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Early treatment response in psychotherapy for depression and personality disorder: links with core conflictual relationship themes

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Abstract

Objective: Depressed personality disorder patients showing an early rapid response (or sudden gain) in psychotherapy have better outcomes. Early responders are five times more likely to recover, despite equivalent ratings of working alliance. We explored core conflictual relationship themes (CCRTs) of early responders compared to others to further elucidate process-outcome links. **Method:** Patients ($N = 20$) with diagnosed major depression and personality disorder received 16 weeks of psychodynamic therapy. Early response was defined as a 50% reduction in Beck Depression Inventory symptoms during the first six sessions. Transcripts of therapy session three for early responders ($n = 10$) and others ($n = 10$) were analyzed using the CCRT Leipzig/Ulm method, identifying 728 components scored by two independent judges. **Results:** Relationship narratives showed CCRT-wish satisfaction was lower for those not having an early response, for both CCRT "Response of Other" and "Response of Self" components. These patients told narratives of others as more unreliable, aggressive, and less supportive, with less feelings of being loved and a lower experience of being self-determined. **Conclusions:** Specific negative relationship patterns may inhibit the ability to benefit from both therapy and extra-therapy relationships, contributing to a slower treatment response.

Keywords: depression; personality disorders; psychoanalytic/psychodynamic therapy; core conflictual relationship theme; early treatment response

Clinical or methodological significance of this article: Previous work shows patients experiencing an early rapid response (ERR) to psychotherapy are five times more likely to recover compared to those who do not, despite equivalent ratings of working alliance. This study found more negative relationship patterns in non-ERR patients (vs. their EER counterparts), through the Core Conflictual Relationship Theme method. These findings provide further data to elucidate phenomena influencing response trajectories in psychotherapy.

Introduction

A considerable proportion of individuals do not respond to psychotherapy (Lambert, 2013). One avenue to pursue in addressing this issue involves enhancing treatment response through matching a particular client with the treatment most likely to be of benefit; that is, adopting a precision medicine approach (Cohen & DeRubeis 2018). The relationship between improved treatment outcomes in depression and early rapid response (ERR) to therapy is one way in which response trajectories have been investigated. Definitions of ERR vary (e.g., Beckham, 1989; Ilardi & Craighead, 1994), but all focus on a considerable reduction in depressive symptoms within the *early* stages of therapy (e.g., a 50% reduction in Beck Depression Inventory score *within the first 6 sessions*; Beckham, 1989). These early reductions are associated with improved response and remission rates at the conclusion of treatment and up to 12 months later, versus more gradual or delayed responses (Beckham, 1989; Crits-Christoph et al., 2001; Haas, Hill, Lambert, &

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Morrell, 2002; Hayes et al., 2007; Ilardi & Craighead, 1994; Renaud et al., 1998). ERRs occur across a range of modalities including CBT, psychodynamic psychotherapy, systemic behavioural family therapy, and non-directive supportive treatment (Beckham, 1989; Crits-Christoph et al., 2001; Haas et al., 2002; Hayes et al., 2007; Ilardi & Craighead, 1994; Renaud et al., 1998).

Similar to ERR is the concept of *sudden gains* in therapy, which are also associated with improved treatment outcomes (Aderka, Nickerson, Bøe, & Hofmann, 2012; Tang & DeRubeis, 1999). Sudden gains refer to large reductions in depressive symptoms between consecutive therapy sessions (Tang, DeRubeis, Beberman, & Pham, 2005; Tang & DeRubeis, 1999) and can occur at any time during treatment; though they generally occur in the early stages (n.b., in the original study by Tang and DeRubeis (1999), the 5th-6th session interval was the median time-point at which sudden gains occurred).

Processes Associated with Treatment Response

Studies have attempted to document the mechanisms through which ERRs and sudden gains occur. For example, Hardy et al. (2005) explored the role of patient characteristics and found no difference between sudden gain and non-sudden gain patients in age, gender, marital status, severity of depressive symptoms, personality disorder, or the number of good and bad life events that occurred during the course of therapy. Patients with sudden gains, however, were more likely to be employed and had marginally higher levels of dysfunctional attitudes at intake.

Treatment-specific factors in early treatment response phenomena have also been investigated. For example, Tang and colleagues found that sudden gains were associated with cognitive changes (e.g., changes in beliefs, schemas or learning of new techniques) occurring in the preceding session (Tang et al., 2005; Tang & DeRubeis, 1999). While sudden gains in psychodynamic therapy may be related to greater accuracy of therapist interpretation (Andrusyna, Luborsky, Pham, & Tang, 2006).

Running counter to the treatment-specific hypothesis, Kelly, Roberts, and Ciesla (2005) found no relationship between sudden gains and cognitive change in their CBT study. Others argue that rapid improvements often occur before specific therapeutic techniques are applied (Haas et al., 2002; Ilardi & Craighead, 1994, 1999). Early symptom change is associated with better outcomes in a relatively consistent proportion of patients (~30–40%) across a variety of therapeutic modalities; including pharmacotherapy and pill placebo with clinical management (Haas et al., 2002; Renaud et al., 1998; Vittengl, Clark, & Jarrett, 2005). Therefore it is possible that early treatment response may be influenced by factors that are common across different therapy modalities (Haas et al., 2002; Ilardi & Craighead, 1994, 1999; Renaud et al., 1998; Vittengl et al., 2005).

Common Factors, Therapeutic Alliance and Early Treatment Response

Core ingredients across different modalities such as therapeutic alliance, empathy, expectations regarding treatment, cultural adaptations of treatment, and therapist-specific effects have a powerful influence on psychotherapy outcome (Wampold, 2015). For example, the relationship between interpersonal characteristics and ERR has been investigated (Comninos & Grenyer, 2007). Patients experiencing an ERR (37%) were five times more likely to recover by the end of treatment (vs. non-ERR group) and outcomes were retained at 12-month follow-up. At pre-treatment, the ERR group (vs. non-ERR group) displayed fewer interpersonal problems, including less fear of intimacy, lower domineering personality style, and less interpersonal withdrawal and helplessness. Despite these differences, both groups rated therapeutic alliance similarly in the third therapy session, consistent with previous studies suggesting that early therapeutic alliance may not be related to early response status (Hardy et al., 2005). Therefore despite the conscious perception of a good alliance, past experiences of interpersonal problems or negative expectations may undermine the patient's capacity to benefit from the therapeutic relationship.

Relationship Patterns and Early Treatment Response

The notion of relationship patterns playing out in the therapeutic relationship has a long history in the psychoanalytic tradition; encapsulated in one form as the central relationship pattern or Core Conflictual Relationship Theme (CCRT; Crits-Christoph, Demorest, Muenz, & Baranackie, 1994; Luborsky, 1998). It refers to an individual's central relationship pattern; comprising mental representations of interpersonal relationships, including their associated wishes and affects (Crits-Christoph et al., 1994; Luborsky, 1998). Key past relationships shape these patterns and they provide a mental "blueprint" to guide new interactions—although this occurs largely out of consciousness. Concepts implicating central

relationship patterns underlie various theories of personality, through the early notion of the "transference template" (Freud, 1912/1958) to the more modern "relationship schema" (Young, Klosko, & Weishaar, 2006), attachment style (Levy, Kivity, Johnson, & Gooch, 2018) and personality traits (Grenyer, 2018). Indeed, the rich history of attachment theory (Ainsworth & Bowlby, 1991) provides a particularly developmental lens through which to understand early formation of relationship bonds between infant and caregiver—and the potential for their disruption. All of these theories converge on the notion of a conflictual or maladaptive central relationship pattern of self and other leading to the development of psychological symptoms to be mastered (Grenyer, 2002).

