The first session matters: Therapist responsiveness and the therapeutic alliance in the treatment of borderline personality disorder

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The data that support the findings of this study are available from the corresponding author upon reasonable request.

Abstract:

Objectives: The focus of the present research is to investigate the impact of therapist responsiveness at the very first session of therapy on the evaluation of therapeutic alliance from the therapist's perspective and from patient's perspective in the context of guideline-based treatment for borderline personality disorder.

Design: The study has a correlational and longitudinal design applied to a 10-session therapy in a naturalistic setting.

Methods: A total of 4 trained raters evaluated therapist responsiveness during the first session of therapy. After each therapy session, therapists and patients filled out the short form of the Working Alliance Inventory (Horvath & Greenberg, 1989) measuring working alliance; the sample included 13 therapists and 47 patients. Correlational analysis as well as hierarchical linear modeling exploring the relationship between first session therapist responsiveness and working alliance were performed.

Results: The global evaluation of responsiveness revealed a significant relationship with the temporal evolution of the alliance rated from the therapists' perspective.

Discussion: There is the necessity to further explore therapist appropriate responsiveness which could potentially explain several psychotherapy research results. Moreover, it could help in finding alternatives in order to facilitate patients' early engagement in therapy as well as facilitating the building process of therapeutic alliance. Finally, an effort should be made in order to study more individualized operationalization of responsiveness.

Practitioner points:

- The first session of psychotherapy is a decisive moment for initial patient's engagement

- Therapist responsiveness in the context of BPD is relevant as it is particularly challenging for therapists and as it may be crucial to improve the development of working alliance
- Therapist responsiveness assessed by an external rater could potentially be used to predict the evaluation of working alliance
- More individualized ways of exploring therapist responsiveness should be studied

Keywords:

Therapist Responsiveness; Borderline Personality Disorder; Therapeutic Alliance; First Session; Good Psychiatric Management

THE FIRST SESSION MATTERS: THERAPIST RESPONSIVENESS AND THE THERAPEUTIC ALLIANCE IN THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

Borderline personality disorder (BPD) is the most common personality disorder in clinical settings (Skodol et al., 2002). It is characterized by instability in interpersonal functioning, self-image and affects as well as by a strong impulsivity (American Psychiatric Association [APA], 2013) often leading to self-harming behaviors and suicide attempts (Gunderson & Ridolfi, 2006). The complexity and severity of the disorder often require patients with BPD to undertake long-term treatments and multiple hospitalizations, which cause significant psychological distress for patients and important functional impairment (Cristea et al., 2017). Additionally, psychotherapy with people presenting with BPD can be challenging, especially with respect to establishing and maintaining a good working alliance, which is of primordial importance. In fact, there exists a large body of research showing that working alliance is consistently correlated with therapy success (Bernecker et al., 2014; Flückiger et al., 2018). A recent meta-analysis conducted by Lambert et al. (2018) concluded that the reason why some patients do not benefit from therapy or get worse as a result of therapy is generally to be found in the therapeutic relationship. The complication with BPD is that one of its core features, interpersonal relationship instability, has a particularly strong impact on the collaborative aspect of therapy. More precisely, the difficulties in the interpersonal sphere make the development of a stable and positive therapeutic alliance extremely challenging for patients presenting with BPD and their therapists (Bender, 2005; Lingiardi et al., 2005). Some authors reported, for specific contexts, a significantly high drop-out rate of BPD patients (Lingiardi et al., 2005; Yeomans et al., 1994). Given the importance of working alliance for therapy outcome as well as the adverse impact of interpersonal instability on the development of a therapeutic relationship in the context of BPD, one needs to address how to create the

favorable conditions to establish and maintain working alliance, in particular for this specific personality disorder (Goldman et al., 2018). Little attention has been given so far to the early influence of therapists' characteristics and their use of specific techniques on the development of therapeutic alliance (Lingiardi et al., 2005; Spinhoven et al., 2007). It appears that therapists, using specific attitudes and interventions, are highly influential in the process of establishing working alliance (Yeomans et al., 1994). Generally speaking, a lot happens in early sessions: numerous variables can be studied early in therapy that can be informative on later trajectories of change (e.g., Constantino et al., 2018; Lutz et al., 2020; Lutz et al., 2009). In the current study, the focus will be on therapist behaviors during the first session of psychotherapy: it is the crucial moment of initial relationship engagement that can lead to the client either deciding not to come back to therapy or to open up and create the foundation of a trusting relationship (Armstrong, 2000; Principe et al., 2006; Sexton et al., 2005). First sessions are particularly important in respect to alliance: during the very first session, therapists may have an especially important role in facilitating patients' early engagement in therapy (Hilsenroth & Cromer, 2007; Horvath, 2001; Horvath & Luborsky, 1993). Successful therapists appear to do this by providing a good balance between technical skills and personal characteristics, such as warmth and empathy (Lavik et al., 2018). For instance, the meta-analysis conducted by Elliott et al. (2018) confirms the importance of empathy as it has been found to be a strong predictor of therapy outcome. They also emphasize that, in order for therapy to be successful, therapists need to adjust to client's needs and understandings. In light of this, a promising way to understand how to improve the establishment of working alliance is to consider early therapist role, more specifically, we will focus on therapist responsiveness.

