy – affects the therapist's, but not the client's, perceptions of the alliance over time. The therapeutic alliance may be understood as a global indicator of "good" or "good enough" collaboration and bonding between the therapist and client. It is possible that the therapist may not only rate the alliance as a function of the momentary assessment, but also in terms of the underlying theory, and his/her clinical experience (Horvath, 2000). A therapist doing "the right thing at the right time" very early in treatment facing clients with personality disorders may be able to, based on theory and his/her experience, assess the collaborative process as a generic, emergent property of the therapy. We may speculate that the therapist's assessment and case formulation when facing clients with personality disorders, may influence this process.

Disorder-Specific Responsiveness

Disorder-specific therapist responsiveness as defined by Karterud et al. (2011) as competent delivery of mentalization-fostering interventions was examined with regards to its links with the progression of the therapeutic alliance (client and therapist perspectives) and

outcome (symptom change after a brief psychiatric treatment). The summary score of MBT competence was used. Results, presented in Table 11.1, suggest that there was no link between MBT competence and alliance progression or the outcome (Berthelin, 2018; Lepdor, 2018).

We may conclude that disorder-specific responsiveness, in the form of a competent delivery of evidence-based treatment in the very beginning of therapy for BPD may be relevant for a particular therapy context (Möller et al., 2017), but it remains unclear whether it is essential for other therapy contexts, even for the same psychological disorders. This may put into question a disorder-specific approach to therapist responsiveness. While several treatments for BPD, including MBT, have been developed based on defined as "specific" theorization of BPD-underlying processes, they are increasingly being used for a broader range of disorders because the processes seem to fit to broader client populations. Similarly, our results do not confirm the relevance of a BPD-specific conception of responsiveness. We also have to admit that it remains unclear whether therapist responsiveness can really be operationalized as therapist competence, both in terms of mentalization and in general. Such global evaluation of competency in psychotherapy may obstruct a more descriptive approach to the interaction process. This methodological problem may have played a role in our results (for a fuller discussion of this problem, see Stiles, 2013, and Chapter 1 of this volume).

Individualized Responsiveness

Individualized responsiveness as defined by Caspar (2019) was examined with regard to its links with the progression of the therapeutic alliance from both client and therapist perspectives and outcome (symptom change after a brief psychiatric treatment). Verbal and non-verbal components of the individualized motive-oriented therapeutic relationship (MOTR) were differentiated. Results suggest that the verbal component of MOTR was linked with the

progression of the therapeutic alliance rated by the therapist, but not with the client's rating nor with outcome (see Table 11.1). The non-verbal component of MOTR was linked, once again, with the progression in the therapists' ratings of the alliance (but not the clients'), and the more the therapist was non-verbally responsive to the client with BPD, the better the outcome at the end of the brief treatment.

We may conclude that the individualized motive-oriented therapeutic relationship, in particular its non-verbal component, has both an impact on the quality of the collaborative process and symptom change in treatments for BPD. As such, it confirms earlier work of the centrality of the non-verbal aspects of responsiveness when working with clients with major depression and PDs (Caspar et al., 2005; Kramer et al., 2011). The individualization of the therapeutic relationship in the context of personality disorders was discussed as having the potential to "wash out" otherwise strong predictors of outcome (Kramer & Stiles, 2015). This means that we assume that in standard (less individualized) treatments, intake predictors are linked with outcome measured at the end of treatment, while these effects will be weakened – be "washed out" – through the responsive component. In a series of studies, our group has empirically demonstrated this effect of responsiveness for four different predictors of symptom reduction in the context of treatment for BPD: (a) symptom level at intake (Kramer et al., 2017), (b) in-session frequency of cognitive biases (Keller et al., 2018), (c) in-session interpersonal agreeableness (Zufferey et al., 2019), and (d) in-session social interaction patterns (Signer et al., 2019).