The CCRT method (Luborsky, 1998) involves analysis of patient narratives regarding interactions with others (referred to as relationship episodes; REs). Within each RE, three key components of the CCRT are identified: the wish (what the patient wishes for, needs, or intends from the interaction; W), the response of other (how the patient perceives or expects the other person to respond; RO) and the response of self (how the patient responds to the interaction; RS). The "conflictual" aspect of the CCRT refers to the conflict between what the patient wants and what they experience receiving (e.g., a wish to be admired [W], but perceives the other as rejecting [RO], resulting in feelings of depression [RS].) For consistency in research studies, W, RO, and RS components can be selected from lists of standardized categories. The CCRT represents the most pervasive W, RO, and RS across a sample of relationship narratives (Luborsky, 1998). A "valence" is also ascribed to the RO and RS components of the CCRT. Positive valence indicates non-interference with satisfaction of the W whereas a negative valence indicates that W satisfaction is impeded (Grenyer & Luborsky, 1998). A more negative valence of RO and RS components thus signifies less interpersonal wish fulfilment.

Luborsky generated the CCRT method as a way to identify pervasive relationship patterns underlying interpersonal difficulties and, ultimately, to inform the focus of psychodynamic psychotherapy. Numerous studies support the validity of the CCRT method (Luborsky & Crits-Christoph, 1998) and a reformulation of the category structure, the Core Conflictual Relationship Theme - Leipzig/Ulm method (CCRT-LU) improved formulation specificity and interrater reliability (Albani, Pokorny, Blaser, & Gruninger, 2002). The CCRT technique permits investigation of a range of clinically relevant aspects of relationship themes. For example, CCRT "pervasiveness" (i.e., rigidity) correlates with psychopathology severity (e.g., Albani et al., 2002; Albani, Pokorny, Blaser, König, & Thomä, 2003; Cierpka et al., 1998; Crits-Christoph et al., 1994; Luborsky & Crits-Christoph, 1998). Moreover, both CCRT pervasiveness and valence scores change over the course of psychotherapy in association with outcome measures (e.g., Albani et al., 2002, 2003; Cierpka et al., 1998; Crits-Christoph et al., 1994; Luborsky & Crits-Christoph, 1998).

Whilst Luborsky stipulated that the most common W, RO, and RS comprise the CCRT as the focal point of therapy, it is noted that most patients generally exhibit a number of central relationship patterns. Importantly, these patterns are found to recur within the therapeutic relationship, particularly in early sessions (Connolly, Crits-Christoph, Barber, & Luborsky, 2000).

The current study sought to use the CCRT-LU method to investigate relationship patterns and treatment response. A subset of patients with comorbid depression and personality disorder were drawn from the earlier study by Comninos and Grenyer (2007). Personality disorders are highly comorbid with depression (Lenzenweger, Lane, Loranger, & Kessler, 2007) and display higher rates of treatment nonresponse (Newton-Howes et al., 2014). We hypothesized that compared to patients showing ERRs to psychotherapy, the CCRT profiles of their counterparts who do not would be characterized by i) more negative valence of RO and RS components, indicating greater interference with satisfaction of their wishes, and ii) greater endorsement of RO and RS components that may interfere with the therapeutic bond (e.g., expectation of rejection, interpersonal withdrawal, and/or domineering behaviour).

Method

Participants

Participants ($N = 20$) were a subset drawn from the Comninos and Grenyer (2007) study, and underwent psychodynamic psychotherapy for major depression at a university health clinic. All participants met DSM-IV diagnostic criteria for major depression and comorbid personality disorder (Cluster A, two; Cluster B, six; Cluster C, twelve; Not otherwise specified, eight), assessed by the Structured Clinical Interview of the DSM-IV (First, Spitzer, Gibbon, & Williams, 1997). Exclusion criteria included: current substance dependence, schizophrenia or other psychotic disorder, bipolar disorder, obsessive compulsive disorder, eating disorder, organic brain disorder, or serious medical conditions (e.g., cancer).

Selection criteria and characteristics of the subset of patients included in the current study have

previously been described (McCarthy, Caputi, & Grenyer, 2017; McCarthy, Mergenthaler, & Grenyer, 2014) and thus are outlined only briefly here. The subset included 10 ERR (Early Rapid Response) and 10 non-ERR patients (n.b., ERR defined as a 50% reduction in Beck Depression Inventory [BDI] symptoms during the first six sessions). ERR and non-ERR groups were carefully matched for demographics (age, gender, education, relationship status, employment status), intake diagnosis (distribution of co-morbid personality disorder clusters were approximately equal), measures of symptomology (BDI and Global Assessment of Functioning [GAF]), and chronicity of depression (McCarthy et al., 2014). One patient from the non-ERR group was excluded from the final analyses due to outlying data relating to atypical themes discussed in the chosen session. Characteristics of the analyzed sample are presented in Table I.

Psychotherapy

Patients attended 16 weekly one-hour sessions of supportive-expressive psychodynamic psychotherapy (Luborsky et al., 1995), a manualised, time-limited therapy with empirical support for the treatment of depression (Driessen et al., 2015). Therapists were 10 doctoral-level clinical psychologists with relevant training in this psychotherapy model applied to depression and personality disorders. Therapist adherence to the manualised treatment was monitored by a clinical psychologist with extensive experience in short-term psychodynamic therapy (i.e., a 1 year-long intensive program including group and individual supervision). There were no differences in treatment adherence or competence ratings across therapists.

Table I. Group characteristics of patients diagnosed with depression and personality disorder receiving psychodynamic psychotherapy.

Characteristic	ERR (n = 10)	Non-ERR (n = 10)	t	p
Intake BDI (M, SD)	27.2 (7.8)	29.2 (5.6)	−0.58	0.57
Session 6 BDI (M, SD)	11.0 (3.0)	24.8 (8.5)	−1.33	0.21
Termination BDI (M, SD)	5.8 (3.6)	22.7 (11.1)	−4.56	<.001***
Follow-up BDI (M, SD)	8.5 (6.8)	19.6 (7.7)	−3.34	0.004**
Age (M, SD)	43.6 (12.0)	43.4 (13.5)	0.03	0.98
Education (years; M, SD)	12.7 (2.2)	13.8 (2.2)	−1.08	0.29
Gender (M:F)[a]	5:5	5:4		1.0
In a relationship (Y:N)[a]	7:3	5:4		0.65
Currently employed (Y:N)[a]	6:5	5:4		1.0
Chronically[b] depressed (Y:N)[a]	8:2	8:1		1.0

Note. ERR = early rapid response. BDI = Beck Depression Inventory.
[a]Fisher's exact test.
[b]Chronicity defined as the presence of dysthymia, comorbid personality disorder, or a treatment resistant diagnosis (n.b., treatment resistance was defined as a failure to respond to two adequate courses of antidepressant treatment).
*$p \leq 0.05$. **$p \leq 0.01$. ***$p \leq .001$.

