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Psychotherapy of Dependent Personality Disorder: The Relationship of Patient–Therapist Interactions to Outcome

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Objective: So far, only a few studies have focused on psychotherapy for Dependent Personality Disorder (DPD). DPD is marked by a repetitive pattern of efforts aiming at maintaining close relationships, which may present as a lack of assertiveness and as a difficulty in making routine decisions. The present study aims at exploring processes of change taking place during the working phase of a clarification-oriented psychotherapy (COP) by focusing on the in-session patient–therapist interaction, as it changes during treatment and their links with treatment outcome. *Methods:* $N = 74$ patients with DPD were recruited in a naturalistic setting; they underwent long-term COP. Sessions 15, 20 and 25 were video- or audio-recorded and analyzed using the Process-Content-Relationship Scale, an observer-rated instrument that measures the quality of the interaction processes from patient's and therapist's perspectives. Therapy outcomes were assessed with the Personality Inventory – Dependency Subscale, Beck Depression Inventory, Inventory of Interpersonal Problems and Self-efficacy Scale at intake and discharge of therapy. Three-level Hierarchical Linear Modeling was applied to test the hypotheses. *Results*: Improvement in interaction processes was observed in all patient's and therapist's variables over the sessions

Giorgio E. Maccaferri, MD, is Medical Senior Lecturer and psychiatrist and psychotherapist in the Department of Psychiatry at the University of Lausanne, Switzerland. He is Head of Psychiatry Consultation-Liaison and Emergency-Crisis Units at the Northern Sector of Lausanne University Hospital (CHUV), Switzerland. *Daniela Dunker-Scheuner* is a Cognitive Behavioral Therapy (CBT) psychologist psychotherapist according to Swiss Federal Law. She is Head of CBT Unit Training in the Department of Psychiatry (Institute of Psychotherapy) at Lausanne University Hospital (CHUV), Switzerland. *Yves De Roten* is Senior Researcher and Lecturer at the University of Lausanne and Head of Research at the Center for Psychotherapy Research (Institute of Psychotherapy, Psychiatry Department – CHUV), University of Lausanne, Switzerland. *Jean-Nicolas Despland*, MD, psychiatrist and psychotherapist, is a full professor at the University of Lausanne and Director of the University Institute of Psychotherapy in the Psychiatry Department (CHUV), Switzerland. *Rainer Sachse*, PhD, is a German psychologist and psychotherapist and developer of the Clarification Oriented Psychotherapy (COP). He is Professor of Clinical Psychology and Head of the Bochum Institute for Psychological Psychotherapy, Germany. *Ueli Kramer*, PhD, is Privat Docent, psychotherapy researcher, and clinical psychotherapist, according to Federal Law, in the Department of Psychiatry (University Institute of Psychotherapy and General Psychiatry Service, CHUV), at the University of Lausanne, Switzerland. He holds an adjunct appointment in the Department of Psychology at the University of Windsor, Canada.

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Address correspondence to Giorgio Enrico Maccaferri, Institute of Psychotherapy, Lausanne University Hospital and University of Lausanne, Lausanne, Switzerland. E-mail: Giorgio.Maccaferri@chuv.ch

15, 20, 25. Overall, this increase in quality of interaction process was unrelated with outcome, but decrease in dependency traits was predicted by increase in therapist's quality of relationship offer, understanding of content and directivity over the course of the working phase of COP. *Conclusions*: Studying interaction processes in DPD provides an initial understanding of differential roles of potential mechanisms of change in effective treatment.

Dependent Personality Disorder (DPD) affects between 1% and 5% of the general population (American Psychiatric Association [APA], 1994, 2013; Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007; Loranger, 1996). DPD occurs frequently in psychiatric inpatients (Jackson et al., 1991; Mezzich, Fabrega, & Coffman, 1987; Oldham et al., 1995) and women are more frequently diagnosed with a DPD than men (Bornstein, 1993, 1997; Bornstein, Riggs, Hill, & Calabrese, 1996; Conley, 1980; Jackson et al., 1991; Loranger, 1996). These patients are more subject to depression, eating, somatisation and panic disorders than other personality disorders (Barzega, Maina, Venturello, & Bogetto, 2001; Bienvenu et al., 2009; Coyne & Whiffen, 1995; Overholser, 1996; Rost, Akins, Brown, & Smith, 1992; Tisdale, Pendleton, & Marler, 1990). DPD can be associated with separation anxiety disorder in patients with alcohol and drug abuse (Loas et al., 2002). Chronic physical illnesses (gastrointestinal problems, sleep disturbances) may be observed as co-occurring problems, and could both predispose to, or be the consequence of the disorder (Sachse, Breil, Sachse, & Fasbender, 2013).