One cautionary note is that the direct comparison between the three different operationalizations of therapist responsiveness may be criticized, as the data used for all three empirical demonstrations were drawn from a study where the effects of MOTR in brief treatment

for BPD was tested. Therefore, it is not possible to rule out that the design may have introduced a bias favoring the individualized operationalization of responsiveness. Initially, the study was not designed to assess generic nor disorder-specific responsiveness.

Clinical Illustration of Individualized Therapist Responsiveness at the Beginning of BPD Treatment

Sandra, 29 years old, consults a psychotherapist for problems related with impulsivity, suicidal thoughts and impulses, loneliness, and lack of perspective. Sandra's clinical presentation is consistent with the diagnosis of Borderline Personality Disorder (BPD), as evidenced by the SCID semi-structured interview. The client mentions that she has had several previous intimate relationships that all ended in stormy ways. Currently, Sandra does not have a partner, as she is still strongly affected by the last relationship that her boyfriend ended a year before; at the beginning of treatment, Sandra does not have a job. The client has just been released from a two-week inpatient stay in a psychiatric hospital, where the diagnosis of bipolar disorder I was discussed with her, without certainty. Despite the latter, Sandra seems to accept this diagnosis, but also felt somewhat unhappy with it, as she shares with her current therapist. The current therapist invests several of the initial sessions to assess in detail what the actual problems are. In this context, the correct diagnosis of BPD is discussed; the affective instability observed in the psychiatric hospital was attributable to her affective reactions to the interpersonal triggers (i.e., of rejection) in her intimate and professional life.

The individualized conceptualization to guide therapist's responsiveness holds that an idiographic formulation must be made before the therapist can select a specific verbal and non-verbal set of motive-oriented interventions (Caspar, 2019). In the present case, the therapist used Plan Analysis to formulate the case of Sandra. The principles of how to develop a case

formulation are explained elsewhere (Caspar, 2019). I will focus on the relationship implications of the Plan analytic formulation, as they played out early in this treatment (session 4). Figure 11.1 proposes a part of the Plan Analysis for Sandra, which was elaborated by the therapist based on the information collected after the first session. Plan Analysis depicts the client's individual experiences and behaviors (which may be found at the bottom of the graphical representation in Figure 11.1 (e.g., "explains her distress with 'bipolar disorder'"). The therapist must then develop hypotheses for possible underlying Plans and motives, explaining these observed behaviors and experiences. For example, the behavior "explains her distress with 'bipolar disorder' may serve the lower-level Plan of "explain your experience" (as shown with the direct instrumental linkage), which again may be underpinned by a higher-level, more general, purpose or Plan ("Try to make sense"). The latter may be explained by the very general motives of "maintain control", "maintain integrity" and "assert yourself" (by convention, all Plans are written as imperative towards the Self). In addition, the formulation shows that Sandra expresses that she "could kill herself", which may serve in this specific case the purpose (or motive, or Plan) to "threaten the therapist". The goal of this Plan may ultimately be to help her control the therapeutic relationship – avoid being left alone – and maintain control in her life in general. By explaining her distress with a biological (and thus ego-external) explanation that she suffers from "bipolar disorder" may serve to explain her disruptive experience (e.g., the Plan, not in the Figure, "symbolize what is happening") to her and help her to make sense of it which serve the purpose, as explained above, to assert herself, maintain her integrity and maintain control.

A therapist using the motive-oriented therapeutic relationship may retain all items in bold in Figure 11.1 to develop a complementary intervention to the client's Plans. This means that this therapist may express compassion for the client trying to make sense out of her hitherto

inexplicable experience, or her efforts to try to find a good explanation. In contrast, the therapist should *not* act in complementary ways to the sub-Plan "show that you are a particular patient", as this may increase the likelihood that this Plan will be used more often to serve the upper Plan "make sure the other is alarmed", which may prove problematic for the collaborative process.