Measures

Core conflictual relationship Theme - Leipzig/Ulm method. The relationship patterns of patients were assessed using the Core Conflictual Relationship Theme - Leipzig/Ulm method (CCRT-LU) method (Albani et al., 2002), which rates all scorable core relationship theme components within the whole session. The CCRT-LU method uses a hierarchical list of standardized categories to classify Wish (W), RO (Response of Other), and RS (Response of Self) components. At the top of the hierarchy, harmonious or disharmonious classes comprise six superclusters: *Loving* and *Strong* (Harmonious), and *Weak*, *Unpleasant*, *Fighting*, and *Leaving* (Disharmonious). Following this, categories are organized into 13 clusters, 30 mid-level categories, and 119 base-level categories. Albani et al. (2002) introduced sub-dimensions of direction in the "Wish" category, allowing classification of object-related and subject-related wishes; however, for the purposes of this project we retained the traditional single W component only.

CCRT profiles. CCRT profiles were generated for each patient, comprising the relative endorsement of each W, RO, and RS CCRT-LU category across all REs. Repeat endorsements of components within each RE were culled so that any individual W, RO, and RS base-level category was endorsed only a single time within a single RE. Redundancy of components are expected so not separated for analysis. The number of endorsements of each CCRT-LU category was expressed as a percentage of all expressed W, RO, or RSs across REs. Profiles are presented at both the supercluster and cluster level, with data representing the mean proportion of endorsements.

Consistent with another exploratory study of similar size, CCRT-LU profiling was limited to the cluster level given that the small sample size did not permit feasible comparisons between groups at the

mid- or base-level categories (Drapeau & Perry, 2004).

Valence. RO and RS components are classified as having a positive or negative valence. A positive valence reflects that RO/RS accords with wish satisfaction, while a negative valence indicates RO/RS that interferes with wish satisfaction (Grenyer & Luborsky, 1998). Each RO and RS component was attributed a valence score according to a four category scale (1 = strongly positive, 2 = positive, 3 = negative, 4 = strongly negative). The mean RO and RS valence was calculated within each RE and then averaged across all REs.

Pervasiveness. An index of W, RO, and RS pervasiveness was calculated for each patient by dividing the total number of cluster categories endorsed by the total number of cluster categories (i.e., 13).

Procedure

Data was collected using verbatim transcripts of patients' third psychotherapy session. Individual thought units (scorable utterances) corresponding to W, RO, or RS components were identified within the transcript and scored using tailor-made categories, as described by Luborsky and Crits-Christoph (1998). Subsequently, each component was converted to CCRT-LU base-level categories (Albani et al., 2002) and valence scores attributed to RO and RS components. Ten transcripts were scored by two independent judges in order to assess scoring reliability (authors BH and MG).

Statistical Analysis

Interrater reliability for the scoring of CCRT-LU components was assessed at the cluster level using Cohen's Kappa. Interrater agreement on valence scores was assessed using Pearson's *r*. Comparisons between ERR and non-ERR groups were performed using Student's *t*-tests with Cohen's d effect size estimates. Variables with non-normal distributions were either transformed or analyzed using Mann-Whitney U tests. Statistical significance was set at .05 for comparisons of CCRT valence and pervasiveness. For the CCRT category profile comparisons, significance was set at .10, without correction for multiple comparisons, consistent with other exploratory studies of this size (Drapeau & Perry, 2004).

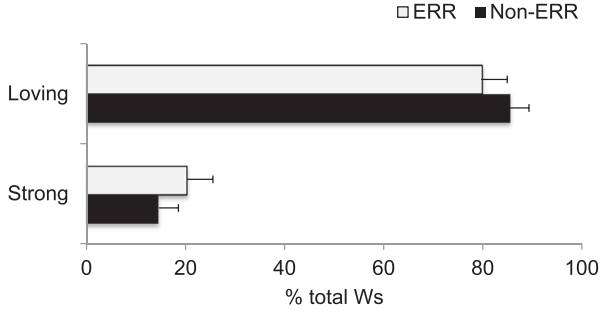

Figure 1. Wish (W) supercluster profile. Mean proportions (SE) of expressed Ws classified according to the CCRT-LU category system.

Results

Interrater Reliability

Across the total 728 CCRT components scored at the cluster level, interrater reliability was good (K = .61). With respect to each CCRT component individually, interrater reliability was fair for Ws (K = .546, n = 143) and RSs (K = .566, n = 298), and good for ROs (K = .607, n = 287). Interrater agreement for valence scores was high for both RO (r = .898, n = 286) and RS (r = .787, n = 294) components.

CCRT Profiles

Wishes

Superclusters. All Ws identified across patient narratives fell within the harmonious superclusters (i.e., *Loving* and *Strong*). ERR and non-ERR groups

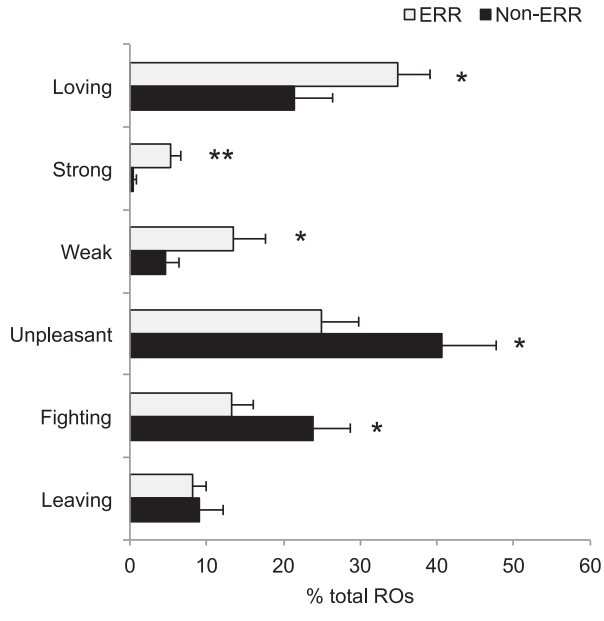

Figure 2. Response of Other (RO) supercluster profile. Mean proportions (SE) of expressed ROs classified according to the CCRT-LU category system. $^{*}p < .10$, $^{**}p < .01$.

Table II. Wish (W) cluster profiles for early rapid response (ERR) versus non-ERR patients.

Supercluster	Cluster	ERR ($n = 10$) Mean % (SD)	Non-ERR ($n = 9$) Mean % (SD)	t	p	d
Loving	Attending	15.6 (12.8)	21.0 (13.2)	−0.89	0.38	0.42
	Supporting	26.5 (14.7)	20.8 (14.1)	0.85	0.41	0.40
	Loving/Feeling Well	37.6 (23.9)	44.8 (23.1)	−0.66	0.52	0.31
Strong	Self-Determined	20.3 (16.6)	13.5 (12.7)	1.00	0.33	0.46

expressed similar W profiles at the supercluster level, with most Ws classified as *Loving* for both groups (see Figure 1).

Clusters. At the cluster level, the most prevalent Ws for the ERR group were: *Loving/Feeling Well*, followed by *Supporting* (see Table II). The non-ERR group most commonly endorsed *Loving/Feeling Well*, followed by *Attending To*, clusters. There were no statistical differences between groups in terms W supercluster proportions or cluster endorsements.