It was reported that patients with DPD present with a repetitive pattern of specific need expression, in particular the need to be taken care of, along with a systematic pattern of submissiveness and lack of agency, or a lack of assertiveness and a difficulty in making routine decisions. These patients may seem compliant, but may actually *present* as particularly compliant, while often silently rebelling against other's opinions (then possibly having anger outbursts; Bornstein, 1998). Such a pattern may have the function of self-protection (by doing so, the patient avoids losing the contact with the other, and does not have to put oneself in the other's shoes). Clinically, this pattern may take the form of a typical "dependent" – non-autonomous – relationship, marked by so-called "clingy" behaviors (Millon, 1996, 2011). Core problems may involve the patient's fear of abandonment or of interpersonal separation that leads, for example, to the inability to take routine decisions without advice from others, the tedious belief that the self is unable to function without support, a core fear of disagreeing with others, a feeling of vulnerability and helplessness when let alone, and a desperate seeking of another relationship when one end (APA, 2013; Bornstein, 1995, 1997, 1998; Bornstein et al., 1996; Shilkret & Masling, 1981; Simpson & Gangestad, 1991; Sroufe, Fox, & Pancake, 1983). Specific interpersonal patterns of functioning (Bornstein, 2012; Carcione, Conti, Dimaggio, Nicolò, & Semerari, 2001; Dimaggio et al., 2007) include: poor self-esteem (e.g., "If my boyfriend laughs with his friends, he doesn't need me and I feel inadequate"); poor self-efficacy (e.g., "Without my mother I'm nothing! Alone I'm paralysed"); disorganized state (e.g.,"I want to satisfy everybody but finally I lose my prioritization skills") and poor meta-cognition (on the level of full-blown PD; Carcione et al., 2011; Semerari et al., 2014). When a person with DPD disagrees with a significant other's goal, he/she may rebel against what he/she perceives as an interpersonal constriction of his/her identity. As a result, instead of affirming their identity and boundaries, these patients, harboring a fear of being rejected and separated from the other, may develop guilt, shame, regret, self-pity and fear of punishment.

A seemingly "easy" patient with DPD may actually be quite difficult to treat in psychotherapy, involving specific interaction

manoeuvers very early in the therapy process (Bornstein et al., 1996; Sachse, Breil, & Fasbender, 2013; Sachse, Breil, Sachse, et al., 2013; Sachse & Kramer, 2018; Sachse, Schirm, & Kramer, 2015). An example of an interaction manoeuver in DPD may be a patient who presents himself/herself as being particularly in need, as always available to others and as totally reliable for others. He/she may also display a particularly submissive behavior as a non-conscious interaction manoeuver to express helplessness, in order to receive all-encompassing help from others, including the therapist. A patient with DPD may also urge for receiving "emergency sessions"; this request may provoke in the therapist unhelpful reactions, such as leaning toward taking up too much responsibility or intervening too actively (Emery & Lesher, 1982; Perry, 1996). Interaction manoeuvers encompass the patient's attempt to create a specific image of him-/herself in the interaction partner and the patient's attempt, sometime in subtle ways, to provoke a manoeuver-conform answer from the interaction partner (Sachse, 2020).

Clarification-Oriented Psychotherapy (COP)

COP is an integrative treatment form with its roots in humanistic psychotherapy, designed for patients with personality disorders (for an illustration on DPD, see Sachse & Kramer, 2018; Sachse & Sachse, 2016; Sachse, Sachse, & Fasbender, 2011; Sachse, Breil, & Fasbender, 2013; Sachse, 2020). It focuses on addressing the internal determinants which underly the interaction manoeuvers (i.e., schemes, emotions, cognitions, patterns). COP theory distinguishes between two levels of action regulation in the individual: the level of authentic motives and the level of strategic interaction manoeuvers (Sachse et al., 2011). It is assumed that interaction manoeuvers are particularly harmful to the individual's mental health, and the productivity of the therapeutic work. Interaction manoeuvers generally involve indirect and nontransparent expressions of the motives, which may have long-term consequences (i.e., chronic conflicts in close relationships, social isolation) and may indirectly limit the individual's capacity to access to his/her underlying motives. Therefore, fostering specific insight into the interaction manoeuvers-underlying schemes and motivations becomes of utmost importance.

Consequently, the initial phase in COP (see Table 1) involves the direct work on interaction manoeuvers in the therapeutic relationship, with the aim of establishing a deeply trusting and strong therapeutic relationship. Sachse et al. (2011) propose to use the complementary or motive-oriented therapeutic relationship in this initial phase of therapy (see Caspar, 2007): therapist is advised to be complementary to the level of motives (and not to the level of interaction manoeuvers), thus to proactively structure the therapeutic relationship in a way that satisfies the patient's core relationship motives. For patients with personality disorders, this initial phase of treatment can take a few sessions, and in severe cases, this treatment focus may last 10 to 20 sessions. For example, for a patient for whom the motives of solidarity and dependability are assumed to be central, the therapist may convey relationship messages such as "I stand with you, and in order to help you, I will offer a different perspective on your problems, this is not intended

TABLE 1. Phase Model of Clarification-oriented Psychotherapy for Dependent Personality Disorder