The concept of responsiveness was first introduced by Stiles et al. (1998), aiming to explain why, often, results of psychotherapy research need to be interpreted with caution. Responsiveness describes the dynamic nature of interactions as well as their uniqueness: the

emerging context influences the way people interact, therefore there is a continuous influence of behaviors and responses adopted, meaning that every interaction is unique (Stiles et al., 1998; Stiles, 2009; Stiles, 2013). Responsiveness represents a quality of one party's behavior towards the other, thus, it is not a dyadic or symmetrical construct. Furthermore, responsiveness is implicitly present in every interactional situation. When talking specifically about the role of therapists in psychotherapy, it is more suitable to refer to it as appropriate responsiveness: therapists do their best to be appropriately responsive in order to obtain the desired outcome (Stiles et al., 1998; Stiles, 2009; Stiles, 2013). As responsiveness is broad in scope, it can refer to actions happening on large time scales, such as how treatment is planned and which interventions are chosen, or on shorter time scales, such as adjustment in facial expressions and voice modulation. In the current study, the definition of therapist responsiveness is the one formulated by Elkin et al., (2014):

> 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. (p.53)

Therapist responsiveness is a crucial ingredient for therapy success as it allows therapists to tailor the intervention. The examples demonstrating how responsiveness allows therapists to individualize therapy are numerous and we believe it is helpful to enumerate at least a few. For instance, therapists react responsively to their clients when expressing warmth and empathy, especially considering that there is no universal set of characteristics that define an empathic therapist (Elliott et al., 2018). It is also useful to think about goal consensus: in order to reach it, therapists need to be responsive and collaborate with their clients (Tyron et al., 2018). As a last example, we can consider how individualizing therapy and being responsive to client's characteristics and needs has an impact on patient's outcome expectations, which in turn

correlate with treatment outcome (Constantino et al., 2018). Despite the obvious importance of appropriate therapist responsiveness, it also acts as an obstacle to the correct interpretation of research results. The necessity to include responsiveness in research designs is straightforward: every intervention is unique because people are responsive, as a result, this variable adds an uncontrolled variability that complicates the interpretation of results (Crits-Christoph et al., 2013; Stiles, 2013). As an example, responsiveness allows us to explain a frequent lack of correlation between a therapeutic ingredient and outcome. Even though a certain variable largely contributes to therapy success, the frequency at which it is employed varies according to patient's needs: because therapists work in a responsive way, there is no pre-established frequency of use of a technique, meaning that often no correlation with the outcome variable will be found (Stiles et al., 1998; Stiles, 2009; Stiles, 2013).

Recently, in an effort to consider responsiveness in psychotherapy research, a number of scales have been developed to measure therapist responsiveness. One of these scales is the quantitative scale used in this study, which was developed by Elkin et al. (2014): the Therapist Responsiveness Scale. The aim of their study was to investigate the relationship between therapist responsiveness in the first two sessions of therapy and patient's early engagement in the therapeutic process in the context of depression treatment. Interestingly, the results showed that appropriate therapist responsiveness at the beginning of therapy predicted patient's early engagement in therapy. We can imagine that the results found by Elkin et al. (2014) on a sample of patients with major depression also apply to patients with personality disorders, in particular BPD; the present paper will investigate this question.

Appropriate responsiveness in the context of BPD is of particular interest due to the specificities of the disorder. Patients with BPD may often adopt a number of behaviors that challenge the therapy process (McMain et al., 2015). For instance, they may manifest self-destructing behaviors, such as self-mutilation, they may display only specific personality traits

while other relevant ones remain hidden or they may require some extra attention such as additional or longer therapy sessions. Sometimes, these behaviors have instrumental goals, such as avoiding sensitive topics that would be too difficult to confront or testing the stability of the therapeutic alliance. These psychopathological manifestations of BPD in the therapeutic process have direct implications on therapist responsiveness: the therapist is required to carefully consider how to be appropriately responsive in order to reach therapeutic goals without falling into the trap of only accommodating patients' immediate requests, such as providing extra attention or being always available (Kramer, 2021). Moreover, the challenges of therapy in the context of BPD can make therapists feel overwhelmed, pessimistic or frustrated, resulting in non-appropriate therapist responsiveness and counterproductive behaviors (McMain et al., 2015).