Response of other

Superclusters. RO supercluster profiles are presented in Figure 2. 40.3 percent ($SD = 15.4$) of ROs from the ERR group fell within the harmonious superclusters (*Loving* and *Strong*), compared to only 21.9% for the non-ERR group ($t(17) = 2.594$, $p = .019$, $d = 1.19$). The top RO superclusters endorsed by the ERR group were: *Loving*, followed by *Unpleasant*. In contrast, the most prevalent RO supercluster for the non-ERR group was: *Unpleasant*, followed by *Loving* (refer to Figure 2). With the exception of the *Leaving* supercluster, the endorsement of all other RO superclusters significantly differed between ERR and non-ERR groups. ERR patients were more likely than non-ERR patients to express ROs classified as *Loving* ($t(17) = 2.027$, $p = .059$, $d = 0.93$), *Strong* ($U = 11.5$, $Z = -2.893$, $p = .004$, $d = 1.48$), and *Weak* ($U = 23.5$, $Z = -1.783$, $p = .075$, $d = 0.83$). Non-ERR patients were more likely to endorse ROs classified as *Unpleasant* ($t(17) = -1.830$, $p = .085$, $d = 0.83$), and *Fighting* ($t(17) = -1.837$, $p = .084$, $d = 0.83$).

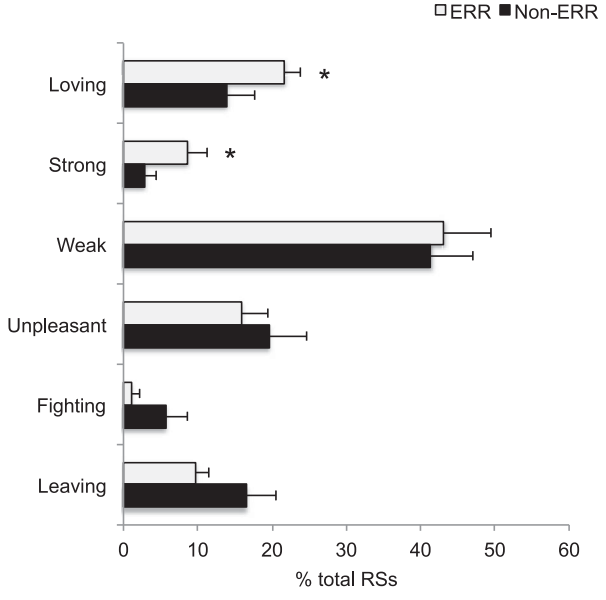

Figure 3. Response of Self (RS) supercluster profile. Mean proportions (SE) of expressed RSs classified according to the CCRT-LU category system. $^{*}p < .10$.

Clusters. RO cluster profiles are presented in Table III. The RO cluster most commonly endorsed by the ERR group was *Supporting*, followed by *Unreliable*. The most prevalent RO clusters for the non-ERR group were *Unreliable*, followed by *Rejecting*. ERR patients were significantly more likely than non-ERR patients to endorse ROs from the *Supporting* ($d = 0.65$) and *Being Self-Determined* ($d = 1.50$) clusters, whereas they were less likely than non-ERR patients to endorse ROs from the *Unreliable* cluster ($d = 1.19$).

Valence. The average valence of ROs was significantly different between groups ($t(17) = -3.097$, $p = .007$, $d = 1.42$), ERR patients ($M = 2.71$, $SD = .31$) displayed lower (i.e., more positive) mean RO valence, versus the non-ERR group ($M = 3.17$, $SD = .35$).

Response of self

Superclusters. RS supercluster profiles are presented in Figure 3. 30.3 percent ($SD = 12.4$) of RS components for the ERR group were classified within harmonious superclusters, compared to only 16.8% ($SD = 13.1$) for the non-ERR group, ($t(17) = 2.303$, $p = .034$, $d = 1.06$). The *Weak* supercluster was the most commonly endorsed RS supercluster for both the ERR and non-ERR groups, accounting for approximately 40% of all RSs. The second most endorsed RS superclusters were *Loving* for the ERR group, and *Unpleasant* for the non-ERR group. Compared to the non-ERR group, ERR patients were

Table III. Response of Other (RO) cluster profiles for early rapid response (ERR) versus non-ERR patients.

Supercluster	Cluster	ERR ($n = 10$) Mean % (*SD*)	Non-ERR ($n = 9$) Mean % (*SD*)	*t*	*p*	*d*
Loving	Attending	7.7 (7.5)	5.1 (4.6)	37.50[a]	0.53	0.42
	Supporting	17.9 (15.6)	9.1 (11.1)	2.26	0.038*	0.65
	Loving/Feeling Well	9.4 (6.5)	7.3 (12.0)	29.50[a]	0.20	0.22
Strong	Self-Determined	5.3 (4.4)	0.5 (1.0)	11.50[a]	0.004**	1.50
Weak	Depressed/Resigning	1.4 (2.6)	0.3 (0.8)	35.00[a]	0.25	0.57
	Dissatisfied/Scared	4.6 (5.2)	2.0 (3.5)	31.50[a]	0.24	0.59
	Determined by Others	7.4 (9.8)	2.3 (3.0)	30.50[a]	0.22	0.70
Unpleasant	Angry/Unlikeable	3.4 (4.2)	5.6 (7.5)	41.00[a]	0.73	0.36
	Unreliable	11.6 (8.7)	23.4 (11.1)	−2.06	0.019*	1.19
	Rejecting	10.1 (6.6)	15.4 (9.7)	−1.40	0.18	0.64
Fighting	Dominating	8.0 (8.3)	15.4 (13.2)	27.00[a]	0.14	0.67
	Annoying/Attacking	5.3 (5.2)	8.4 (12.3)	42.50[a]	0.84	0.33
Leaving	Withdrawing	8.1 (5.8)	5.3 (4.6)	1.16	0.26	0.53

[a]Mann-Whitney *U* test statistic.
*$p \leq 0.05$.
**$p \leq 0.01$.
***$p \leq .001$.

significantly more likely to endorse RSs from the *Loving* supercluster, ($t(17) = 1.767$, $p = .095$, $d = 0.80$), and the *Strong* supercluster, ($U = 20.0$, $Z = -2.093$, $p = .036$, $d = 0.83$). Greater endorsement of *Fighting* and *Leaving* RS superclusters by non-ERR patients versus ERR patients did not reach statistical significance.

Clusters. RS cluster profiles are presented in Table IV. The RS clusters most commonly endorsed by the ERR group were *Being Dissatisfied/Scared* followed by *Loving/Feeling Well*. The non-ERR group endorsed three RS clusters to similar degrees: *Being Angry/Unlikable*, closely followed by *Being Determined by Others* and *Withdrawing*. Compared to the non-ERR group, ERR patients were significantly more likely to endorse RSs classified as Being Self-Determined ($d = 0.82$), Dissatisfied/Scared ($d = 0.89$) and Rejecting ($d = 0.92$) (see Table IV).

Valence. The ERR group displayed significantly lower (i.e., more positive) mean RS valence (M = 2.81, $SD = .19$) compared to their non-ERR counterparts (M = 3.04, $SD = .27$; $t(17) = -2.125$, $p = .049$, $d = 0.97$).

Pervasiveness of CCRT components. Pervasiveness of Wish, Response of Other, or Response of Self components across relationship episodes did not significantly differ for the ERR versus non-ERR groups.