[INSERT FIGURE 11.1 HERE]

In the following excerpt from session 4, the therapist was implementing a complementary response to the Plans "Explain your experience" and "Try to make sense". Such an intervention was chosen to lessen the intensity and frequency of a behavior like sticking to her initial explanation in the context of a "bipolar disorder". It is hypothesized that this latter client behavior, if not addressed using a motive-oriented therapeutic relationship intervention, may become problematic preventing the client from full engagement in psychotherapy focusing on her core problems. The therapist's responsiveness to Sandra's underlying motives are presented in bold.

Sandra: «I have a lot of girlfriends. My feeling is that they move much quicker through life than me. I kind of stay where I am…»

T: «Mmhm.»

S.: « I had a boyfriend during six years, now we are separated for one year and I am still struggling with it.»

T: «Mmhm.»

S: «This means that I am unfit to move forward in my life. Is it my character? Or maybe my illness, bipolar disorder… maybe.»

T: «These are a lot of questions, yes, you are asking. «Why is this?» «Where does it come from?»....You really want to know and you really want to solve these

problems.»

S: «Exactly.»

T: «I see you really want to answer some of these questions. You really want to make sense of what you are going through. I want to tell you that you are at the right place here to ask these questions.»

S: «Yes, I really want to make sense. Know who I really am.»

This brief excerpt from session 4 demonstrates that therapist responsiveness to the individual's underlying motives is already possible as part of a discussion of diagnosis and presenting problems. In fact, it might be at this early stage of therapy that client's commitment and engagement in therapy are being formed and the therapist may orient his/her behaviors and intervention proactively towards an individualized responsive approach to treatment.

Later in treatment, Sandra non-verbally dismissed the therapist's effort to help her structure her day and find a new job; she expressed self-contempt over her failure and uttered that she may have been "better off dead". From a case formulation perspective, the therapist understood that in this specific moment the Plan "show that you are a difficult patient", or "make sure the other is alarmed" is activated. In order to intervene effectively using individualized responsiveness, the therapist may here ask him-/herself what the purpose for these activated Plans are: according to Figure 11.1, it may serve the client to control the relationship, and more generally "avoid losing the other" and "maintain control". A complementary therapist behavior, one that is oriented explicitly towards the underlying motives, takes into account these purposeful motives and tries to satisfy them within the therapeutic relationship. In order to do that, the therapist may say: "I can see the struggle you are in now to find meaning in your life (*general empathic stance*), and I want to tell you that you decide the rhythm with which you

move forward in this task (*oriented towards the individual's motive "maintain control"*); whatever happens during therapy, you can count on me and the resources we have here to support you in your search for meaning" (*oriented towards the individual's motives "avoid losing the other" and "try to make sense*").

Individualized responsiveness appears as an integrative, clinically meaningful, and empirically supported, principle of change when interactions become particularly challenging, and specific problems related with personality disorder threaten to affect the psychotherapy process and outcome.

Diversity and Therapist Responsiveness

While on a conceptual level, personality disorders – as potential client features – are responsive to their cultural context (Mulder, 2018), I would argue that the principle of therapist responsiveness cuts across any culture. Rather, the specific client behaviors and therapist behaviors that constitute the nuts and bolts of responsiveness in the treatment of PDs may vary as a function of cultural context. For example, a therapist may want to diagnose a client with dependent personality disorder in a given culture based on the client's unassertive, self-effacing and particularly shy presentation. A therapist in a different culture may understand such behavior as part of courtesy and politeness viewed as normal interaction and behavior in that specific context (Mulder, 2018).

Client expressiveness may evoke different therapist, and contextual, responses, as a function of the acculturation of both interaction partners. The strength of family ties and social cohesiveness is discussed as important cultural moderators of development of a diagnosis of PD (Paris & Lis, 2012). For example, in India, the mean age of first consultation for clients presenting with any PDs was 29 years, which contrasts with the child and adolescent

psychotherapy offer and early detection programs for personality difficulties other countries may have (Narayanan & Rao, 2018). This was interpreted as a consequence of particularly strong social and family ties which may contain some of the PD features during early adulthood. Such late clinical development of the actual disorder may both be linked with better treatment outcomes (i.e., the family ties may act as a resource for treatment) and poorer treatment outcomes (i.e., the time before treatment begins may contribute to the pervasiveness of the pathological pattern over time which may resist change).