In view of the theoretical background, the goal of the current study is to explore the impact of therapist responsiveness in the first session of therapy on the evaluation of working alliance in the context of brief therapy for patients with BPD. Responsiveness will be evaluated using the Therapist Responsiveness Scale (Elkin et al., 2014). Out of all the components of the responsiveness scale by Elkin et al., (2014), three were the result of the aggregation of 5-minute items, which we judged not suitable for the goal of the study: the frequency of therapist behaviors measured by these components varies in order to be appropriate to the context, which means that a high or low score does not translate in high or low responsiveness, therefore no correlation can be studied. As a consequence, the global responsiveness item was chosen*:* this item best summarizes the concept and correlation analyses can be performed with it (Elkin et al., 2014). Regarding working alliance, for the purposes of the present research it seems appropriate to include both patient's and therapist's perspective in complement to an observer-rated perspective on therapist responsiveness. Additionally, the temporal evolution of working alliance over the entire course of therapy will be considered. This is because it seems that the

evolution of working alliance is not necessarily linear: it reflects a dynamic process, thus, its evaluation at one particular time, or the global mean of evaluations at different moments, will not summarize it sufficiently well (Ardito & Rabellino, 2011; Kramer et al., 2009; Stiles & Goldsmith, 2010). We hypothesize that the degree of appropriate therapist responsiveness measured using the global responsiveness item during the first therapy session will predict the mean of the 10-session ratings as well as the temporal evolution, over the course of brief therapy, of working alliance as assessed a) by patients and b) by therapists. Lastly, for exploratory purposes, we will examine final 10^{th} session alliance score differences, as assessed a) by patients and b) by therapists, between high and low responsive therapists.

Methods

Participants

The present study draws on archival data from a randomized controlled trial aiming to examine the effectiveness of brief psychiatric treatment augmented with a case formulation methodology, compared with the standard brief psychiatric treatment (Kramer et al., 2014). Participants were outpatients at a French-speaking University Clinic; the study was presented to clients at the beginning of their treatment. Out of the larger sample of 60 completers, a number of 13 patients had to be excluded because working alliance data were missing or were incomplete. Thus, the sample of the current study consists of 47 patients: 30 patients were female (63.8%) and participants' age ranged from 20 to 55 years (M=33, SD=9.28). All participants of the study had a diagnosis of BPD according to the DSM-IV-TR (American Psychiatric Association [APA], 2000). Comorbid disorders were assessed using the Mini International Neuropsychiatric Interview (Lecrubier et al., 1997) and the SCID-II; no significant differences between the current sample and the original one were observed in respect to the distribution and frequencies of comorbidities, thus, information reported in the original study applies to the present one. Participants' information is presented in Table 1.

A total of 13 therapists took part in the study, more specifically: 6 were in psychiatry residency training, 5 were psychologists-psychotherapists and 2 therapists were nurses. A total of 9 therapists had 2 to 3 years of clinical residency while 4 therapists had 4 years or more. More specifically, 3 psychotherapists took on together 25 cases (53% from the study sample): the first was a male psychologist, 38 years old and had 6 years of training in psychotherapy and psychiatry, the second was a female psychologist, 32 years old and 3 years of training in psychotherapy and psychiatry, and the third was a female psychologist, 31 years old and 4 years of training in psychotherapy and psychiatry. All therapists were supervised during the whole study process; supervisors had received training in psychodynamic psychotherapy and specific training for treatment of BPD. In detail, 1 therapist treated 12 patients, 1 therapist treated 8 patients, 1 therapist treated 5 patients, 2 therapists treated 4 patients, 3 therapists treated 3 patients 5 therapists treated 1 patient each.

Raters

All ratings were conducted by four Master's Level students in Clinical Psychology; the four raters had some previous background in research methods as well as some working experience in clinical practice. Prior to the rating phase, the raters were trained on the correct use of the Therapist Responsiveness Scale developed by Elkin et al. (2014). A total of seven meetings of the duration of 1 hr 30 min under the supervision of the person in charge of the project were organized in order to read the manual, assess multiple sessions, discuss the ratings and clarify any possible concern; the sessions assessed during the training were not sessions that were included in the current study. Additionally, consultation from the developer of the scale was obtained when needed. Out of the 47 cases evaluated, 27 sessions (57.45%) were rated by two raters in order to check for inter-rater reliability calculating intraclass correlation coefficients (ICC), while 20 cases (42.55%) were coded by one person only. A one-way random-effect model based on single ratings and consistency was performed. The inter-rater

reliability can be interpreted as good to excellent (Cicchetti, 1994) with an ICC (1,1) score of 0.81(0.74-0.86).

Treatment

Participants were randomly assigned to one of the two experimental conditions: the first treatment condition applied General Psychiatric Management (GPM; Gunderson & Links, 2008), the second condition consisted of implementing Motive Oriented Therapeutic Relationship (MOTR; Caspar, 2007) to GPM in order to further individualize treatment.