Phase	Designation	Interventions
1	Relationship	Basic therapeutic relationship, motive-oriented therapeutic relationship, resource activation
2	Definition of mission	Confrontation with negative consequences of interactional manoeuvers, addressing avoidance
3	Clarification	Clarification of manoeuver-underlying schemes
4	Processing	Modification of schemes, processing of alienation
5	Transfer	Use of new insight for real-world interaction partners

Note: Adapted from Sachse (2020).

to annoy you, but is geared to help you improve", or "I am reliable as therapist, you can count on my help within the boundaries of this relationship". Only then the clarification process – the fostering of self-awareness in the patient on his/her interaction-underlying assumptions, emotions, motives, experiences and cognitions – can start in a productive manner (Sachse et al., 2011). The latter corresponds to the actual working phase of therapy (see Table 1). Here the experiential access to the content is fostered: it is critical here that the worked-on contents are central and the patient is minimally avoiding these central contents. Therapists are advised to convey elements of a precise understanding of the patient situation, to implement process-directivity (Greenberg, Ford, Alden, & Johnson, 1993) consisting of alternating between gentle guiding and following of the patient's process toward the assumed core content. In order to do process-directivity effectively, the therapist develops at the outset of therapy a detailed case formulation on the individual patient's underlying core contents to change, along with the problematic interaction manoeuvers and the core motives (Sachse, 2019). Later in therapy, the specific problematic contents are reprocessed, using a version of a Gestalt-type two-chair dialog (phase 4, see Table 1), followed by a transfer into real-world phase (phase 5).

Efficacy and Effectiveness of Treatment for DPD

Studies assessing the effectiveness and efficacy for treatments of DPD are generally lacking, while some studies focus on patients with DSM-IV Cluster C Personality Disorders. We may assume that different types of therapies may produce similar effects for problems related with DPD (e.g., Leichsenring & Leibing, 2003; Svartberg, Stiles, & Seltzer, 2004) but the focus of intervention may differ according to the theoretical orientation. For example, Bartak et al. (2010) conducted a large prospective multicentre study, comparing the effectiveness of a psychotherapeutic treatment in five different settings (outpatient, day-hospital, inpatients long term, inpatient and day hospital short-term psychotherapy). Interestingly, the results showed that all patients on average improved, in particular, those in the short-term inpatient setting. Muran, Safran, Eubanks, and Gorman (2018) assessed a training protocol of cognitive-behavioral therapy (CBT), treated by novice CBT therapists. In particular, the authors investigated the effectiveness of this training protocol to improve therapist's skills to understand and resolve ruptures in the therapeutic alliance. This training protocol focused on the therapeutic alliance was effective as regards the decrease in patient dependency and in therapist control on the one hand, and the increase in the frequency of therapist use of affirmation and expressiveness.

In a naturalistic trial on $N = 15$ patients with DPD undergoing COP, pre-post effect sizes were found to be large (*d's* varying between 1.00 and 2.49 for outcome measures on depression, self-efficacy and dependency traits, Sachse & Sachse, 2016). COP was associated with the reduction of dependent, obsessive and submissive behaviors and improved self-efficacy pre and post-therapy. In a randomized controlled trial, Bamelis, Evers, Spinhoven, and Arntz (2014) compared a treatment called "clarification-oriented psychotherapy" with schema-focused therapy and treatment as usual in a mixed sample of patients with Personality Disorders, including DPD, over 3 years. The results showed that the treatment designated as COP was effective, but less effective than schema-focused therapy. Because treatment integrity was not part of this study, it remains unclear whether this treatment, despite its designation, was delivered according to the state of the art of COP.

Clearly, there is a need for more effectiveness and efficacy studies on DPD, and in particular a need for gaining a deeper understanding of potential mechanisms of change related with psychotherapy of DPD, and COP may be an interesting context to this research question in a systematic way, by focusing on

patient and therapist contributions (Doss, 2004; Kazdin, 2009). A potential mechanism of change in treatments for DPD may involve the quality of the interaction process, as displayed in the therapy session. Patient's self-awareness of his/her interaction manoeuvers, and the underlying architecture of assumptions, schemes, emotions, cognitions and motives – achieved by the clarification process – may contribute to the alleviation of problematic dependency behaviors, as well as clinical distress in DPD. Understanding which core interaction process changes over therapy and is related to symptom change in the end of treatment is precious for rendering treatments for DPD more effective.

Aims of the Study

The present process-outcome study aimed at understanding symptom change and potential mechanisms of change that take place during a clarification-oriented psychotherapy relevant for patients suffering from DPD, by focusing on patient and therapist contributions to the quality of the in-session interaction. In order to address this question, at first, we must demonstrate pre-post changes on DPD-relevant outcomes (i.e., depression, self-efficacy, interpersonal problems and dependency). Patient quality of relationship (i.e., absence of interaction maneuvers), centrality of content and absence of processual avoidance, along with the quality of therapist relationship offer, process-directivity and empathic understanding – forming together the core interventions of modern humanistic psychotherapy – should be studied as change process variables. We formulated the specific hypotheses:

a. the quality of interaction processes (i.e., patient and therapist in-session contributions) increases during working-phase of COP (between session 15 and 25); and
b. these changes in in-session interaction processes are related to therapeutic outcome (i.e., pre-post changes in depression, self-efficacy, interpersonal problems and dependency) in the end of treatment.