Implications for Practice and Training in Therapy for Personality Disorders

Gunderson (2016) argued that while the specific evidence-based psychotherapies for borderline personality disorder are the gold standard of clinical intervention, training therapists in one, or more, of these psychotherapy models is a lengthy, expensive and cumbersome process. The result is non-optimal service to the general population in terms of BPD treatment. Based on this argument, he developed a good-enough, easily learnable, and easy to disseminate psychiatric treatment, the Good Psychiatric Management (Gunderson & Links, 2014), that condenses the essential "good enough" therapist attitudes and interventions to help solve the core problems of these clients. Similar considerations may be made concerning psychotherapies for other PDs (Livesley et al., 2016).

Therapist responsiveness, conceptualized as a central component explicating change in psychotherapy from the very first contact on when working with clients with PDs, should be taken into account by therapists in their training. Clinicians from different therapy approaches may learn how to identify interpersonally constraining client behaviors and how to formulate a case according to their intervention theory (Kramer, 2019b). As shown in this chapter, Plan Analysis is one formulation method among others fostering responsive interventions. Before

learning effective, and somewhat complex, psychotherapy techniques, training in case formulation and responsiveness, integrated into a series of good-enough interventions, may be a cost-effective strategy and help increase the effectiveness of the interventions delivered by trainees.

Conclusions

Therapist responsiveness represents an opportunity in the clinical work with personality disorders but also creates problems in research designs in the same. A differentiation of conceptualizations of appropriate responsiveness as a function of the granularity of the client behavior the therapist responds to may help. A generic conceptualization may be complemented by a disorder-specific, and an individualized approach to appropriate therapist responsiveness. While they all show potential for increasing the effectiveness of therapy and offer rigorous assessments, the non-verbal aspect of an individualized appropriate therapist responsiveness, based on case formulations, stands out as a particularly promising intervention tool. Training psychotherapists to respond in warm, welcoming, prizing and committed ways may be helpful for some cases with PD, while other cases with PD may only develop the required deep trust in the therapeutic relationship when the therapist proposes an individually tailored psychotherapy relationship, by responding non-verbally with what may be “the right thing at the right time”.

Future work in the field of responsiveness in the treatment of personality disorders includes a more systematic study of responsiveness in other PD categories than BPD, as well as more controlled trials and case studies. In addition, it may be necessary to study less appropriate therapist responsiveness (Stiles et al., 1998), such as therapist reassurance of the client’s problematic in session behaviors, therapist overt and covert criticism of client behavior and their effects on process and outcome.

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Footnote

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[2] Written with capital P to underline the difference with meaning in common language: "Plans" in Plan Analysis may not necessarily be conscious nor rational.

Table 11.1. Three different operationalizations of responsiveness and their links with the progression of the therapeutic alliance and with outcome in brief treatment for borderline personality disorder

Responsiveness Operationalization	Progression of the Therapeutic Alliance		Outcome
	Client-rated	Therapist-rated	
Generic (n = 59)[1,2]	C = 0.32, p = .40	**C = 0.91, p = .01**	r's between -.22 and .05 (ns)
Disorder-specific (n = 49)[3,4]	F = 0.14, p = .71	F = 0.15, p = .70	r = .00 (ns)
Individualized (n = 56)			
1. Verbal	C = .0.08, p =.82	**C = 1.57, p = .00+**	B = 14.56, p = .11
2. Non-verbal	C = 0.05, p =.88	**C = 0.96, p = 00+**	**B = 20.30, p = .02**

Note. C: Coefficient of Hierarchical Linear Modeling; p: p-value; r = Pearson's correlation coefficient; ns: non-significant; Statistically significant effects in bold; F: F-statistics; B: standardized β coefficient of linear regression analysis.

[1]Culina (2019)

[2]Fiscalini (2019)

[3]Berthelin (2018)

[4]Lepdor (2018)