Discussion

The aim of the current study was to investigate relationship patterns of depressed patients with personality disorders who experienced an early and rapid response (ERR) to treatment compared to their non-ERR counterparts. Consistent with previous research, those with an early rapid response improved on BDI both at termination and over the full 12-month follow-up compared to those without a rapid response (Table I). Results indicate that both ERR and non-ERR groups displayed similar relationship wishes, yet differed in their perceptions of how others respond to them, and their own subsequent responses.

With regard to the wish component of the CCRT (Core Conflictual Relationship Theme), the most commonly endorsed wish for both ERR and non-ERR patients was for a relationship characterized by love, closeness, and feeling good (refer to Figure 1 and Table II). Compared to EER patients, CCRT valence data indicate that Wish satisfaction was significantly lower for the non-ERR, both in terms of the Response of Other (RO) and Response of Self (RS).

The non-ERR patients were also more likely to perceive others as unreliable and aggressive, and less supportive (see Figure 2 and Table III). In turn, the typical response of non-ERR patients to interpersonal interactions involved less feelings of being loved/loving and self-determined (i.e., in control, confident) than the ERR group (see Figure 3 and Table IV).

These findings support the hypotheses of the current study: Compared to the ERR group, non-ERR patients exhibited a more negative central relationship pattern. In other words, they

Table IV. Response of Self (RS) cluster profiles for early rapid response (ERR) versus non-ERR patients.

Supercluster	Cluster	ERR ($n = 10$) Mean % (*SD*)	Non-ERR ($n = 9$) Mean % (*SD*)	*t*	*p*	*d*
Loving	Attending	4.6 (5.6)	3.2 (4.5)	37.50[a]	0.53	0.28
	Supporting	2.1 (3.0)	0.4 (0.8)	33.00[a]	0.24	0.77
	Loving/Feeling Well	15.1 (7.7)	10.3 (9.2)	1.23	0.23	0.57
Strong	Self-Determined	8.6 (8.6)	2.9 (4.7)	20.00[a]	0.036*	0.82
Weak	Depressed/Resigning	7.7 (6.1)	12.0 (7.4)	−1.39	0.18	0.63
	Dissatisfied/Scared	24.0 (14.4)	12.4 (11.5)	1.93	0.07*	0.89
	Determined by Others	11.4 (7.0)	17.0 (10.4)	−1.40	0.18	0.63
Unpleasant	Angry/Unlikeable	11.8 (9.8)	19.0 (15.9)	33.50[a]	0.35	0.55
	Unreliable	1.3 (3.0)	0 (0)	36.00[a]	0.17	0.61
	Rejecting	2.8 (3.2)	0.5 (1.5)	24.00[a]	0.048*	0.92
Fighting	Dominating	0 (0)	0.4 (1.2)	40.00[a]	0.29	0.47
	Annoying/Attacking	1.1 (3.4)	5.3 (9.2)	29.50[a]	0.10	0.61
Leaving	Withdrawing	9.7 (5.7)	16.5 (12.7)	−1.55	0.14	0.69

[a]Mann-Whitney *U* test statistic.
*$p \leq 0.10$.
**$p \leq 0.01$.
***$p \leq .001$.

commenced therapy with a mental blueprint of relationships characterized by a lower expectation that interpersonal interactions provide what they intend or wish. We propose that this underlying relationship pattern impaired the capacity for non-ERR patients to rapidly engage and benefit from the therapeutic relationship, thus contributing to their lack of an early response. Importantly, in line with psychoanalytic thinking regarding unconscious processes, this may occur despite the conscious perception of a positive working alliance (Greenson, 1965). This points to the benefit of deriving a greater understanding, through further research and during clinical practice, of patients' unconscious or implicit relationship patterns and how they may influence the formation of the therapeutic alliance. For example, in the present study, patients who did not improve were struggling with a response of other theme of feeling unsupported, weak, and that others were unreliable. This points to possible parallels with their experience of the relationship with the therapist and helps to elucidate the challenges they were having in being able to benefit from treatment.

The *Self-Determined* cluster comprises themes of autonomy and self-control and there was a low endorsement of RSs within this cluster by the non-ERR group in the present study. This finding converges with Comninos and Grenyer's (2007) finding of lower interpersonal mastery in non-ERR patients, compared to early responders (i.e., the original study from which participants in the present study were drawn). Increases in positive RS categories parallel increases in interpersonal mastery and the reduction of symptoms over the course of psychotherapy (Grenyer & Luborsky, 1996).

Comninos and Grenyer (2007) also reported a more domineering personality style in non-ERR versus ERR patients. This was indicative of problems relating to "controlling, manipulating, being aggressive toward, and trying to change others" (Alden, Wiggins, & Pincus, 1990). These behaviours largely correspond to the CCRT-LU *Fighting* supercluster. In the current study, non-ERR patients endorsed more ROs from the *Fighting* supercluster compared to ERR patients (refer to Figure 2) indicating that they perceive others to act in a domineering manner towards them. These results suggest that, compared to ERR patients, non-ERR patients may be more susceptible to power-struggles—a factor that would be expected to inhibit therapeutic gains (Muran, Segal, Samstag, & Crawford, 1994). Indeed, several studies reported high domineering style to predict lower therapeutic alliance during treatment (Connolly Gibbons et al., 2003; Renner et al., 2012).

Non-ERR patients in the study by Comninos and Grenyer (2007) also displayed greater fear of intimacy and interpersonal withdrawal. We had therefore expected to see greater endorsement by non-ERR patients of self-responses (RSs) classified as *Leaving/Withdrawing*, which comprises behaviours such as retreating, being distrustful, and being closed. Whilst this tendency was evident, we did not have the power to substantiate this trend (refer to Figure 3 and Table IV).

Some of the variation in relationship patterns of ERR and non-ERR patients may indicate differing rates of relationship "success," as opposed to marked variation in relationship style. That is, ERR patients were more likely to experience relationships in which their wish was satisfied; however when this

did not occur, they displayed a pattern of negative responses of both other and self (ROs and RSs) similar to the non-ERR group. Thus in negative relationship experiences, both groups most commonly endorsed ROs within the *Unpleasant* supercluster (others are unreliable, rejecting) and RSs within the *Weak* supercluster (includes feeling depressed, scared, and/or incapable).

There were, however, some discrepancies in style that emerged in the context of negative relationship experiences. While RSs for both groups were predominantly classified as *Weak,* they differed in their endorsement of clusters within this supercluster (see Table IV). Compared to their slower counterparts (non-ERR group), rapid responders (ERR patients) showed higher endorsement of the *Dissatisfied/Scared* cluster, comprising feelings such as anxiety, frustration, and guilt. In contrast, the non-ERR patients primarily endorsed *Determined by Others*, which includes themes of being helpless, subjected, and dependent. ERR patients also endorsed ROs within the *Weak* supercluster significantly more than non-ERR patients. One interpretation of these results is possible differences in perceived locus of control, with ERR patients focusing on being self-determined, while non-ERR patients perceive control of their wishes to be in the hands of the other. Activating agency in patients is one of the core principles of successful psychotherapy for people with personality disorder (Bateman, Gunderson, & Mulder, 2015).