METHOD

Participants

A total of *N*= 74 German-speaking patients with DPD were recruited in a naturalistic setting. These patients were self-referred and followed-up at a Consultation Center specialized in the treatment of personality disorders. All patients met criteria on the SCID-II diagnosis of DPD (SCID; First & Gibbon, 2004), although initial formulation of their distress might be linked to another psychological problem. DSM-IV-diagnoses (APA, 1994) were established by trained researcher-clinicians using the Structured Clinical Interview for DSM-IV (SCID; First & Gibbon, 2004) for axes I and II of the DSM-IV. Some patients had one or two additional diagnoses for personality disorders (28 (38%) with histrionic personality disorder, 10 (14%) with narcissistic personality disorder, and 13 (18%) with any other personality disorder, multiple mention possible). In all cases, it was the therapist's clinical decision (approved by the supervisor) that the primary diagnosis was Dependent Personality Disorder. Patients with Borderline Personality Disorder and Antisocial Personality Disorder were excluded. All patients underwent a long-term clarification-oriented psychotherapy lasting between 40 and 100 sessions, one session weekly. The mean age of the sample was 39.90 years (*SD* = 11.11); 64 patients were female (86.5%). Given the naturalistic context, no information on initial patient intake at the Consultation Center during the time of study, nor of drop-out was systematically assessed. All patients provided written informed consent concerning the use of their data for this study and the research protocol was approved by the

institute's internal board and all relevant external instances.

Twenty-nine therapists (psychologists and psychiatrists) treated the patients. The mean age of therapists was 28, with at least 2 years of clinical residency training in psychotherapy.

Treatment

Clarification-oriented psychotherapy (COP) represents an adaptation of patient-centered psychotherapy to the specific problems related to personality disorders, and in particular DPD (Sachse, Breil, & Fasbender, 2013; Sachse, Breil, Sachse, et al., 2013). This treatment involves the step-by-step working through specific interpersonal manoeuvers, such as patient displaying passivity and submissive behavior as a non-conscious strategy to appear helpless and in this manner receive extra help. After the focus on the interpersonal manoeuvers, the core task of the COP therapist is to clarify and render explicit the network of assumptions, emotions and motives underlying a patient's interaction problems. A manual describes the stages and techniques involved in COP for DPD (Sachse, Breil, Sachse, et al., 2013), which was used to train all therapists who were also supervised by the model's developers. Treatments lasted between 40 and 100 weekly sessions, with a mean of 60 sessions.

Instruments

Inventory of Interpersonal Problems

(IIP-64; Horowitz, Alden, & Wiggins, 2000). The IIP-64 is a self-report scale of interpersonal distress. The intensity of each symptom is rated on a five-point Likert-type scale (0–5), ranging from 0 = "Not at all" to 4 = "Extremely". Higher scores indicate more maladaptive relationship behavior. The 64 items are grouped into eight subscales (with eight items each): domineering/controlling, vindictive/self-centered, cold/distant, socially inhibited, nonassertive, overly accommodating, self-sacrificing and intrusive/needy. The average at intake was 4.40 (SD = 1.23).

Self-Efficacy Scale

(SWE-Selbstwirksamkeit; Schwarzer & Jerusalem, 1999). This self-assessment scale rated on a Likert-type scale (1–4), ranging 1 = "Not at all" to 4 = "Exactly true", is designed to assess the strength of an individual's belief in his own ability to carry out certain behavior in order to achieve a specific goal (e.g., "If someone opposes me, I can find ways to get what I want"; "When I am confronted with a problem I can usually find several solutions"; "I'm confident that I could deal efficiently with unexpected event"). Average at intake was 28.49 (SD = 6.67).

Personality Inventory-Dependency Subscale

(PSSI; Kuhl & Kazén, 1997). This self-questionnaire rated on a dichotomous scale (True/False) assesses the different dimensions of personality (14 sub-scales assessing non-pathological personality constructs implemented in the DSM-IV and ICD-10 diagnostic schemes). The subscale for DPD was used in the present study. The items are grouped into eight categories, linked to eight DSM-IV-TR diagnostic criteria for dependent personality disorder. Average at intake was 16.16 (SD = 5.62).

Beck Depression Inventory-II

(BDI-II; Beck, Steer, & Brown, 1996). The German version of the BDI-II was used in the present study; this version has shown satisfactory validation coefficients (Hautzinger, Bailer, & Worall, 1995). The BDI-II is a 21 items self-report questionnaire, rated on a four-point Likert-type scale (0–3) and assessing the intensity and severity of depressive symptoms (clinical cutoff of 10 for mild

depression). Internal consistency for the scale for this sample was .89. Average at intake was 15.86 (SD = 9.39).