General Psychiatric Management was developed by Gunderson and Links (2014) in order to provide a more basic and accessible approach for therapists working with patients suffering from BPD. Among the main principles of GPM, there is a strong focus on psychoeducation and on patient's personal life problems, as well as an effort to be active, supportive and validating, and to provide a genuine relationship (Gunderson et al., 2018). The recommendations and practices adopted in GPM derive from a conceptualization of the disorder that has at its core interpersonal hypersensitivity (Gunderson & Lyons-Ruth, 2008). In the second condition of the study by Kramer et al. (2014), Therapeutic Relationship was based on Plan analysis (Caspar, 2007). Plan analysis allows therapists to gather information about the motives and needs of each patient in order to be able to provide an individualized therapeutic relationship offer (MOTR) that will not reinforce problematic elements. The MOTR was implemented starting from session 2, and the present study focuses on therapist responsiveness during session 1, therefore, it makes sense that we assume a formal equivalence between the two conditions at the first session.

Measures

The Therapist Responsiveness Scale (Elkin et al., 2014)

The Therapist Responsiveness Scale is based on observer rating and it evaluates therapist responsiveness. The scale is subdivided in three parts; each item of the questionnaire

is rated on a Likert-scale ranging from 0 to 4. Part I of the scale assesses 5-minute intervals of the sessions, this part measures the presence of appropriate responsiveness as well as behaviors indicating a lack of appropriate responsiveness. Part II consists of items rated considering the whole session with the aim of obtaining a global impression. Part III of the scale consists of items rated globally, the aim of this last section is to obtain an overall impression from the person rating the session. Particularly relevant is the global responsiveness item included in part III which measures and summarizes the whole concept studied.

The Working Alliance Inventory – Short form (WAI-short form, Horvath & Greenberg, 1989)

The short form of the Working Alliance Inventory is a 12-item self-reported questionnaire which measures the following three domains of working alliance: the agreement between patient and therapist on the goals of therapy, their agreement on the tasks necessary to achieve the therapy goals and the bond between patient and therapist. The items are evaluated on a Likert-scale ranging from 1 (never) to 7 (always); a total score is obtained by summing up single scores. Both patients and therapists filled in the questionnaire at the end of every therapy session.

Procedure

The research was approved by the local ethics board. As shown in the preliminary analysis section, the two groups were equivalent regarding the therapist responsiveness variable, thus, the distinction between treatment conditions is not taken into account. The total length of the treatment offered to patients and included in the study was of 10 sessions; when needed, a longer treatment was offered but sessions beyond the 10^{th} session were not part of the study; for more information on the follow-up period after this initial 10-session treatment, see Kramer et al. (2017). All first sessions were video-taped.

After students' training was completed, ratings of first therapy sessions' video-tapes were carried out individually and independently, that is without discussing the cases.

Statistical analyses

The analysis testing the relationship between therapists' responsiveness at the first session of therapy and the mean of the 10-session ratings of working alliance as assessed by a) patients and b) therapists were planned as follows: first of all, a correlation analysis is conducted, if significant correlations are identified, then regression analysis is performed. Non-parametric correlations are conducted in this study due to non-normal distribution of data. In order to test these hypotheses, IMB SPSS Statistics (Version 24) was used.

To explore whether appropriate therapist responsiveness at the first session of therapy, as assessed by a) patients and b) therapists, is likely to predict the temporal evolution of working alliance, we performed a two-level hierarchical linear model using HLM7 (Bryk & Raudenbush, 1987). Worthy of note is that raw session scores were entered in the analyses, since we were interested in the slope (not in the intercept). The skewed distribution of patients by therapist (some therapists only treated 1 or 2 patients, others many more) contributed to the instability of a three-level HLM (therapists on the third level). Nevertheless, as a control analysis, we re-ran all analyses controlling for therapist effect and results remained consistent with what will be reported below[1]. Additionally, we re-ran analyses controlling for initial severity assessed using the OQ45 at intake; initial severity did not have an impact on the results, which stayed consistent with what will be reported below. The equations used were the following:

Level-1 Model

[1] Therapist effect on therapeutic alliance rated by therapists: Coefficient: 0.221; SE = 0.314; t-ratio: 0.703, df = 44, p = .486
Therapist effect on therapeutic alliance rated by patients: Coefficient: -0.030; SE= 0.519; t-ratio: -0.059; df = 44; p = .953

$$Working\_Alliance_{ij} = \pi 0i + \pi 1i*(SESSION_{ti}) + e_{ti}$$

Level-2 Model

$$\pi 0i = \beta 00 + \beta 01*(Global\_responsiveness_i) + r0i$$

$$\pi 1i = \beta 10 + \beta 11*(Global\_responsiveness_i) + r1i$$

In order to test whether there are significant differences between the 10th session alliance score differences, as assessed a) by patients and b) by therapists, between high and low responsive therapists, we ran two independent t-tests: a) between 10th session working alliance scores rated by patients who were treated by therapists with high responsiveness and patients treated by therapists with low responsiveness, b) between 10th session working alliance scores rated by therapists with high responsiveness and therapists with low responsiveness.