These findings are clinically relevant in highlighting the importance of therapists striving to understand how past relationship patterns influence the perception and vicissitudes of the therapeutic relationship. There has been a long history of clinical work and research seeking to understand the activation of core relational themes including attachment (Shedler, 2010), and they have been shown to be both clinically relevant (Grenyer, 2012) and powerful in relation to predicting outcomes (e.g. Levy et al., 2018). These findings are particularly salient in that all patients had personality disorder, meaning the core relational themes were active and long-standing, thus differences between the groups are of particular interest.

Limitations and Future Research Directions

The limitations of the current study must be acknowledged. Firstly, the small sample size provided limited statistical power in detecting between group differences. As acknowledged, CCRT data was derived from narratives related within a single therapy session. The possibility that data may be skewed by session-specific themes exists. Additionally, adherence to supportive-expressive psychodynamic psychotherapy was monitored by only one clinical psychologist. Future research studies may overcome these limitations through replicating and extending the current findings using methods to collect narratives across multiple sessions. Additionally, although scoring of the CCRT-LU components showed adequate interrater agreement, the values were lower than those in the CCRT-LU method validation study (Albani et al., 2002), perhaps reflecting the relative inexperience of the scorers (BH and MG, both doctoral level clinical psychologists working within a university laboratory with a psychodynamic research framework).

These findings relate to depressed personality disorder patients, and future studies may wish to investigate relationship patterns and early treatment responses across other diagnostic groups and treatment formats. In addition to the role of patients' relationship patterns, the influence of therapist factors in the psychotherapy process must also be acknowledged (e.g., Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012), particularly with regard to the interpersonal challenges, and emotional and cognitive responses experienced by therapists providing psychotherapy for patients with personality disorders (Bourke & Grenyer, 2010, 2013, 2017). The "interpersonal dance" of psychotherapy involves not only patients' relationship narratives but also those of their therapists, and the dynamic interaction between both partners (Tishby & Wiseman, 2014; Wiseman, 2017; Wiseman & Tishby, 2017). A fuller understanding of the link between early treatment response and relationship patterns may be garnered through future studies that explore both patient and therapist relationship narratives, and their interaction.

Future studies may wish to explore additional variables that may distinguish ERR and non-ERR patients. In the current study, these groups were carefully matched in terms of demographic characteristics. Findings indicate differences in relationship style (as assessed through CCRT profile); interpersonal phenomena observed at the level of clinical description. Additional patient (and therapist) characteristics may be associated with these differences. Further investigation, particularly through collecting data more broadly from different levels of analysis (e.g., self-report, neuropsychological, neuroimaging), may enhance understanding of factors associated with and also underlying relationship style (e.g., see Wade-Bohleber et al., 2019, for an investigation of neural correlates during the recall of relationship episodes). This converges with recent research addressing the clinical heterogeneity of

depression through identifying neurobiological substrates of distinct subtypes and corresponding differential treatment response (Drysdale et al., 2017).

A further consideration in interpreting the current findings concerns the complexity encountered not only in presentation but also in the course of depression (Richards, 2011; Steinert, Hofmann, Kruse, & Leichsenring, 2014). Future longitudinal studies could focus on the role of nuanced trajectories of remission and recurrence in depression (for an example investigating heterogeneity in the course of alcohol use disorder see: Maisto, Hallgren, Roos, & Witkiewitz, 2018). The findings of the present study also point toward the need for further empirical elucidation of the mechanisms of psychotherapy for depression, though this is a formidable challenge (Lemmens, Müller, Arntz, & Huibers, 2016). A significant difficulty in this respect involves the fact that most often change does not occur in a linear fashion over time; but rather suddenly, in discrete moments (Lemmens et al., 2016). A further perspective in characterizing the mechanisms of psychotherapy concerns recent contributions from the clinical neurosciences in investigating neurobiological changes associated with psychotherapy and neurobiological markers that may predict treatment response (e.g., Jiménez et al., 2018; Marceau, Meuldijk, Townsend, Solowij, & Grenyer, 2018). Rather than promoting a reductionist biological approach, incorporating neurobiological data in psychotherapy process-outcome research has the potential to elucidate mechanisms of change in a more nuanced fashion, as has been done with CCRTs (Loughead et al., 2010). Though applying neuroimaging methods to the study of interpersonal processes is a formidable challenge, it also has the potential to illuminate the essential relational mode of the human brain (Hari, Henriksson, Malinen, & Parkkonen, 2015). Further exploration of these processes as they apply to the relational aspects of psychotherapy may help to characterize mechanisms of change (e.g., Benelli et al., 2012; Mergenthaler, 2008).

Conclusions

In the current study, patients experiencing an early treatment response to psychodynamic therapy displayed more positive CCRT profiles compared to their counterparts with slower response trajectories. These results support the notion that relationship patterns pervasively influence patients' ability to benefit from the therapeutic relationship, even when therapeutic alliance is consciously perceived as adequate. Clearly relationship patterns that have become chronic and ongoing personality patterns will benefit from additional attention by the therapist on seeking to resolve negative relationship conflicts and enhancing therapeutic trust. Given the links between early treatment response and improved treatment outcomes, further research into the nuances of relationship patterns and prediction of psychotherapy outcomes may enhance personalized treatment selection and individual tailoring of interventions.

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References

Aderka, I. M., Nickerson, A., Bøe, H. J., & Hofmann, S. G. (2012). Sudden gains during psychological treatments of anxiety and depression: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *80*(1), 93–101. doi:10.1037/a0026455

Ainsworth, M. D. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist*, *46*, 333–341. doi:10.1037/0003-066X.46.4.333

Albani, C., Pokorny, D., Blaser, G., & Gruninger, S. (2002). Reformulation of the core conflictual relationship theme (CCRT) categories: The CCRT-LU category system. *Psychotherapy Research*, *12*(3), 319–338. doi:10.1093/ptr/12.3.319

Albani, C., Pokorny, D., Blaser, G., König, S., & Thomä, H. (2003). Study of a psychoanalytic process using the core conflictual relationship theme (CCRT) method according to the Ulm process model. *European Psychotherapy*, *4*(1), 11–32.

Alden, L. E., Wiggins, J. S., & Pincus, A. L. (1990). Construction of circumplex scales for the inventory of interpersonal problems. *Journal of Personality Assessment*, *55*(3-4), 521–536. doi:10.1080/00223891.1990.9674088

Andrusyna, T. P., Luborsky, L., Pham, T., & Tang, T. Z. (2006). The mechanisms of sudden gains in supportive–expressive therapy for depression. *Psychotherapy Research*, *16*(5), 526–536. doi:10.1080/10503300600591379

Bateman, A. W., Gunderson, J., & Mulder, R. (2015). Treatment of personality disorder. *The Lancet*, *385*(9969), 735–743. doi:10.1016/S0140-6736(14)61394-5

Beckham, E. E. (1989). Improvement after evaluation in psychotherapy of depression: Evidence of a placebo effect? *Journal of Clinical Psychology*, *45*(6), 945–950.