Processing-Content-Relationship Scale

(Bearbeitungs-, Inhalts- Beziehungsskalen (BIBS; Sachse et al., 2015) is an observer-rated instrument assessing the quality of the therapeutic interaction according to COP. An observer-rated approach to assess these process variables was selected because of the core assumptions of interaction that is only visible and best assessable by observation, and in order to control for possible shared variance with the self-reports measuring outcome. Each of the 54 items is rated on a Likert-type scale, ranging from 0 to 6. Global ratings are made for both patient's and therapist's perspective using segments lasting 10 min of the middle of the video-/audio-recorded session. Higher scores indicate better interaction quality. From the patient's perspective, three sub scales are defined (process, content, and relationship), from the therapist's perspective, six subscales are defined (relationship, understanding, process-directiveness, therapeutic work with focus on process, on relationship and on content assumptions). Table 2 presents the number of items per sub-scale and examples of items for each. Certain subscales require the definition of the individual's core content (e.g., a conviction like "Relationships are not trust worthy"); for these items, it was required that raters code the central content beforehand on video or audio material on this patient (and achieve acceptable inter-rater reliability on this coding). Excellent psychometric properties were reported for the BIBS, overall and per subscale (Sachse et al., 2015). Inter-rater reliability was established on a regular basis on 30 cases (41%), using three different raters, and yielded an average of .78. Cronbach's alpha for all patient sub scales together average at .70 and Cronbach's alpha for all therapist sub-scales together average at .83.

Procedure

Outcomes were assessed using all four self-report questionnaires (IIP, SWE, PSSI, BDI) at the beginning of treatment and in the end. Sessions 15, 20 and 25 were video- or audio-recorded and analyzed using the Processing-Content-Relationship Scale (BIBS). The sessions were selected a priori in order to reflect the early working phase of COP, thus assuming that for the first session (15), the patient and therapist work on some core contents (rather than focusing on constructing a working alliance as may be the case in the first sessions of COP). Each coding was done based on the rater's assumptions related to the patient's activated core motives, interaction manoeuvers

TABLE 2. Processing-Content-Relationship Scale

Subscales	*N*	Example of item
Patient subscales		
Content	7	The patient adopts an internal perspective.
Avoidance	7	The patient avoids central content by normalizing or generalizing.
Interaction games	3	The patient tries to control the therapist.
Therapist subscales		
Relationship	6	The therapist reacts in a warm way.
Understanding	6	The therapist's verbalizations focus on central content.
Process-directivity	8	The therapist follows a specific and relevant question related to the central content.

Notes: Adapted from Sachse et al. (2015); *N* = number of items.

and assumptions, based on the entire session. Then, the quality of interaction was assessed using 10-min excerpts for each session, between minute 10 and 20. Global ratings per session were established for each of the 54 items of the BIBS. A total of three trained independent (blind) raters were used for BIBS; raters were blind to session number, study hypotheses, each other's rating and outcome data.

Statistical Analyses

Preliminary analyses encompassed the demonstration of pre-post change on outcome indices (IIP, SWE, PSSI-DEP and BDI) using Paired Sample *t*-tests. In order to test hypothesis one on the change on interaction process markers between sessions 15, 20 and 25, we conducted three-level Hierarchical Linear Modeling (HLM; Bryk & Raudenbush, 1987), with sessions on level 1, patients on level 2 and therapists on level 3 (nested design). In order to test hypothesis two, we re-run the 3-level HLM, by adding the outcome (pre-post change) for each of the interaction process variables on level 2.

RESULTS

Preliminary Analyses

Symptoms and problems improved between pre and post-therapy: IIP ($t(1, 69) = 7.52$; $p = .00+$; $d = 0.97$), SWE ($t(1, 72) = 9.34$; $p = .00+$; $d = 0.96$); PSSI-DEP ($t(1, 73) = 8.98$; $p = .00+$; $d = 0.88$); BDI ($t(1, 68) = 9.63$; $p = .00+$; $d = 1.08$). In terms of Reliable Clinical Change Index (Jacobson & Truax, 1991), we observed for BDI: 58/74 (78%) of reliable change (19% unchanged; 3% deteriorated); and for IIP: 19/74 (26%) reliable change (73% unchanged; 1% deteriorated). For methodological reasons, we did not perform the RCI for PSSI-DEP and SWE. Overall, symptomatic changes went into the expected direction and presented large effect sizes.