Results

Preliminary analysis

There was no significant difference in the mean score of therapist responsiveness between the GPM condition (*M*=3.48, *SD*=.18) and the MOTR condition (*M*=3.46, *SD*=.14), *t*(45)=.07, *p* >.05 (table 2); the mean of therapist responsiveness for the full sample was of 3.47 (*SD*=.75). Therapist responsiveness was non-normally distributed, with skewness of -1.03 (*SD*=.35) and kurtosis of -.40 (*SD*=.68).

A post-hoc power analysis yielded a minimum N of 53 for an expected medium effect size, an alpha-level of .05, one predictor and power coefficient of .80.

Relationship between therapist responsiveness and patients' ratings of working alliance

No significant association could be identified between the *Global responsiveness item* evaluating first therapy session and the mean of the 10-session scores of working alliance rated by patients, *rs*= .26, *p*=. 08. Thus, the initial hypothesis is not supported by the results.

The two-level hierarchical linear model testing whether first session therapist responsiveness could predict the temporal evolution of patients' evaluation of working alliance over 10-session did not reveal a significant effect, coefficient= 0.32, SE= 0.38, *t* ratio= 0.86, d.f.= 45, *p*= 0.40. Thus, the initial hypothesis is not supported by the results. This result is depicted in figure 1.

Relationship between therapist responsiveness and therapists' ratings of working alliance

No significant association could be identified between the *global responsiveness item* evaluating first therapy session and the mean of the 10-session scores of working alliance rated by therapists, *rs*= .18, *p*=. 23. Thus, the initial hypothesis is not supported by the results.

The two-level hierarchical linear model revealed a significant effect: the *global responsiveness item* predicted the temporal evolution of the working alliance evaluation done by therapists, coefficient= 0.92, SE= 0.38, *t* ratio= 2.43, d.f.= 45, *p*= 0.02. This model explains 2.5% of the total variance. The initial hypothesis is supported. This result is depicted in figure 2.

Final session alliance scores differences between high and low responsiveness therapists

No significant difference could be identified between the patient-rated working alliance score at session 10 for patients treated by therapists with high responsiveness (*M*=69.43, *SD*=10.23) and patients treated by therapists with low responsiveness (*M*=53.20, *SD*=17.37), *t*(10)= -2.05, p=.068. This result is depicted in figure 1.

No significant difference could be identified between the therapist-rated working alliance score at session 10 when comparing therapists with high responsiveness (*M*=61.25, *SD*=6.92) and therapists with low responsiveness (*M*=56, *SD*=6.67), *t*(11)= -1.35, p=.205. This result is depicted in figure 2.

Discussion

The aim of the present study was to investigate whether appropriate therapist responsiveness in the first session of therapy can predict the evaluation of working alliance from therapists' and patients' perspectives. To do so, we considered the mean ratings of working alliance as well as its temporal evolution over the entire course of therapy. Therapist responsiveness was rated using a validated observer-rated scale applied to the very first session of therapy.

Only one of the four relationships tested goes in the expected direction: the statistically significant relationship between the global responsiveness item score during the first session and the temporal evolution of the working alliance over the 10-session therapy rated by therapists. In other words, it was found that the higher the degree of therapist responsiveness in the first session of therapy, the more the therapist evaluation of working alliance increased. First, this result is of particular interest as it supports the necessity of exploring in greater detail the evolution patterns of working alliance over the entire therapy process. Only considering the working alliance mean rating or its evaluation at one point in time risks oversimplifying reality and neglecting some relevant aspects (Ardito & Rabellino, 2011). In fact, this relationship has not been found for the mean rating of working alliance evaluated by therapists and no difference was found when testing whether the final session alliance scores between therapists with low responsiveness and therapists with high responsiveness differed. Secondly, this result supports the importance of taking into account both patient's and therapist's perspectives; in the current study only therapists' evaluation of working alliance could be predicted by therapist responsiveness. It seems that therapists' evaluation of working alliance is mostly based on their theoretical knowledge and professional experience: knowing that their work is appropriate from a theoretical standpoint might influence their evaluation, consequently, their assessment tends to be less subjective than that of patients (Ardito & Rabellino, 2011; Kramer et al., 2008). In the present study, the reasons why responsiveness could not predict patients' evaluation of

