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A Comparison of Core Conflictual Relationship Themes Before Psychotherapy and During Early Sessions

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This report shows (a) that the Core Conflictual Relationship Theme (CCRT) can be rated reliably either from therapy sessions or from a special pretreatment interview in a group of depressed patients, and (b) that the CCRTs obtained before treatment are similar to the CCRTs extracted from the early sessions of brief dynamic psychotherapy. The data suggest that, at least in the early sessions of treatment, the therapist's influence did not significantly alter the patients' CCRTs.

In the last 15 years, several measures of central relationship patterns or dynamic formulations have been presented in the clinical research literature (for a review, see Barber & Crits-Christoph, 1993). The Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1990) method is one of the measures that has received much research attention. Its interjudge reliability has been shown to be adequate in a moderate-sized sample (Crits-Christoph et al., 1988). With regard to validity, various findings have supported the hypothesis that the CCRT method seems to assess a construct consistent with many characteristics of the transference pattern described by Freud (Luborsky & Crits-Christoph, 1990; Fried, Luborsky & Crits-Christoph, 1992).

More recently, however, the difficulty and expense of extracting narratives from sessions, as well as their possible contamination by therapists' suggestions, have led researchers to use data obtained from clinical interviews. Luborsky (1990) developed the Relationship Anecdotes Paradigm (RAP) interview to collect interpersonal narratives from which CCRTs could be extracted. It has been assumed that a CCRT formulation based on narratives told during RAP interviews will be similar to the one obtained from therapy sessions. The present study seeks to investigate this assumption by providing such a comparison, as well as to replicate Crits-Christoph et al.'s (1988) findings on the reliability of the CCRT.

Psychoanalytic data is, for the most part, inferred from the verbal reports or the behavior of patients. Because this data relies on inference, the therapist's interpretation of these behaviors is likely to play a major role in determining their significance (Eagle, 1983). The therapist's theoretical stance will likely influence how he or she interprets the behavior. This interpretation will, in turn, influence the patients, who are prone to accept their therapists' interpretations for a variety of reasons. Thus, argued Grunbaum (1984), patients' data obtained from patients' therapy sessions may be contaminated by the therapists' indoctrination and theoretical point of view and, therefore, cannot be used to validate the underlying theory of treatment. In other words, Grunbaum claims that clinical data has, if any, little scientific value because it tends "in any case to be artifacts of the analysts' self-fulfilling expectations, thus losing much of their evidential value" (1986, p. 217). Although Grunbaum refers to psychoanalysis proper, his criticism applies also to contemporary psychoanalytic theories (Eagle, 1983), to dynamic psychotherapy, and to other therapies.

This critique has the power to question the use of treatment sessions as a way of validating the scientific aspect of the theory because

> if the patient's responses are merely a result of brainwashing, then Freudian analysis might have beneficial emotional effects not because it allows the patient to acquire genuine self-knowledge, but because of suggestion operating as a placebo under the guise of nondirective therapy. (Grunbaum, 1986, p. 221)

The comparison of CCRTs obtained through narratives from therapy sessions and clinical interviews might begin to address this criticism (Luborsky, 1986). To the extent that the CCRTs obtained from interviews preceding psychotherapy are similar to the ones extracted from therapy sessions, we are more confident that the clinician's influence, at least in the early sessions of therapy, is not as pervasive as Grunbaum has suggested and that psychodynamic psychotherapy may be something more than suggestion.

Method

Nineteen patients (15 women, 4 men; mean age, 40, *SD* = 9.6) participated in a training study involving 16 sessions of time-limited supportive–expressive dynamic psychotherapy for depression (Luborsky, 1984; Luborsky, Mark, Hole, & Popp, in press). Eight patients were never married, and 4 were divorced, separated, or widowed. Patients

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either were referred from other clinics within the hospital of a major northeastern medical center or had responded to advertising in the community. Only patients with a Research Diagnostic Criteria diagnosis of major depression without psychotic features, brain impairment, or current drug or alcohol abuse were entered into the study. Patients needed to have been diagnosed using the Schedule for Affective Disorders and Schizophrenia (Endicott & Spitzer, 1978) on two consecutive interviews spaced 1 week apart before entering treatment. At the second intake interview, the average level of depressive symptoms as measured by the Beck Depression Inventory was 28 (SD = 7.5); patients' average score on the Health Sickness Rating Scale was 49.0 (SD = 6.1). Eleven patients had at least one probable or definite coexisting personality disorder diagnosis.

Core Conflictual Relationship Theme

The Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1990) describes the relationship pattern or conflict in terms of three components: (a) wishes, needs, or intentions expressed by the subject (wishes): (b) expected or actual responses from others (ROs); and (c) responses of self (RSs); i.e., the patient's own emotional, behavioral, or symptomatic responses to others' responses.