The quality of process variables may be used as an indicator of the process adherence to the model delivered. Analyses revealed that the averages of all six subscales of the BIBS correspond to the averages found in the initial validation studies of the scale (Sachse et al., 2015); however, the averages found in the present study were notably higher than the ones found in a standard psychodynamic approach for personality disorders (Kramer & Sacse, 2013). Patient content averaged at 13.69 (SD 7.33), avoidance (process) at 6.72 (4.87), functional relationship at 9.51 (4.00) and interaction manoeuvers 5.28 (3.38; the higher the score the better the quality of the interaction). Therapist understanding averaged at 25.99 (7.77) and process-guidance at 26.72 (8.73; the higher the score the better the quality of the interaction). Thus, we can tentatively conclude that the treatment was delivered in an adherent way, consistent with the relevant validation studies.

Change in the Quality of the Interaction Process

During working phase of clarification-oriented psychotherapy, the quality of the patient–therapist interactions focusing on core contents increased; all changes were significant over three time points (sessions 15, 20 and 25) and the highest scores were found at session 25, when compared with sessions 15 and 20 (Fig-Figure 1). Over time, the patients presented with fewer and fewer in-session interactional maneuvers, less in-session avoidance of the central contents, and the contents itself observed in the session were increasingly central and significant. The therapists contributed by an increasingly positive therapeutic relationship offer, a more precise and deeper in-session understanding of the patient and increased frequencies of in-session use of process directivity (see Figure 1, and Table 3).

Links between Interaction Process Changes and Outcome

Linking interaction processes with outcome was tested by three-level Hierarchical

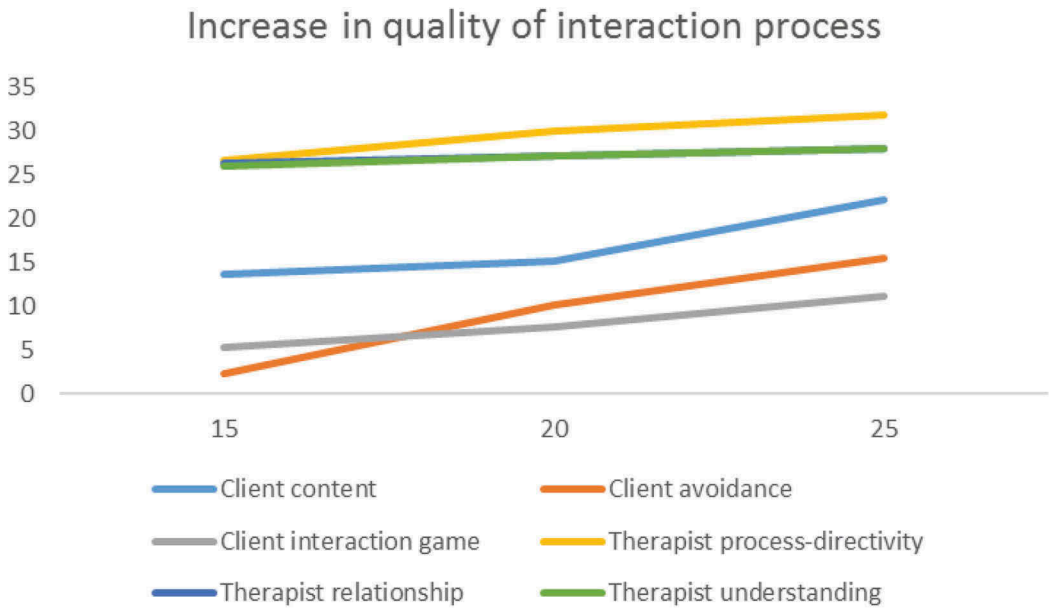

FIGURE 1. Averaged changes in interaction processes between sessions 15, 20, and 25 of clarification-oriented psychotherapy for dependent personality disorder (N = 74). All changes significant over three timepoints (Hierarchical Linear Modeling).

Linear Modeling, taking into account therapist effects (for IIP: t (28) = 4.31, p = .00+; for SWE: t(28) = 2.96, p = .01; for PSSI: t(28) = 0.84, p = .41; for BDI: t(28) = 2.55, p = .02). Table 3 displays the analyses for the patient's contributions and Table 4 for the therapist's contributions. There was no link between patient's in-session content changes, nor with in-session avoidance or interaction manoeuvers changes, nor with therapy changes in symptoms or problems.

Change in therapist relationship offer, understanding and process-directivity were related with symptom change at the end of therapy in terms of decrease in disorder-specific dependency traits (relationship: PSSI p = .01; understanding: PSSI p = .00+; process directivity: PSSI p = .01).

The observed models were not affected by the type of co-morbid personality disorder or the number of co-morbid personality disorders.

DISCUSSION

The present naturalistic process-outcome study aimed at exploring potential processes of change that take place during an integrative form of psychotherapy for dependent personality disorder (DPD), the clarification-oriented psychotherapy (COP).

Main findings of this study were: COP is effective in a naturalistic context for treating Dependent Personality Disorder (DPD); during working phase, the quality of the therapeutic interaction increases; and change in in-session *therapist* behaviors predicts decrease in dependency problems in DPD, but not change in in-session *patient* behaviors.