Benelli, E., Mergenthaler, E., Walter, S., Messina, I., Sambin, M., Buchheim, A., … Viviani, R. (2012). Emotional and cognitive processing of narratives and individual appraisal styles: Recruitment of cognitive control networks vs modulation of deactivations. *Frontiers in Human Neuroscience*, *6*, Article 239. doi:10.3389/fnhum.2012.00239

Bourke, M. E., & Grenyer, B. F. S. (2010). Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis. *Psychotherapy Research*, *20*(6), 680–691. doi:10.1080/10503307.2010.504242

Bourke, M. E., & Grenyer, B. F. S. (2013). Therapists' accounts of psychotherapy process associated with treating patients with borderline personality disorder. *Journal of Personality Disorders*, *27*(6), 735–745. doi:10.1521/pedi_2013_27_108

Bourke, M. E., & Grenyer, B. F. S. (2017). Therapists' metacognitive monitoring of the psychotherapeutic process with patients with borderline personality disorder. *Journal of Psychiatric Practice*, *23*(4), 246–253. doi:10.1097/PRA.0000000000000247

Cierpka, M., Strack, M., Benninghoven, D., Staats, H., Dahlbender, R., Pokorny, D., … Albani, C. (1998). Stereotypical relationship patterns and psychopathology. *Psychotherapy and Psychosomatics*, *67*(4-5), 241–248.

Cohen, Z. D., & DeRubeis, R. J. (2018). Treatment selection in depression. *Annual Review of Clinical Psychology*, *14*, 209–236. doi:10.1146/annurev-clinpsy-050817-084746

Comninos, A., & Grenyer, B. F. S. (2007). The influence of interpersonal factors on the speed of recovery from major depression. *Psychotherapy Research*, *17*(2), 230–239. doi:10.1080/10503300600849140

Connolly, M. B., Crits-Christoph, P., Barber, J. P., & Luborsky, L. (2000). Transference patterns in the therapeutic relationship in supportive-expressive psychotherapy for depression. *Psychotherapy Research*, *10*(3), 356–372. doi:10.1093/ptr/10.3.356

Connolly Gibbons, M. B., Crits-Christoph, P., de la Cruz, C., Barber, J. P., Siqueland, L., & Gladis, M. (2003). Pretreatment expectations, interpersonal functioning, and symptoms in the prediction of the therapeutic alliance across supportive-expressive psychotherapy and cognitive therapy. *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, *13*(1), 59–76. doi:10.1093/ptr/kpg007

Crits-Christoph, P., Connolly, M. B., Gallop, R., Barber, J. P., Tu, X., Gladis, M., & Siqueland, L. (2001). Early improvement during manual-guided cognitive and dynamic psychotherapies predicts 16-week remission status. *The Journal of Psychotherapy Practice and Research*, *10*(3), 145–154.

Crits-Christoph, P., Demorest, A., Muenz, L. R., & Baranackie, K. (1994). Consistency of interpersonal themes for patients in psychotherapy. *Journal of Personality*, *62*(4), 499–526.

Del Re, A. C., Flückiger, C., Horvath, A. O., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance–outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review*, *32*(7), 642–649. doi:10.1016/j.cpr.2012.07.002

Drapeau, M., & Perry, J. C. (2004). Interpersonal conflicts in borderline personality disorder: An exploratory study using the CCRT-LU. *Swiss Journal of Psychology*, *63*(1), 53–57. doi:10.1024/1421-0185.63.1.53

Driessen, E., Hegelmaier, L. M., Abbass, A. A., Barber, J. P., Dekker, J. J., Van, H. L., … Cuijpers, P. (2015). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis update. *Clinical Psychology Review*, *42*, 1–15. doi:10.1016/j.cpr.2015.07.004

Drysdale, A. T., Meng, Y., Fetcho, R. N., Dubin, M. J., Liston, C., Gunning, F. M., … Casey, B. J. (2017). Resting-state connectivity biomarkers define neurophysiological subtypes of depression. *Nature Medicine*, *23*(1), 28–38. doi:10.1038/nm.4246

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1997). *Structured clinical interview for DSM-IV Axis I and Axis II disorders*. Washington, DC: American Psychiatric Press.

Freud, S. (1912/1958). The dynamics of transference. In J. Strachey (Ed,), *Standard edition of the complete psychological works of sigmund freud* (Vol. 12, pp. 97–108). London: Hogarth Press and The Institute of Psycho-Analysis.

Greenson, R. R. (1965). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly*, *34*(2), 155–181. doi:10.1080/21674086.1965.11926343

Grenyer, B. F. S. (2002). *Mastering relationship conflicts: Discoveries in theory, research and practice*. Washington, DC: American Psychological Association Books.

Grenyer, B. F. S. (2012). The clinician's dilemma: Core conflictual relationship themes in personality disorders. *ACPARIAN*, *4*, 25–27.

Grenyer, B. F. S. (2018). Revising the diagnosis of personality disorder: Can it be single, clinical and factorial? *Australian and New Zealand Journal of Psychiatry*, *52*(2), 202–203. doi:10.1177/0004867417741984. Epub 2017 Nov 16

Grenyer, B. F., & Luborsky, L. (1996). Dynamic change in psychotherapy: Mastery of interpersonal conflicts. *Journal of Consulting and Clinical Psychology*, *64*(2), 411–416.

Grenyer, B. F. S., & Luborsky, L. (1998). Positive versus negative CCRT patterns. In *Understanding transference. The core conflictual relationship theme method* (pp. 55–63). Washington, DC: American Psychological Association.

Haas, E., Hill, R. D., Lambert, M. J., & Morrell, B. (2002). Do early responders to psychotherapy maintain treatment gains? *Journal of Clinical Psychology*, *58*(9), 1157–1172. doi:10.1002/jclp.10044

Hardy, G. E., Cahill, J., Stiles, W. B., Ispan, C., Macaskill, N., & Barkham, M. (2005). Sudden gains in cognitive therapy for depression: A replication and extension. *Journal of Consulting and Clinical Psychology*, *73*(1), 59–67. doi:10.1037/0022-006X.73.1.59

Hari, R., Henriksson, L., Malinen, S., & Parkkonen, L. (2015). Centrality of social interaction in human brain function. *Neuron*, *88*, 181–193. doi:10.1016/j.neuron.2015.09.022

Hayes, A. M., Feldman, G. C., Beevers, C. G., Laurenceau, J.-P., Cardaciotto, L., & Lewis-Smith, J. (2007). Discontinuities and cognitive changes in an exposure-based cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, *75*(3), 409–421. doi:10.1037/0022-006X.75.3.409

Ilardi, S. S., & Craighead, W. E. (1994). The role of nonspecific factors in cognitive-behavior therapy for depression. *Clinical Psychology: Science and Practice*, doi:10.1111/j.1468-2850.1994.tb00016.x/full

Ilardi, S. S., & Craighead, W. E. (1999). Rapid early response, cognitive modification, and nonspecific factors in cognitive behavior therapy for depression: A reply to Tang and DeRubeis. *Clinical Psychology: Science and Practice*, doi:10.1093/clipsy.6.3.295/full

Jiménez, J. P., Botto, A., Herrera, L., Leighton, C., Rossi, J. L., Quevedo, Y., … Luyten, P. (2018). Psychotherapy and genetic neuroscience: An emerging dialog. *Frontiers in Genetics*, *9*, Article 257. doi:10.3389/fgene.2018.00257

Kelly, M. A. R., Roberts, J. E., & Ciesla, J. A. (2005). Sudden gains in cognitive behavioral treatment for depression: When do they occur and do they matter? *Behaviour Research and Therapy*, *43*(6), 703–714. doi:10.1016/j.brat.2004.06.002

Lambert, M. J. (2013). *Bergin and Garfield's handbook of psychotherapy and behavior change*. Hoboken, New Jersey: John Wiley & Sons, Incorporated.