The CCRT is extracted using the following steps: (a) Relationship episodes are delineated in the transcribed material; (b) independent judges read each relationship episode in the transcript and identify each of three components (wishes, ROs, and RSs); (c) for each component, the types with the highest frequency across all relationship episodes are identified, and their combination constitutes a preliminary CCRT formulation; (d) On the basis of this preliminary CCRT formulation, the same judge re-identifies, where needed, the types of wishes, ROs, and RSs; (e) the judge can change the original rating based on the recount of all wishes, ROs, and RSs. In addition, judges were asked to translate their tailor-made scoring into standard categories. Details regarding the reliabilities of delineating relationship episodes and of the CCRT can be found in Crits-Christoph et al. (1988) and Luborsky and Crits-Christoph (1990). Briefly, they reported that, in a sample of 35 psychotherapy patients, interjudge agreement as measured by weighted kappas was .70 for ROs and .61 for wishes and for RSs.

RAP Interview Method

Instructions for administration of the RAP interview are as follows:

> Please tell me at least 10 incidents or events, each about an interaction between yourself in relation to another person. Some incidents may be recent and some old. Each one should be a *specific* incident. For each one tell 1) when it occurred, 2) who the other person was, 3) some of what the other person said and what you said, and 4) what happened at the end. The other person might be anyone—your father, mother, brothers and sisters or other relatives, friends or people you work with. The accounts should be about specific incidents not just amalgams of several incidents.

Those interviews are recorded and then transcribed. The CCRTs are extracted from the interviews in the same manner as they are extracted from therapy sessions. The mean time usually required for a patient to tell 10 episodes is about 30 min.

The patients were seen in supportive–expressive dynamic psychotherapy for 16 sessions by four different experienced therapists (Diguer, Barber, & Luborsky, 1993). The therapists participated in the training phase of a treatment development project. The RAP interviews were given by a research assistant before therapy began. Sessions 3 and 5 were transcribed, but for the 2 patients for whom we found fewer than 10 complete relationship episodes, Session 4 was added. The transcribed RAP interviews and therapy sessions were then rated by two different teams of two judges. Each judge worked independently, used the standard categories (Barber, Crits-Christoph, & Luborsky, 1990), and followed the CCRT scoring manual (Luborsky & Crits-Christoph, 1990). All judges were experienced psychodynamic clinicians who had been trained in the CCRT method by Lester Luborsky.

Because there are many standard categories (35 wishes, 30 ROs, and 31 RSs) with some having similar meanings (e.g., wish to be understood vs. to be respected vs. to be accepted), assessing the judges' agreement on the most frequent standard categories would have been too stringent a criteria for calculating reliability; that is, we did not want to say that if one judge decided that the main wish was "to be understood" and the other judge thought it was "to be accepted," the interjudge agreement was 0. In addition, there were many cases in which different standard categories were high in frequency; that is, more than 2 or 3 standard categories were the most frequently used by one judge for a specific patient. To resolve these two problems, we used Barber et al.'s (1990) grouping of the standard categories, the clustered standard categories. There are eight clustered standard categories for each CCRT component (more details on the procedure used to derive the clustered standard categories can be found in Barber et al., 1990). All standard categories ratings were recoded by the research assistant into their appropriate clusters. For all analyses involving the clustered standard categories, the two most frequent ratings for each CCRT component from each judge were chosen.

Results and Discussion

Reliability of the CCRTs Derived From the RAP Interviews

All 19 RAP interviews were rated by two independent judges. The degree of interjudge agreement on the clustered standard categories is presented in the top tier of Table 1. To correct for chance agreement, we followed Crits-Christoph et al.'s (1988) use of the weighted kappa (Cohen, 1968) for assessing interjudge reliability of the rating for each of the three CCRT

Table 1
Interjudge Agreement and Reliability for the CCRT From the RAP, Therapy Sessions, and the Comparisons of CCRTs From RAP Interview Versus Sessions

Variable	% agreement between the judges	Weighted κ: Clustered categories	Weighted κ: Standard categories
CCRT from RAP interviews			
Wishes	84	.68	—
ROs	100	.60	.56
RSs	89	.65	—
CCRT from Sessions 3 and 5			
Wishes	94	.81	—
ROs	100	.64	.77
RSs	88	.73	—
Comparing CCRT from session to CCRT from RAPS			
Wishes	77	.52	—
ROs	100	1.0	—
RSs	77	.40	—

Note. CCRT = Core Conflictual Relationship Themes; RAP = Relationship Anecdotes Paradigm; ROs = responses from others; RSs = responses of self.

components. In contrast to regular kappa, weighted kappa allows different weights for different levels of agreement; that is, a higher weight can be given if agreement between the two judges occurred on the most frequent clustered standard categories, a lower weight if the second highest rating from one judge matched the most frequent rating of the other judge, and a lowest weight if judges agreed only on the second most frequent ratings. More specifically, the two most frequent clustered standard categories of wishes (or ROs or RSs) for each patient from one judge were compared to the two most frequent wishes of the other judge. If the most frequent wish rated by each judge matched, a weight of 1.00 was given; if the most frequent clustered standard wish category of one judge matched the next most frequent of the other judge, a weight of .66 was given. If only the two second most frequent categories matched, a weight of .33 was given. Crits-Christoph et al. (1988) used identical weights. This computation was performed separately for wishes, ROs, and RSs and is presented in the second column of Table 1. All of these kappas were in the acceptable range.