COP seems to be effective in a naturalistic context that is a specialized Consultation Center for treating DPD. The treatments under study were delivered in a model-adherent way. Specific symptoms and problems

TABLE 3. Links between Changing Process (Patient's Variables) and Outcome in Clarification-Oriented Psychotherapy for Dependent Personality Disorder (N = 74)

Variables	Coefficient	SE	*t*-ratio	d.f.	*p*
Content					
IIP *Diff.*	−0.43	0.37	−1.15	65	.25
SWE *Diff.*	−0.04	0.14	−0.28	65	.77
PSSI *Diff.*	−0.07	0.16	−0.46	72	.64
BDI *Diff.*	0.03	0.10	0.33	67	.74
Avoidance					
IIP *Diff.*	−0.04	0.31	−0.13	65	.89
SWE *Diff.*	0.00	0.11	0.01	65	.98
PSSI *Diff.*	0.05	0.14	0.37	65	.71
BDI *Diff.*	−0.00	0.08	−0.00	67	.99
Interactional games					
IIP *Diff.*	−0.35	0.19	−1.86	65	.06
SWE *Diff.*	−0.08	0.07	−1.17	65	.24
PSSI *Diff.*	−0.06	0.08	−0.72	65	.47
BDI *Diff.*	−0.06	0.05	−1.25	67	.21

Notes: Three-level Hierarchical Linear Modeling, taking into account therapist effects, for IIP: $t(28) = 4.31$, $p = .00+$; for SWE: $t(28) = 2.96$, $p = .01$; for PSSI: t(28) = 0.84, $p = .41$; for BDI: $t(28) = 2.55$, $p = .02$.
IIP: Inventory of Interpersonal Problems; SWE: Selbstwirksamkeit scale;
PSSI: Personality Inventory-Dependency Subscale
BDI: Beck Depression Inventory.

TABLE 4. Links between Changing Process (therapist's Variables) and Outcome in Clarification-Oriented Psychotherapy for Dependent Personality Disorder (N = 74)

Variable	Coefficient	SE	*t*-ratio	d.f.	*p*
Relathionship					
SWE *Diff.*	−0.16	0.16	−1.00	65	.32
PSSI *Diff.*	−0.63	0.18	−3.42	65	.01
BDI *Diff.*	−0.05	0.11	−0.44	65	.65
Understanding					
IIP *Diff.*	−0.40	0.43	−0.92	65	.36
SWE *Diff.*	−0.14	0.16	−0.91	65	.37
PSSI *Diff.*	−0.69	0.18	−3.91	65	.00+
BDI *Diff.*	−0.07	0.11	−0.58	65	.56
Process-directiveness					
IIP *Diff.*	−0.67	0.50	−1.33	65	.18
SWE *Diff.*	−0.07	0.19	−0.41	65	.67
PSSI *Diff.*	−0.58	0.22	−2.64	65	.01
BDI *Diff.*	−0.02	0.14	−0.17	65	.86

Notes: Three-level Hierarchical Linear Modeling, taking into account therapist effects, for IIP: $t(28) = 4.31$, $p = .00+$; for SWE: $t(28) = 2.96$, $p = .01$; for PSSI: t(28) = 0.84, $p = .41$; for BDI: $t(28) = 2.55$, $p = .02$.
IIP: Inventory of Interpersonal Problems; SWE: Selbstwirksamkeit scale;
PSSI: Personality Inventory-Dependency Subscale
BDI: Beck Depression Inventory.

improved, including decrease in depression, in dependency traits, in interpersonal problems and increase in self-efficacy, with effect sizes varying between 0.88 and 1.08 (large effects).

During the designated working phase of clarification-oriented psychotherapy, the quality of the patient–therapist interactions focusing on core contents increased. In COP, the working phase is recommended to be introduced only after relationship work and specific work on the therapeutic mission, while monitoring and reducing experiential avoidance. Our result speaks to a generic trend toward better process in highly disturbed patients presenting with dependency patterns. On average, all measured patient and therapist contributions to the quality of in-session interaction steadily increased between sessions 15 and 25. This means that, from the viewpoint of an individual's trajectory over time, change is positive in all process variables.

Increase in quality of in-session therapist behaviors predicted decrease in dependency problems in DPD, but change in patient's behaviors did not predict outcome. As outlined by Kazdin (2009), an important step in the identification of a mechanism of change in psychotherapy is the establishment of systematic links between process variables and outcome. This hypothesis was not completely confirmed; the changes in patient's in-session interaction processes remained completely unrelated to outcome. While we were initially surprised by this result, it can be understood from different perspectives. Firstly, it could be that focusing on sessions 15 to 25 did not measure the actual change that was central for these patients. Indeed, clinical experience suggests that certain patient changes occur only after longer periods of therapy for patients with DPD. Moreover, the conditions for mediational analyses were not met in the present study: the process changes were measured in the middle, without

being able to control for early improvements in the outcomes up to that point. Secondly and relatedly, the learning experience in COP may obey the principle of a sleeper effect where process-outcome links are not significant at discharge from therapy, but may be at follow-up. Trying to predict change in the end of therapy might have been insufficient. Thirdly, it may also be that the patient's change in clarification – or increase in insight – is a by-product of good therapy and despite its theoretical centrality, it may play a less important role for outcome than initially thought. We need to acknowledge that increase in patient insight was related to outcome in long-term psychodynamic psychotherapy (Johansson et al., 2010). More research comparing COP with dynamic psychotherapy may help delineating the differential role of change in insight across types of treatment, by taking into account slightly divergent theoretical definitions and operationalizations.