working alliance are numerous. Patients' perception of working alliance can be largely influenced by their improvement as a result of therapy; the current study comprised of 10 sessions, a relatively short period of time that might be insufficient to observe salient changes (Kramer et al., 2014). Additionally, for BPD patients, working alliance assessments can be subject to strong variations dictated by temporary psychological states that are often unstable and changeable (Levy et al., 2010). There is definitely a lot to unpack about the impact of therapist responsiveness when studying early sessions and working alliance with BPD patients, which are both of crucial importance. Adding responsiveness to the equation offers numerous possibilities to further nuance study results. Because of its ubiquity, responsiveness can be useful in addressing many research questions. For instance, when focusing on alliance ruptures and resolutions, as done by Boritz et al., (2018), therapist responsiveness informs us about how to appropriately address an alliance rupture while maintaining a secure environment for the patient. Additionally, therapist responsiveness can help us understand what facilitates the development of specific subcomponents of working alliance (Bedics et al., 2015) or, moreover, what is the influence of specific patient's characteristics, such as agreeableness, on therapist responsiveness (Hirsh et al., 2012). Surely, it might be suggested that only a more individualized approach of responsiveness might be satisfactory in order to include all relevant information and fluctuations that appear over the course of therapy sessions: more individualized ways of operationalizing responsiveness should be considered (Kramer, 2021). A viable instrument that could more easily allow therapists to adjust and tailor therapy is providing them with regular progress feedbacks, especially considering that it might be particularly difficult to estimate the negative change in patients. As discussed by Lambert et al. (2018), this method has already proven its efficacy. Another good example illustrating how to tailor intervention is the implementation of case formulation using the Plan Analysis Method, which greatly helps therapists to identify specific rules and motives at the core of the

person's functioning (Caspar, 2022). Moreover, while the present study suggests that therapist responsiveness in the very first contact of psychotherapy may be relevant for further processes, particularly the alliance, we should also be cautious about coming to firm conclusions. We need to take into consideration the effects of third variables, such as the patient's symptom intensity, readiness for change, or receptiveness. This should be disentangled in future studies focusing on therapist responsiveness. Such a more comprehensive model would take into account all responsiveness-relevant in-session events and could explain a larger amount of the variance.

As stated previously in the discussion, three of the four relationships tested were not statistically significant. Nonetheless, it is important to reflect on some methodological and statistical aspects that may play a role in the (non-significant) results observed. The global score of therapist responsiveness is an evaluative variable meant to rate the value – good or bad - of the concept studied, and is not a descriptive variable meant to describe a behavior. This is relevant in the context of the present research as we focus on the relationship between therapist responsiveness and the working alliance, which is an evaluative variable too. As argued by Stiles (1998; 2013), evaluative process variables, such as working alliance, partly incorporate the concept of adequate responsiveness. Thus, it was quite logical to assume that two evaluative variables, especially two that measure somewhat overlapping constructs, would easily correlate. Interestingly, this was not the case in our research. A first partial reason might be that there was not enough variance in the responsiveness variable, as shown in the preliminary analysis section, which made it harder to identify correlations. However, in all probability, the main reason would be that in the context of BPD, the Therapist Responsiveness Scale does not allow us to fully detect all of the salient elements that make up therapist responsiveness. BPD can be subject to rapid fluctuations, therefore, there may be many frequent changes in responsiveness: rating therapist responsiveness frequently, considering

very short time intervals, could allow us to detect with greater accuracy all of the sudden changes taking place.

Lastly, a significant achievement of this study is the transportability of the Therapist Responsiveness Scale. Not only did we use the scale to rate therapy sessions that took place in a French-speaking context, but also, we applied it to a sample of patients with a different disorder: Elkin et al. (2014) validated the scale with a sample of patients suffering from major depressive disorder while our focus was on BPD.

The study presents some limitations that need to be addressed. The major weakness of the present research is the small sample included in the analyses. It is not to be excluded that with a larger sample some significant correlations between therapist responsiveness and working alliance may have been detected. Another potential weakness is generated by the fact that we performed secondary analysis of archival data and all limitations of the original study apply to the present one. These limitations mainly concern videotape characteristics which sometimes made it difficult to rate non-verbal communication: in rare cases, the therapists were not fully visible on camera or the audio quality was poor. Moreover, we considered therapist responsiveness only at the very beginning of therapy, thus neglecting the evolution of therapist responsiveness over the entire course of therapy; considering its evolution over time could allow us to gain more knowledge about the impact and role of this concept. Two more limitations that have already been brought up in the discussion need to be cited in this section. The responsiveness variable showed only little variance, consequently making it more difficult to identify correlations between variables; and the short duration of therapy – 10 sessions – might not be enough to identify the effects investigated in this research. Furthermore, as presented in the methods section, it should be acknowledged that three therapists treated over half the sample, it is possible that this sub-group of therapists might differ from the rest of the group in that they were all psychologists and were more experienced. Finally, even though in

the present paper only the full sample was considered in the analyses, it is necessary to acknowledge that, as presented in table 2, the two sub-groups significantly differed in their initial OQ45 score.