The high degree of agreement but only fairly good kappas is likely due to the narrow range of categories of CCRT components, especially ROs, that these patients displayed. Seventeen patients (89%) were rated as having their RO as "rejecting and opposing," one had the RO "understanding or accepting," and one patient's RO was "upset." Because the judges used only three of the eight clustered standard categories for the ROs, we recalculated the degree of agreement and the weighted kappa for the ROs using the 30 standard categories instead of the eight clusters. Using the standard categories, we observed that all RO standard categories were used at least once by one of the two judges. The weighted kappa obtained using the 30 standard categories was .56 (shown in the third column of Table 1).

Reliability of the CCRTs Derived From Therapy Sessions

Two other independent judges rated the CCRTs from the sessions for those 17 patients of the 19 who entered treatment and for whom audiotapes were available (see the middle tier of Table 1). The adequate reliability coefficients found in the present study for the CCRT components derived from therapy sessions replicate Crits-Christoph et al.'s (1988) findings in another moderate-sized sample. Again, the same problem outlined in the previous section occurred with the ROs from the sessions (16 of 17 patients had the clustered standard categories RO "rejecting," whereas the other patient's RO was "like me"). We, therefore, recalculated the weighted kappa for the ROs and, as presented in Table 1, the kappa was adequate. As with the ratings from the RAPs, these two different judges used all 30 RO standard categories at least once.

Correspondence Between CCRTs From RAPs (Before Therapy) With CCRTs From Sessions

To compare the two sets of ratings, we needed first to combine the ratings from each independent team of judges. In the cases in which there was agreement between the two judges who scored the RAPs, the categories that were agreed on were used in the comparison with the CCRT from sessions and vice versa. In the cases in which there was no agreement between the two judges, the clustered category that was the most frequently rated across relationship episodes by any of the two judges for a specific patient was selected for comparison with the clustered category from the other team of judges. The same process was used for second most frequent category. The results from this comparison were summarized in part in a previous review of the CCRT (Luborsky, Barber, & Diguer, 1992).

The comparison of the CCRT ratings from the RAPs and the therapy sessions for the 17 patients indicated a relatively high level of agreement between the two methods of deriving the patients' CCRT, suggesting a relatively high level of similarity between the CCRT obtained from pretreatment data with the CCRT obtained from sessions early in treatment (see the bottom tier of Table 1). Thus, even when we corrected for chance agreement, a moderate-to-good level of correspondence was found between the CCRTs derived from the two different sources of material. Using a different terminology, moderate alternate-form reliability was found for the wishes and responses from self across the two methods of deriving narratives for CCRT formulations. In regard to the ROs, the two methods yield excellent alternate-form reliability when one uses the clustered standard categories. From a psychometric point of view, one needs to realize that the "alternate forms" and the "responses" (patients' narratives) are very different in the two methods, at least, on the surface. As an anonymous reviewer noted, this lack of perfect match between the two "forms" may have reduced the reliability estimates.

These results support the conclusion that the relationship themes that emerge early in treatment are quite similar to the themes that emerge during an independent interview that precedes the therapy. These findings are likely to increase researchers' confidence that the RAP interview can be used to determine patients' psychodynamic themes independently of treatment.

In terms of addressing Grunbaum's (1984) critique, we have presented tentative and preliminary empirical evidence that the CCRT in early sessions of psychodynamic therapy is not likely to be primarily the result of therapists' influence. At the same time, our data do not indicate that the CCRTs obtained before treatment versus early in treatment are identical. The present findings are especially meaningful to the extent that the CCRT is indeed measuring the complex and controversial but central psychoanalytic concept of transference. Indeed, Fried et al. (1992) have shown that the CCRT expressed in the relationship with the therapist is similar to the CCRT expressed in other relationships. Future studies, however, will need to replicate our preliminary findings using material from before and during psychoanalytic sessions.

One major limitation regarding the generalizability of the results of this study is that it is based on a sample of patients who had received a diagnosis of major depressive episode in accordance with the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM-III;* American Psychiatric Association, 1980). It may be, for example, that the restricted range of response from others obtained in the present sample is characteristic of depressed patients, but not of other groups of patients; that is, depressed patients tend to see others as rejecting. Thus, replication in larger samples as well as in heterogeneous groups of patients is recommended.

Other factors could also have affected the results of this study.

The correspondence between pretreatment and early-in-treatment CCRTs may be due to the relatively severe state of depression in which the patients presented at the time. Depression may have influenced the content of the narratives in a convergent direction at both times; that is, in the two kinds of narratives, depressed patients may tend to perceive others as "rejecting," or include others who "are rejecting" or cause others to reject them. The kappa coefficient, however, was intentionally used to deal with this base rate problem. It is also possible that the judges' use of only two or three clustered standard categories for the ROs indicates some problems with the current version of the clustered standard categories.

At least 1 month had passed between the RAP interview and the third treatment session. During this month, many changes may have occurred (e.g., slight changes in the CCRT and moderate relief of depression) that could have lowered the reliability estimates. Thus, the two procedures may be even more similar than the results suggest.

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