Lemmens, L. H. J. M., Müller, V. N. L. S., Arntz, A., & Huibers, M. J. H. (2016). Mechanisms of change in psychotherapy for depression: An empirical update and evaluation of research

aimed at identifying psychological mediators. *Clinical Psychology Review*, *50*, 95–107. doi:10.1016/j.cpr.2016.09.004

Lenzenweger, M. F., Lane, M. C., Loranger, A. W., & Kessler, R. C. (2007). DSM-IV Personality disorders in the national comorbidity survey replication. *Biological Psychiatry*, *62*(6), 553–564. doi:10.1016/j.biopsych.2006.09.019

Levy, K. N., Kivity, Y., Johnson, B. N., & Gooch, C. V. (2018). Adult attachment as a predictor and moderator of psychotherapy outcome: A meta-analysis. *Journal of Clinical Psychology*, *74*(11), 1996–2013. doi:10.1002/jclp.22685

Loughead, J. W., Luborsky, L., Weingarten, C. P., Krause, E. D., German, R. E., Kirk, D., & Gur, R. C. (2010). Brain activation during autobiographical relationship episode narratives: A core conflictual relationship theme approach. *Psychotherapy Research*, *20*(3), 321–336. doi:10.1080/10503300903470735

Luborsky, L. (1998). The early life of the idea for the core conflictual relationship theme method. In *Understanding transference. The core conflictual relationship Theme method* (pp. 3–13). Washington, DC: American Psychological Association.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference. The core conflictual relationship theme method*. Washington, DC: American Psychological Association.

Luborsky, L., Mark, D., Hole, A. V., Popp, C. A., Goldsmith, B., & Cacciola, J. (1995). Supportive-expressive dynamic psychotherapy for depression: Axis I. In J. P. Barber, & P. Crits-Christoph (Eds.), *Dynamic therapies for psychiatric disorders: Axis I* (pp. 13–42). New York: Basic Books.

Maisto, S. A., Hallgren, K. A., Roos, C. R., & Witkiewitz, K. (2018). Course of remission from and relapse to heavy drinking following outpatient treatment of alcohol use disorder. *Drug And Alcohol Dependence*, *187*, 319–326. doi:10.1016/j.drugalcdep.2018.03.011

Marceau, E. M., Meuldijk, D., Townsend, M. L., Solowij, N., & Grenyer, B. F. S. (2018). Biomarker correlates of psychotherapy outcomes in borderline personality disorder: A systematic review. *Neuroscience and Biobehavioral Reviews*, *94*, 166–178. doi:10.1016/j.neubiorev.2018.09.001

McCarthy, K. L., Caputi, P., & Grenyer, B. F. S. (2017). Significant change events in psychodynamic psychotherapy: Is cognition or emotion more important? *Psychology & Psychotherapy: Theory, Research & Practice*, *90*(3), 377–388. doi:10.1111/papt.12116

McCarthy, K. L., Mergenthaler, E., & Grenyer, B. F. S. (2014). Early in-session cognitive-emotional problem-solving predicts 12-month outcomes in depression with personality disorder. *Psychotherapy Research*, *24*(1), 103–115. doi:10.1080/10503307.2013.826834

Mergenthaler, E. (2008). Resonating minds: A school-independent theoretical conception and its empirical application to psychotherapeutic processes. *Psychotherapy Research*, *18*(2), 109–126. doi:10.1080/10503300701883741

Muran, J. C., Segal, Z. V., Samstag, L. W., & Crawford, C. E. (1994). Patient pretreatment interpersonal problems and therapeutic alliance in short-term cognitive therapy. *Journal of Consulting and Clinical Psychology*, *62*(1), 185–190.

Newton-Howes, G., Tyrer, P., Johnson, T., Mulder, R., Kool, S., Dekker, J., & Schoevers, R. (2014). Influence of personality on the outcome of treatment in depression: Systematic review and meta-analysis. *Journal of Personality Disorders*, *28*(4), 577–593. doi:10.1521/pedi_2013_27_070

Renaud, J., Brent, D. A., Baugher, M., Birmaher, B., Kolko, D. J., & Bridge, J. (1998). Rapid response to psychosocial treatment for adolescent depression: A two-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*(11), 1184–1190. doi:10.1097/00004583-199811000-00019

Renner, F., Jarrett, R. B., Vittengl, J. R., Barrett, M. S., Clark, L. A., & Thase, M. E. (2012). Interpersonal problems as predictors of therapeutic alliance and symptom improvement in cognitive therapy for depression. *Journal of Affective Disorders*, *138*(3), 458–467. doi:10.1016/j.jad.2011.12.044

Richards, D. (2011). Prevalence and clinical course of depression: A review. *Clinical Psychology Review*, *31*(7), 1117–1125. doi:10.1016/j.cpr.2011.07.004

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, *65*(2), 98–109. doi:10.1037/a0018378

Steinert, C., Hofmann, M., Kruse, J., & Leichsenring, F. (2014). The prospective long-term course of adult depression in general practice and the community. A systematic literature review. *Journal of Affective Disorders*, *152-154*, 65–75. doi:10.1016/j.jad.2013.10.017.

Tang, T. Z., & DeRubeis, R. J. (1999). Sudden gains and critical sessions in cognitive-behavioral therapy for depression. *Journal of Consulting and Clinical Psychology*, *67*(6), 894–904.

Tang, T. Z., DeRubeis, R. J., Beberman, R., & Pham, T. (2005). Cognitive changes, critical sessions, and sudden gains in cognitive-behavioral therapy for depression. *Journal of Consulting and Clinical Psychology*, *73*(1), 168–172. doi:10.1037/0022-006X.73.1.168

Tishby, O., & Wiseman, H. (2014). Types of countertransference dynamics: An exploration of their impact on the client-therapist relationship. *Psychotherapy Research*, *24*(3), 360–375. doi:10.1080/10503307.2014.893068

Vittengl, J. R., Clark, L. A., & Jarrett, R. B. (2005). Validity of sudden gains in acute phase treatment of depression. *Journal of Consulting and Clinical Psychology*, *73*(1), 173–182. doi:10.1037/0022-006X.73.1.173

Wade-Bohleber, L. M., Boeker, H., Ernst, J., Grimm, S., Brügger, N., Berwian, I. M., … Richter, A. (2019). Thinking about the past to shape the present: Neural activation during the recall of relationship episodes. *Behavioural Brain Research*, *359*, 783–791. doi:10.1016/j.bbr.2018.08.001

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277. doi:10.1002/wps.20238

Wiseman, H. (2017). The quest for connection in interpersonal and therapeutic relationships. *Psychotherapy Research*, *27*(4), 469–487. doi:10.1080/10503307.2015.1119327

Wiseman, H., & Tishby, O. (2017). Applying relationship anecdotes paradigm interviews to study client–therapist relationship narratives: Core conflictual relationship theme analyses. *Psychotherapy Research*, *27*(3), 283–299. doi:10.1080/10503307.2016.1271958

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2006). *Schema therapy*. New York: Guilford Press.