Future research should focus on replicating the study using data constructed specifically for that purpose and the design of the research in order to maximize the methodological quality and remove some potential limitations of the current study. Furthermore, in future explanatory analysis, it would be of particular interest to separately analyze sub-components of working alliance in order to test whether one of the components, likely the bond between therapist and patient, presents a stronger relationship with the therapist responsiveness. In addition, it would be fascinating, as suggested by Elkin et al. (2014), to include a number of patients' characteristics, such as patient's hostile behavior, to study their impact on the effects of therapist's responsiveness; for this purpose, the Therapist Responsiveness Scale already presents several items included for exploratory analyses. Finally, we might suggest that a more in-depth analysis of non-appropriate therapist responsiveness as well as individualized therapist responsiveness could represent interesting future directions.

In conclusion, early sessions represent a crucial moment in psychotherapy, especially for the development of working alliance. Therapists' behaviors and characteristics, such as warmth and empathy, play a central role in patients' engagement in therapy, patients' outcome expectations, working alliance trajectory over the entire course of therapy as well as therapy outcome. The underlying ingredient to clinical practice is appropriate therapist responsiveness, and, in the context of BPD, responsiveness may prove especially challenging and therefore important to be studied. We believe that the reasons to include responsiveness in psychotherapy research designs are solid and the current research constitutes a step forward towards this goal and its pursuit in future studies.

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Table 1

Characteristics of the patients (N = 47)

Variable	N (%)
Female	30 (63.8%)
Marital status	
Never married	17 (36.2%)
Married	16 (34%)
Separated, divorced	14 (29.8%)
Employment	
Unemployed	34 (72.3%)
Protected activity	1 (2.1%)
Part-time	5 (10.6%)
Full-time	7 (14.9%)
Medication	
Yes	32 (68.1%)
	M (SD)
Age, years	33.11 (9.28)
Education, years	11.51 (1.78)
GAF	60.77 (8.52)
BPD symptoms, n	6.57 (1.43)
Current axis I disorder	1.85 (1.06)
Current axis II disorder in addition to BPD	0.64 (0.79)

Note: Values are expressed as numbers (with percentages in parenthesis) or as means (with Standard Deviation values (SD) in parenthesis). Diagnostic information is based on the DSM-IV (APA, 1994).

The Global Assessment of Functioning Scale (GAF, American Psychiatric Association, 2000) rates the global functioning of the person as well as the impact of the symptoms on daily life, the scores range from 1 to 100.

BPD symptoms represent the total number of BPD symptoms presented by the person, symptoms were assessed by the SCID-II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997).

Table 2

Between group effects working alliance, therapist responsiveness and symptoms at intake and discharge (N=47)

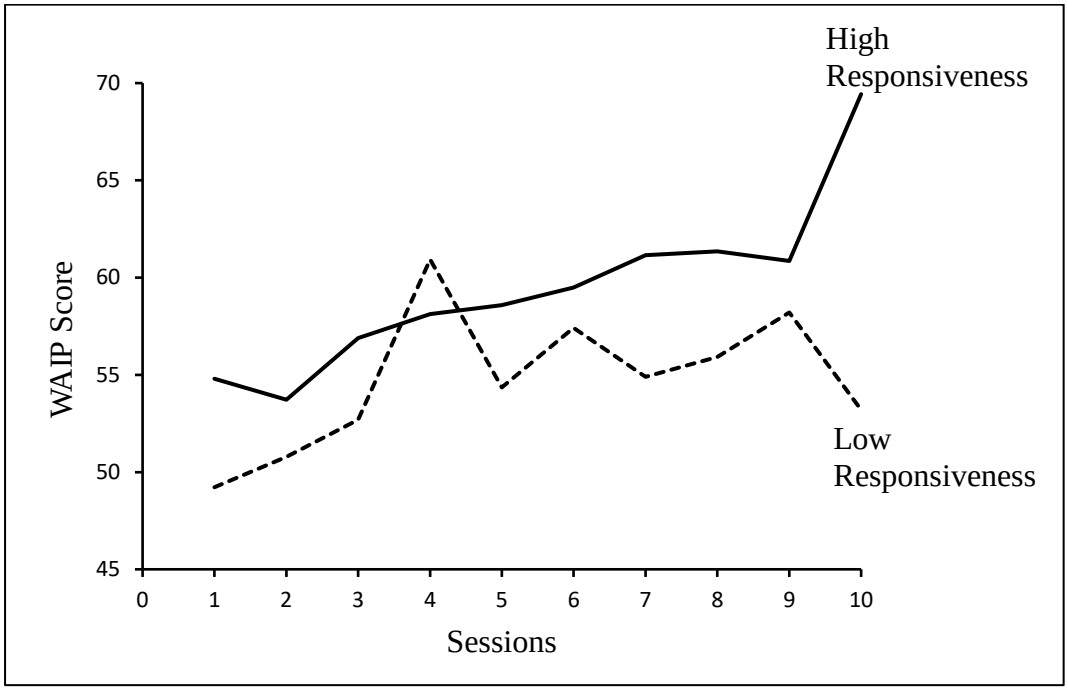
Variable	Condition		*t*-Test	*p*-value
	GPM (*n*=21) *M (SD)*	MOTR : (*n*=26) *M (SD)*	(df =45)	
Mean WAI (Therapist)	51.25 (7.97)	53.46 (8.06)	-.94	.83
Mean WAI (Patient)	57.08 (14.63)	55.96 (11.76)	.29	.77
Mean Therapist Responsiveness	3.48 (0.81)	3.46 (0.71)	.07	.95
OQ45 intake	84.67 (31.8)	101.35 (19.96)	-2.09	.044
OQ45 discharge	79.81 (32.37)	79.96 (22.08)	-.02	.99