Therapist variables predicted the patient's specific change dependency traits over the course of COP. This pattern of results merits particular attention. Out of the three therapist subscales included in the present study, two (understanding the patient's content and therapist relationship offer) represent trans-theoretical, or integrative therapist stances. Therapist relationship (see Table 2, bottom) is a common factor cutting across several models of psychotherapy (Wampold & Ulvenes, 2019), in addition to therapist understanding and empathy (Elliott, Bohard, Watson, & Murphy, 2019). This is also true in the long-term treatments of patients with DPD. In addition, process-directiveness is a core component, more specific to modern humanistic psychotherapies (Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Greenberg et al., 1993; Sachse & Takens, 2002). It is central for COP therapist to focus on process (i.e., working step by step toward the patient's assumed core internal determinants, such as assumptions and experiences, as well as addressing possible patient's avoidance strategies).

Process-directiveness may be most productive when associated with a proactively constructed therapeutic relationship offer (Kramer & Sacse, 2013). When therapists do this in treatment of DPD, their patient's dependent interaction style (i.e., clingy behaviors) decreases. Clearly, the therapist competency in content formulation, process directivity and relationship offer may be a key triad explaining together the effectiveness of COP for patients with DPD. This assumption may be tested in future research on expertise in COP, and also across theoretical models.

The present study has several clinical and training implications. Therapists need to be well trained to guide the patient's process in constructive way. As such, the therapist needs to learn to go beyond a non-directive stance where he/she refrains from intervention and lets the patient chose the content (Rogers, 1957), as much as the therapist needs to learn to go beyond a content directive approach (Beck, 1995) where he/she makes content suggestions on what should be worked on in the session (i.e., in the form of an agenda setting). Our results suggest that the therapists may be advised to learn a process directivity (Greenberg et al., 1993) where the content is decided by patient, and the therapist reflects a central aspect of the content by highlighting it and focuses on core underlying issues, step by step. For example, a patient may present with self-image consistent presentations of the self (i.e., being a particularly harmony-oriented and altruistic person), however, the therapist case formulation assumes that an underlying unresolved shame or guilt issue needs to be clarified and worked through. A COP therapist using process directivity may intervene in subtle and "baby-step" manner, in that always making sure that the therapist reformulation remains within the patient's reach of current understanding of his/her functioning, while at the same time "pushing" the limits of the patient's experience in the Here and Now toward the awareness of the

core content (i.e., related to unresolved shame or guilt in the present example).

There are a number of limitations to the study. The absence of a control group prevents to disentangle therapy-specific process from generic changes; the introduction of comparators (e.g. psychodynamic psychotherapy for COP) would increase generalizability of the findings. While adherence was measured – which is an uncommon asset for a naturalistic pre-post study –, we used the same post-hoc scale as used for the post-hoc process analysis and we could only compare the means of the scale with the means reported in the literature, with no possibility of feedback to the therapist. The quality control of the actual intervention was guaranteed by the clinical supervision. Similarly, the naturalistic context prevented us from reporting detailed patient flows, with number of inclusions, drop-outs, completers, and thus prevented us from differentiating between completer and intent-to-treat analyses, as well as monitor change over follow-up periods. In the three-level HLM, it appeared that the number of therapists was high, while the number of patients treated by each therapist was small, which may suggest an insufficient variance in the nested design. Another limitation was that we did not analyze the impact of non-PD co-morbidity (e,g., presenting depression, anxiety disorders, substance abuse). Finally, outcome was measured pre- and post-therapy; it might have been interesting to analyze middle sessions, with the hypothesis that certain symptom changes might become significant before the end of the therapy.

Conclusion

Despite these limitations, we can state that the present study provided an interesting insight into possible core mechanisms of change in patients suffering from DPD. In particular, clarification-oriented therapy has an effect on interaction processes in patients with DPD: the quality of in-session interaction process increases during central working-phase in psychotherapy. Even if the patient contributions remain unrelated with symptoms decrease, rise in the therapist's quality of relationship, content understanding and process directivity predicted decrease in dependency traits, which may have important implications for therapist training facing patients with dependent personality disorder.

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DATA ACCESS

The corresponding author and all other authors had full access to the data. The data are saved as per regular research protocol and can be made available with mutual agreement depending on the purpose for such demand, through approach to the corresponding author.

DISCLOSURE STATEMENT

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