Variable	Full sample (N=47)	
	Session 1 *M (SD)*	Session 10 *M (SD)*
WAI (Therapist)	46.31 (10.86)	59.23 (7.06)
WAI (Patient)	52.61 (15.37)	62.67 (15.38)
OQ45	93.89 (26.96)	79.89 (26.84)

Note: WAI (Therapist) = therapist's perspective of therapeutic alliance, WAI (Patient) = patient's perspective of therapeutic alliance

Figure 1

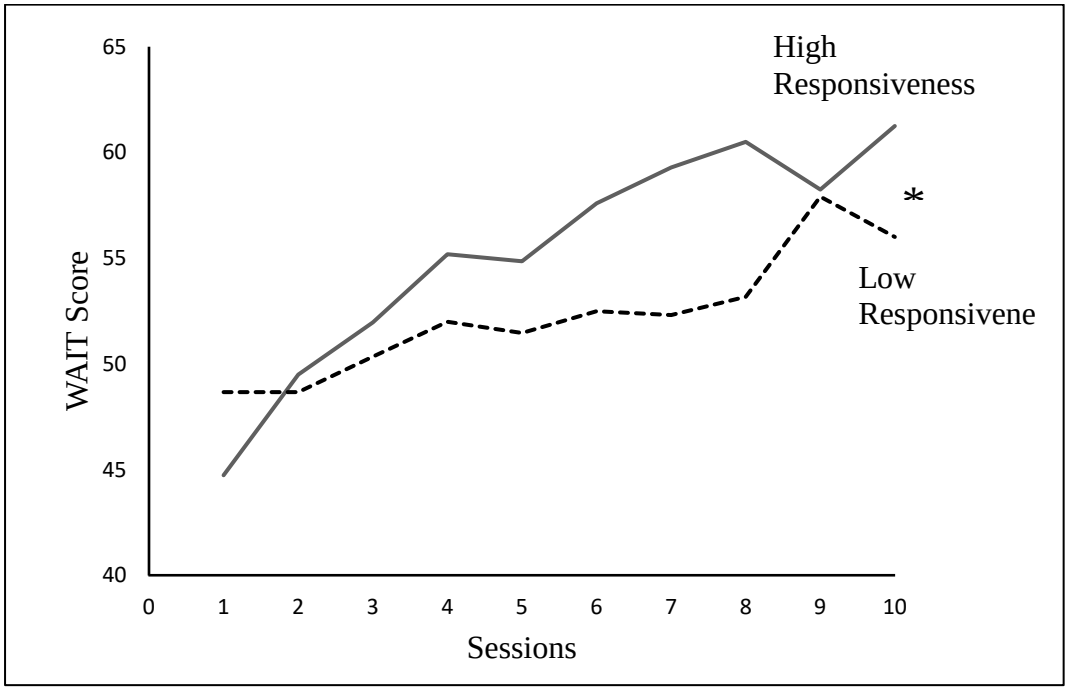
Session-by-session progression of working alliance rated by patients (WAIP) as a function of the level of responsiveness (N=47).



Note: The HLM analysis showed that the first session therapist responsiveness could not predict the temporal evolution of patients' evaluation of working alliance over 10-session, coefficient= 0.32, SE= 0.38, t ratio= 0.86, d.f.= 45, *p*= 0.40.

Figure 2

Session-by-session progression of working alliance rated by therapists (WAIT) as a function of the level of responsiveness (N=47).



Note: The HLM analysis showed that the global responsiveness item predicted the temporal evolution of the working alliance evaluation done by therapists, coefficient= 0.92, SE= 0.38, t ratio= 2.43, d.f.= 45, p= 0.02. * $p < 0.05$.